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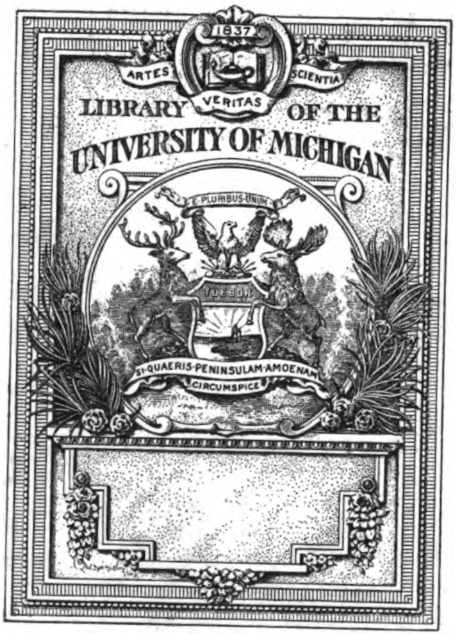

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JAN. 1, 1908. No. 1.

NOTES AND COMMENTS.

A Happy New Year.

THE MEDICAL PRESS AND CIRCULAR cannot omit the duty, even if it wished to deny itself the pleasure, of wishing its increasing circle of readers a Happy New Year. It is unfortunate that in the public mind prosperity of the medical profession connotes a corresponding amount of illness among their patients. Such a fallacy is comparable only to that which assumes that because foreign countries are growing more prosperous Great Britain must be correspondingly poorer. Much illness may mean long doctors' bills, but it does not mean that they are paid, and more than a certain amount of illness means that the community is too much impoverished to support a well-to-do medical profession. *Per contra*, when there is general affluence and money is not "tight," patients more willingly resort to their medical advisers in the early stages of illness and for slight ailments, and not only are they saved much serious trouble thereby, but they are in a position to pay adequate fees, and to pay promptly. The depression resulting from the huge borrowings for the South African war, and from other causes, was felt by medical men in their practices as much as by wine merchants and stockbrokers, and we are, therefore, wishing the community no ill, but, rather, every blessing, when we express the hope that this year may be one of pleasure and profit to medical men.

Gaps in the Ranks.

THE year that is passed has been peculiarly prolific in the deaths of well-known members of the profession; some full of years and honours, others still bearing the burden in the heat of the day. Perhaps the greatest individual loss was that of Sir Michael Foster, who, though he had not practised medicine for many years, was only just below the rank of Darwin, Huxley, and Lyall in his scientific eminence, public reputation, and influence. But close on his heels followed Sir William Broadbent, who never spared his private interests where the weight so rightly attached to his name would be of service to the public. Then we have the great names of a former generation, Dr. Robert Barnes, the best known of [illegible], Mr. Timothy Holmes, as stern and [illegible] in the pursuit of duty as in the conduct [illegible]tion, and Sir Joseph Fayrer, who, as [illegible] Surgeon at Lucknow in the Mutiny, had [illegible] on his death-bed, and heard the pipes bray "The Campbells are Coming" in the nick of time. Dr. Sansom belonged to the last generation and our own, and the same may be said of Dr. W. H. Ransom, who graduated in 1850 and was F.R.S. for nearly forty years. The last fortnight of the year saw two great men pass away in Edinburgh, Professor Annandale and Sir Patrick Heron Watson, both of whom served the Modern Athens faithfully, well, and with distinction.

Other Losses.

GLASGOW lost a great figure and a rare personality in Sir William Gairdner; Manchester, a well-known teacher in Dr. Julius Dreshfeld; Dublin, an eminent surgeon in Mr. E. H. Bennett; Bristol, a leading physician in Dr. Markham Skerritt; Canada, a great man in Sir William Hingston; Paris, its best-known practitioner in the Hon. Alan. Herbert; Brighton, a generous ophthalmologist in Mr. C. J. Oldham; Norwich, a scholarly surgeon in Mr. C. W. Williams; Leeds, a popular figure in Mr. W. H. Brown; Belfast, the doyen of the local profession in Dr. Henry Murney; London, two conscientious workers in Dr. Montague Murray and Mr. Woodhouse Braine; and medical journalism, a well-known figure in Mr. T. H. Wakley. Of them and all others who have fallen by the way we can heartily say, *Requiescant in pace*!

Medical Inspection.

THE most important legislative Act as touching the medical profession, has been the establishment of medical inspection in schools as a compulsory duty on the part of education authorities. The principle of this Act has been warmly supported by medical men; indeed, it may be said to have originated and to have been carried through chiefly by them and their influence. The power for good in this measure is enormous, and we warmly welcome it. At the same time it is beset with pitfalls, and we make no apology for repeating what we have said several times already, that if the new duty is not properly understood and tactfully carried out, we may have all the old disgraceful scenes of the anti-vaccination movement re-enacted. Like the compulsory Elementary Education Act of thirty years ago, no one can say where it may lead to. It is obvious that if children are found with physical defects which are duly reported to the parents, and the latter neglect to have their children attended to, there will be indignation and outcry if any further steps are proposed. With many parents ignorant, many careless, and many prejudiced against the medical profession, difficulties are sure to arise, and these can only be kept within proper bounds by the most careful statesmanship, for there will not be wanting inflammatory agitators and demagogues to fan the flames amongst those persons who care more for political warfare than for the health of children.

Notification of Births.

WHATEVER difficulties there may be ahead with regard to the medical inspection of children in schools, there is no doubt that troublous times are ahead for those local authorities which adopt the Notification of Births Act. To the principle of that Act the profession have no objection; indeed again, it is greatly through their influence that it was brought to the front. That ignorant mothers may have the benefit of the instruction, help, and advice of a lady visitor of proper qualifications, where no medical man is in attendance, is likely to be of value in saving children's lives, but it is monstrous that any part of the duty of notifying such births should be laid on a medical man's shoulders. We leave aside the question of a fee altogether, and say it is an outrage on the liberty of the subject, the sanctity of professional confidence, and the traditions of Hippocrates which the profession respects, that medical men should be made by the State to play the spy on their patients. It wishes to do nothing of the kind, and if in spite of representations made to authorities they still adopt the Act, a policy of passive resistance is only to be anticipated. Medical men are not detectives, and they wish to pry on those who trust them less than on anyone. Moreover, the medical men are perfectly capable of instructing their patients in the rearing of children without the help of "health visitors" or sanitary inspectors. The duty of notification is a civil one which should devolve upon the parents, and them alone.

LEADING ARTICLES.

THE *STAR* AND THE MEDICAL PROFESSION.

THERE is a certain type of croaker existing in this world who regards all attempts at improving the status or repute of the medical profession as a hopeless task, or, at any rate, a task worth undertaking. We strongly disagree with that view. If it had not been for pessimists of the kind, medicine would probably be in a very different position from that which it occupies to-day. The old policy of allowing any street urchin to fling mud at medicine while medical men walked on with affected unconcern, has certainly not paid; its result has simply been that *every* street urchin knows he can fling mud with impunity, and a great many very decent and philanthropic persons believe doctors to be very dirty people because they see them continually bespattered. We have on several occasions of late replied directly to such attacks, and we have reason to know in some cases that a desirable effect has been produced. We believe in criticism ourselves, but we believe in fair and decent criticism. Nor is a little fun out of place, but fun should be used to show up an abuse or to correct a monstrosity. Merely to sneer at the inherent disabilities of a calling is as generous and as facetious as it is to sneer at a deaf boy at school or to trip up a man because he happens to be blind. We recently charged the *Star* with being "perhaps the most persistent reviler of medicine . . . that we have to contend with," and we spoke about the harm done to the poor by its maintaining that attitude. The *Star* has replied to that charge in a long leader, in which it contends that its attitude is not one of hostility to medicine, but only to vaccination and vivisection, and it expresses a wish that THE MEDICAL PRESS AND CIRCULAR would endeavour to see the point of view of the anti-vaccinator and the anti-vivisectionist, for, by making the case for medicine stand or fall by these practices, it is doing medicine a grave injury. We see, more clearly we fancy than our contemporary, the point of view of the classes indicated. But it is necessary to distinguish between the scientific and the political aspects of these questions, if a reply is to be made. To take vaccination first. The *Star* characterises this practice as a "disgusting cult," which we take to be a refined and polished method of intimating that vaccination is not a valuable protective measure against small-pox, but a kind of superstitious rite. If we are wrong in that supposition we are open to correction. It is impossible for any intelligent man who has studied the question to deny the protective influence of vaccination; it is as little open to question as the movement of the earth round the sun or the law of gravitation. The opposition to vaccination originated in certain ill-effects of the operation, mostly due to the entrance of pyogenic organisms through the wound in neglected children, and this opposition has been fanned by fanatical agitators for all it is worth. Any paper which kow-tows to those who deny the efficacy of vaccination to protect against small-pox lays itself open to a charge of ignorance on the one hand, or of a desire to tickle the ears of the ignorant on the other. If we turn to the political side of the question, there is not the slightest reason why a journal as an organ of opinion should not argue that compulsory primary vaccination is not the best means of protecting from small-pox a community containing many such agitators. That is a political question and an open one, and so long as fair argument is used nothing but respect to its supporters would be accorded by those who think otherwise. It is not fair argument, and it is a very silly argument, to assert, as the *Star* does in its article, that medical men support vaccination because of the fees it brings them. It is not fair, because vaccination does not bring the average practitioner a five-pound note a year, and small-pox used to bring him a great many score; it is silly because the only men who make any considerable income out of vaccination are the public vaccinators, and, human nature being what it is, to suppose that practitioners would support the giving of a privileged position and an assured source of income to a rival, for any other than a public motive, is to suppose a palpable absurdity. As to experiments on animals, the same considerations hold. The entire basis and progress of medicine since the dark ages of superstition are built on animal experimentation and the deductions based on it, and to impugn the value of such experiments is again the task of an ignoramus or an interested party. The moral question is apart. It is arguable, on moral grounds, that the lower animals were not given to man for his service; if so, a man who eats no meat or cheese, drinks no milk, wears no leather, drives behind no horse, accepts none of the benefits of medical science, opposes all field sports, and vigorously combats the castration of farm stock, may be considered honest when he opposes experiments on animals; but no other. To attribute cruelty where no cruelty exists, and to allege torture against men striving for the highest good of humanity, are cruel and cowardly acts. The Royal Commission whose sittings are now drawing to a close has offered every opportunity for any evidence of improper experiment by English researchers to be brought forward, and not a tittle has been forthcoming. But the *Star* and papers of its kind go far beyond opposition to vaccination and vivisection. They constantly insinuate that doctors "experiment" on patients in hospital, that unnecessary operations are performed, and that the most valuable remedies approved of by the profession are filthy and disgusting and useless; all, of course, without a shadow of evidence. It is an easy *rôle* to play, and when the public interest is dragged in as a motive, it seems plausible enough; but all medical men who work among the poor know the result is misery, and disease, and reliance on boomed and worthless panaceas till the period when judicious treatment might have saved is passed. There is a far greater and more potent tyranny than the tyranny of any law, and that is the tyranny of prejudice and ignorance; this tyranny the medical profession seeks to remove and the *Star* delights to foster.

WALKING AS AN EXERCISE.

MANY folk are inclined to exclude walking from the group of exercises associated in their minds with the word "athletics." To them the term in question means rowing, boxing, jumping, wrestling, riding, football, cricket, tennis, and a host of other sporting recreations—anything, in a word, but the first that mankind acquires at the outset of his brief sojourn upon the earth. Yet it may be questioned whether walking is not the most healthful, as it is certainly the most readily available and least costly of all forms of physical recreation. Carried to an excess, like most other sublunary things, it is likely, more or less, to defeat its own purposes. For instance, no one imagines that a postman's span of days is notably lengthened owing to the fact that he systematically covers a long distance every day of his working life while walking his rounds. As a rule, one associates the average postman with the conception of a spare, wholesome man, but certainly not with any great bodily development or with any special tendency towards longevity. It would be interesting, indeed, to have some statistics on this point, if such be forthcoming, either from St. Martin's-le-Grand or from Somerset House. So far as the man in the street is concerned, it is pretty certain that town dwellers are apt to ride in cab, car, omnibus, or railway-carriage, when it would be infinitely better for their health were they to walk. The chief object nowadays is to save time, and it is difficult or impossible for a busy man to find leisure for walking from point to point, when golden moments may be saved by resorting to the simpler methods of transit that are the main-spring of modern civilisation. Under such circumstances it is somewhat reassuring to note that a vast commercial centre like Manchester is able to support a flourishing pedestrian club. A thirty-mile walk was one of the prominent features in last season's programme, but that was put in the shade by a well-patronised jaunt from Birmingham to Bristol, a distance of some 203 miles, by way of the picturesque Wye Valley. Such clubs are well worth support throughout the kingdom. Even in the largest cities it is always feasible to fix the starting-point somewhere in the outskirts, so as to be clear of bricks and mortar from the outset. Walking is an exercise, that, from its nature, is adapted to all sexes and to all ages, so that young men and old may therein join together in a healthy, rational, and altogether innocent form of recreation. Twenty miles should be readily within the compass of every robust adult person as a reasonable day's march. Thirty miles is a full but not excessive limit for a strong man in good training, although forty miles is the traditional allowance fixed for him in the popular mind. From the medical point of view, walking as a regular exercise can hardly be too highly commended. Writers on longevity have again and again shown that persons attaining old age are almost invariably persons of active habits who have been given all their lives to walking rather than to riding. It may, indeed, be laid down as a primary principle of health that a healthy man ought, wherever possible, to walk some eight or ten miles daily. Not only is that form of bodily activity available for the strong and hearty, but it is also applicable, and sometimes beneficial, to the weakly and ailing. A patient suffering from some form of heart disease, for instance, may keep his circulatory apparatus in good order by systematic walking exercise, where he would be strictly debarred from all kinds of violent physical exertion. In giving advice of this kind, the medical profession is acting in its usual disinterested manner, for it is clear that the more healthy persons become as the result of walking the less will they require the services of medical men. It is to be hoped that the pedestrian clubs will come to the rescue before walking has become a lost art, and that they will be able to assert the rights of passenger locomotion on country roads which are at present seriously threatened by the ceaseless rush of the aggressive motor.

CURRENT TOPICS.

A Hospital without X-Rays.

NOWADAYS any general hospital not furnished with an X-ray installation may be regarded as much behind the times. There are many cases, both medical and surgical, in which a skiagraph examination is absolutely essential to the formation of a correct diagnosis, whereon the life of a patient obviously may hinge. The Guest Hospital, at Dudley, appears to be in the ill-equipped position in point, according to the evidence forthcoming at a recent inquest. A child of four swallowed a flat whistle the size of a halfpenny. A local medical man felt the foreign body in the throat, but was unable to remove it, and sent the child to the hospital mentioned. The senior house-surgeon failed to detect anything in the œsophagus, but the child gradually sank and died. He stated that no X-ray apparatus was in the hospital, and admitted that no attempt was made to procure a skiagraphic examination elsewhere. A post-mortem examination revealed the whistle impacted in the pyloric orifice of the stomach, and death was attributed to starvation. Most medical men will be inclined to agree with the Coroner that under the circumstances some more drastic step should have been taken to diagnose the exact state of affairs, especially in view of the precise medical information forthcoming in the first place as to the presence of a foreign body. Perhaps some philanthropic person may now be induced to supply an X-ray installation to the institution.

National Hysteria.

THOSE who maintain that the English national character is changing and becoming more like that proverbially associated with our neighbours across the Channel certainly have some argument on their side. It would seem, indeed, as if the English reputation for stolidity were bound to disappear, and though stolidity may not be an entirely lovable quality, it was more estimable than the excitability which is taking its place. It was during the Boer War that attention was in our time first directed markedly towards this apparently new trait in the English people, and it was then excused as only appearing at moments of relief from great strain. It is true, at any rate, that London was within a short time thoroughly ashamed of the way in which it celebrated the relief of Mafeking, and of some other scenes of similar kind. But on various occasions since then the populace of London has shown the same lack of sanity which characterised it during the war. In particular, the interest exhibited in sensational criminal trials is an unpleasant manifestation of public want of balance. The hysterical excitement surrounding the case known as the Camden Town murder is the latest example. In this case, a man of unattractive personality—to put it mildly—by his own lying and cowardice, finds himself arraigned on the capital charge. There is obviously lack of evidence against him, and the jury does its duty; the man comes out of Court a mob-hero. He is declared "a jolly good fellow," and narrowly escapes being chaired through the streets by a crowd of several thousands assembled to do him honour. His life appears in the weekly papers; he is engaged to give "shows" at music-halls; and for the nine days that elapse before he sinks into his native obscurity he is the hero of London. The whole incident is discreditable to the good sense of the community.

Election of a Hospital Matron.

There has been a very unnecessary fuss made in the Irish papers regarding the recent election of a matron at the Meath Hospital in Dublin. It appears that the successful candidate was elected by a very small majority of the committee. She had been trained at the hospital and had on many occasions acted as matron. The Meath Hospital is peculiar in being the County Infirmary of the County Dublin, and it therefore receives a grant from the County Council, three of whose members are appointed to the committee. Two of these gentlemen, being dissatisfied with the result of the election, reported in set terms to the County Council that the best qualified candidate had not been chosen, and the County Council, accepting their statement, passed a resolution of protest. The action of the County Council in accepting an *ex parte* statement, and acting on it, is injudicious in the highest degree, and injurious to the institution concerned. There is no suggestion that the members of the Hospital Committee acted otherwise than *bonâ fide* and within their legitimate discretion in their choice of a candidate, and, that being so, we can hardly see any justification for the protest of the County Council. It is not the first time, however, that certain members of that body have shown a hectoring disposition towards the management of the Meath Hospital, a disposition which hardly conduces to the efficient working of the Hospital.

The Health of Brass Casters.

The craft of the brass-casters is exercised by a far larger section of the labouring community than is generally recognised. Nor have the peculiar dangers to health incident to its exercise hitherto obtained a fair share of attention at the hands of sanitarians. Poisoning from that source is of a peculiar character, and includes the well-known form of spurious ague connected with the occupation. A serious effort is now being made to include the industry within the scope of industrial sanitary control. Some months ago the National Society of Brass-workers approached the Home Secretary on the point, and the result was the issuing of an order by the Home Office to the effect that, subject to public enquiry, the noxious fumes in brass-casting should be taken away at the point of origin, and that instead of cold water and basins to wash in, as now provided, there should be hot water, with towels, soap, and nail brushes. Opposition to this order has been offered by employers in Glasgow, Edinburgh, Wales, Ireland, and all parts of England, including London. It is interesting to learn, on the other hand, that, after conference, the Birmingham employers and workpeople have decided to apply the new rules, subject to certain modifications. A public inquiry is at present being held in Birmingham by Mr. Wills. As a matter of fact, the trade concerned is one of considerable magnitude, and the question of its sanitary regulation involves issues of vital importance to all concerned, either directly or indirectly, in the maintenance of a high standard of national health.

A Herbalist and Oil of Juniper.

Some serious matters were recently raised in the course of an inquest held at Walkley, near Sheffield, upon the body of a married woman, thirty-eight years of age. From the evidence it was shown that deceased went to a herbalist, named Emily Rose, who prescribed and sold her oil of juniper, to be taken in 15 minim doses, ostensibly for the benefit of the kidneys. As the dose of this highly irritant drug is from 1 to 4 minims, it is hardly to be wondered that the poor woman was seized subsequently with violent vomiting, from which she rapidly sank and died. The medical man who attended deceased testified to her admitting having taken a quantity of oil of juniper, to which he attributed her death. The woman herbalist said she did not know the stuff was poisonous, and admitted she did not know the juniper dose and that she had put no label on the bottle. The jury returned a verdict that death was due to an overdose of oil of juniper, and that it was taken for the purpose of bringing on a miscarriage. Quite apart from the possible criminal element in this case, it seems to us nothing less than a public scandal that ignorant persons should be allowed to deal in deadly drugs in this fashion, acting as they do under a semi-medical guise which imposes only too readily on the credulity of the vulgar. We trust the local police will in future keep a close eye upon the proceedings of Emily Rose, of Walkley.

The Licensing of Cowhouses.

The importance of preserving the national milk supply pure and untainted has been more than ever recognised since the formal scientific recognition of human and bovine tuberculosis as diseases of identical origin. Before any effectual sanitary control can be established it will undoubtedly be necessary to obtain fresh legislation, for instance, in the direction of amalgamating and consolidating the process of rural and urban local authorities, and, if necessary, of compensating owners of condemned tuberculous cattle. At the same time, it is well worth calling the close attention of our urban medical officers of health to their present powers in the control of cowhouses, with a view to safeguarding still further the health of the cows housed therein, to the consequent advantage of consumers. As things go, it is significant that many regulated town dairies are superior to those in country places, where the special Acts do not apply. That defect might be readily made good by a short Act extending and adopting the provisions of the Dairy and Cowsheds Order so as to include town and country in one compulsory scheme. In towns where the regulations are enforced a great amount of protection is thereby afforded to the community. The fact that in London alone no fewer than 300 cowhouses are under careful inspection and license suggests that an immense amount of preventable disease is almost certainly excluded from the milk by the enforced observance of certain standards of cubic space, ventilation, drainage, and cleanliness.

Alcohol in Hospitals.

The average consumption of alcohol in hospitals may be regarded, on the whole, as a fair test of the estimation in which alcohol is regarded as a remedial agent by the medical profession. There can be little doubt that the total hospital consumption has fallen greatly within the past few years. It is a point of no little significance to note that in some instances an additional impulse towards denunciation has come from working men who have been supporters of those institutions. That interesting fact, for instance, was recently mentioned in connection with the Swansea Hospital. Dr. Rawlings, who dealt recently with the medical aspects of alcohol, mentioned that in that particular Institution the bill for alcoholics, thanks chiefly to the working-men representatives, sank from £154 3s. in 1904-5 to £75 in 1906. The amount per occupied bed in 1840 was £2 3s. 7d., which had dropped to 4s. 7½d. in 1907. These figures probably represent roughly the degree to which alcohol has dropped out of the medical armamentarium, in spite of the recent curious attempt to rehabilitate its claims by the notorious manifesto launched upon the public by a self-constituted jury of medical men. Another statement made by Dr. Rawlings emphasises the advance of the temperance movement amongst the medical profession, namely, that when he signed the pledge in 1871 he was the only total-abstaining practitioner in the town, whereas there were now no fewer than eight.

Responsibility of Surgeons for Anæsthetics.

The question of the apportionment of responsibility in the administration of anæsthetics has recently been raised by Dr. F. J. Waldo, the City Coroner. Hitherto the generally accepted view is that the operating surgeon accepts full responsibility, but it is by no means clear what is the strictly legal aspect of the matter. The point has not been raised in the law courts, and until a test case is brought any operating surgeon may find himself faced with an action for damages by the litigious friends of some patient who has unhappily died on the operating-table. There is obviously a good deal to be said on both sides of the question. In former days the danger arose from the surgical procedures, whereas now the latter are often outweighed by the risks of anæsthesia. As a matter of fact, arrangements are often left entirely to the surgeon, who brings his own anæsthetist to the house, under which circumstances it would seem somewhat difficult to absolve him of all responsibility. In some operations, moreover, the surgeon never relaxes his supervision over the general anæsthetic condition of the patient, and should any emergency arise, he is apt to assume full direction of all remedial measures. In a recent inquest held upon a death at Guy's Hospital, the surgeon in charge accepted full responsibility for the anæsthetic which proved fatal. He further admitted that the operation (for the excision of a goitre) was one of special danger from an anæsthetist's point of view, but he had, notwithstanding, handed over the case to a newly qualified house surgeon instead of to one of the expert anæsthetists attached to the hospital. The whole matter is one worthy of careful attention, as, failing some definite solution, operating surgeons may be exposed not only to civil actions for damages, but also to criminal prosecutions, where a death under anæsthetics is associated with any lack of reasonable skill and precaution. For our own part, whatever the law may say, we are inclined to allot a share of the responsibility to the surgeon.

PERSONAL.

Dr. Ludwig Freyberger has been made a magistrate for the County of London.

Dr. C. E. Underhill has been re-elected President of the Royal College of Physicians of Edinburgh.

A bust of the late Mr. George Herring will be unveiled at the Mansion House at the next meeting of the Metropolitan Hospital Sunday Fund.

Lord Farquhar took the chair at the eighth annual meeting of the Presidents of the League of Mercy, held at St. Thomas's Hospital, on December 20th last.

Among the passengers by the White Star Liner "Oceanic," which arrived at Southampton on December 24th, was Dr. J. F. Leys, the Superintendent of the Colon Hospital.

The Army Council has approved as additional members of the staff of Queen Alexandra's Military Hospital:—Surgeon-Major-General A. F. Bradshaw as Consulting Physician, and Lieutenant-Colonel P. J. Freyer as Consulting Surgeon.

Sir Jas. Crichton Browne, M.D., F.R.S., and Drs. W. J. Simpson, J. W. Slaughter, and R. Parker Young have been elected members of the "Social Economy Committee" of the Franco-British Exhibition to be held in London this year.

Dr. R. J. Collie has been placed on the Commission of the Peace for the County of London.

At the Royal College of Surgeons of England on December 23rd, Mr. C. R. Hewitt, who for the past 22 years has held the post of assistant in the college library, received a presentation. The subscribers numbered some 75 friends, on whose behalf Professor William Osler, F.R.S., handed to Mr. Hewitt a piece of plate, suitably inscribed, and a cheque.

The opening lecture of the Mount Vernon Hospital Post-Graduate Course will be given by Sir Thomas Clifford Allbutt, K.C.B., F.R.S., at 7, Fitzroy Square, W., on January 9th, at 5 p.m. The subject of the lecture will be "Angina Pectoris."

The sum of £150,000, left by the late Mr. Edward Wilson to the city of Melbourne, is to be used for building a new hospital.

A CLINICAL LECTURE
ON
THE DIET OF THE AGED. (a)

By HARRY CAMPBELL, M.D., F.R.C.P.Lond.,

Physician to the West End Hospital for Nervous Disease.

Gentlemen,—The subject I propose to speak on to-day is the diet of the aged. It admits of being dealt with in a very comprehensive way, but that would require several lectures, and it is impossible to summarise it in a comparatively few words. First, a few remarks on the teeth. We are familiar with the toothless gums of old people. Edentulous man was probably unknown before the cookery period, because man had to chew his raw vegetable food so much in those times in order to break up the cellulose network, that his teeth had abundant exercise; and I feel sure they got worn down to the level of the gums. There are no people of that kind now, for even the most savage understands cooking. When the teeth of these men were worn down to the level of the gums, it practically meant that they could no longer live. Animal food does not require much mastication, but raw vegetable food does; and if a man had worn his teeth down to the gums, he had either to be carnivorous, or die. Still, he may have done something in pounding his food by means of a stone. Vegetable food which is cooked does not need nearly so much breaking up. But I do not think that early cooking man, before the agricultural period, attained to the edentulous stage. I have examined many skulls of very primitive people, but I do not remember to have come across one in which the teeth had been shed from senile absorption of the alveolar processes. When we come to the late agricultural stage we find it a very interesting one in regard to the teeth, because there is a great amount of soft vegetable food, so that man was able to subsist practically with no teeth at all. The result of eating this soft vegetable food has been to cause a terrible deterioration of the teeth, a fact which does not seem to be realised by even all dentists yet.

With regard to the masticating capacities of the edentulous, when a person loses his teeth the gums harden, and he is able to deal with his food fairly well, as a whole, though tough overdone meat would naturally bother him. And such a person cannot deal with crusts, but he is able to soak them in his tea or coffee. An edentulous person can deal with his food better than can a person with bad teeth; it may be that none of his teeth oppose properly, and they therefore prevent the gums from coming together to break up the food.

There is next the question as to the advisability of providing old edentulous people with false teeth. I have heard it argued that false teeth are not good for old people, because absence of teeth compels the eating of only simple food, the loss of the teeth being an indication for them to return to the food of infancy. But on examination this argument is found to have no basis; because if Nature means anything by edentulism, she means that the time has come for the person to die, because under natural conditions such a person would not be able to obtain sufficient nourishment. Absence of teeth does not prevent the person from eating too much, or from eating improper food, whereas the presence of teeth does enhance the person's masticatory power. So whenever a person can be fixed up with teeth, he or she should have them. I believe dentists say that people should not wait until all the teeth are out before having artificial teeth, but should be fitted with artificial dentures directly the teeth come out; because when they are all out he then finds less difficulty in wearing a plate.

I now want to say something about what I call the ideal diet. From the dietetic point of view, you may divide human beings into those who eat to live, and those who live to eat. Taking an extreme instance of each of those, I would say that a person who eats to live is one who eats moderately, and takes simple, plain foods. He eats no more than is necessary for physiological requirements. Assuming the food to contain the proper ingredients, he eats the minimum quantity which will sustain him at the least weight consistent with the best health of which he is capable. Any food in excess of that cannot do him any good, and it may do much harm. The next essential of an ideal diet is that the food should be simple. By that I mean that it should consist of bread, ordinary dairy produce, any kind of animal produce, provided it is simply cooked, and simple plain pudding with fresh fruit. And of course there should be simple vegetables plainly cooked, a little salt and a little mustard, and tea and coffee, but no condiments and no alcohol. The third essential is, that all the starchy foods should be thoroughly masticated, to break up the cellulose network, which is very indigestible, and liberate the contained food stuffs. During that process the starch is largely digested in the mouth into dextrine and maltose. Therefore in the case of people with weak digestions, I insist that they should spend a long time in masticating their starchy foods, and tell them to take their starchy foods in a form which compels mastication; they should get a good hard crust or a plain biscuit, and chew that until it liquefies in the mouth. That will more efficiently predigest the starch than any of the patent methods or foods. It is better that a person should digest his starch in the laboratory of his own mouth than that he should have it digested for him. Now that the cellulose meshwork is broken up by cookery, the mastication is to digest it in the mouth. Debilitated people should have their animal food minced, but otherwise I do not care whether animal food is chewed or not. Early man conformed to these three essentials; he ate moderately in quantity, on the average, simply because he was obliged to. No doubt at times he gorged himself, and an occasional gorge does no one harm—it may even do good. But he could not do that much, for he had to spend his time in hunting animals for food, and searching for roots and berries. And you must reflect what active lives they lived, and such people can take a good deal of food without over-eating. And of course he conformed in the matter of simplicity, because he had not many foods to choose from. Practically no form was refused by him—game, shell-fish, slugs, flies, ants, rats, and lizards. He had also to conform in regard to starchy foods, because raw vegetables, other than luscious fruits and young shoots had to be considerably masticated.

(a) Delivered at the Medical Graduates' College and Polyclinic, on December 4th, 1907.

Now I come to the application of these remarks to the diet of old people. Had there been time, I would have liked to have said something about the diet of those who live to eat. The contrast would have been very dramatic between what we have been speaking about and the diet of the person who is both epicurean and gourmand, who not only aims at eating nice things but eats enormous quantities.

A few words about the passage of food through the body. In that passage the food goes through three phases. First, that of digestion, which you may say is the conversion of the food into liquid nutrient plasma, which is capable of being assimilated by the tissues. When it comes into contact with the cells of the tissues in undergoes other changes, which we refer to as metabolism. And finally, after the food has been dealt with by the tissues, certain waste products are given out and eliminated. These three functions are most active in early life. But with advancing years these three functions tend to wane. From about 45 years onwards, a man begins to feel that there are many things he could eat in the past but which he now feels disagree with him. That is often because he has learned to recognise the relation between cause and effect. Metabolism is also less active; not only is the food less digested, but it is not metabolised so actively. It may be that the food stuffs are not burned off so efficiently, and there may be imperfectly oxidised products circulating in the blood, giving rise to "rheumatic" and other pains. But the question whether immoderation in food causes evil results chiefly by leading to indigestion or chiefly by giving the tissues too much work to do in the way of metabolism, is a very interesting and difficult question. I have been in the habit of arguing that if a person can only digest his food completely in the stomach and intestines and liver, so that there is poured through the hepatic veins into the general circulation food in a form very presentable to the tissues, that there should not be much harm from it; and that the evils of improper diet refer essentially to the digestive system, and comparatively little to the metabolic system. In Graves' disease, for instance, the metabolism is very active, there is an increased output of carbonic acid and urea, and the cells burn off very rapidly. So it may be that the evils resulting from indiscreet feeding depend not only on the inability of the digestive system to cope with the food but inability of the tissues to cope with it. I think the first of these factors is the more important.

In old age the digestion is still weaker, and the metabolic activity of the tissues less pronounced. The excretion also begins to be defective. The cells of the mucous membrane of the stomach and intestines are found to be largely replaced by fibrous tissue. Moreover, in old age the vital force flickers, and the organs of excretion begin to fail, though not markedly until the senile phase is entered upon. It follows from this that the older a person gets, the more urgent is it for him to, as for as possible, confine his diet to the ideal which I have mentioned; for he has not the reserve fund of younger periods, and cannot, without harm, indulge in all sorts of made-up dishes. We sometimes meet with people who do not seem to have any reserve force, and who, from childhood, could not take any liberties with their food without suffering for it. On the other hand we find wonderful old people who seem able to eat right through a century, but they, of course, are prodigies. It is a sound general rule that the older a person is the more should he conform to the ideal diet. Otherwise I do not think that the diet of the aged should differ from the diet of the young. Of course if a person is very feeble you can predigest his food a little.

I will mention a case or two. A gentleman, 66 years of age, came complaining of nose-bleedings, flushings of the head, and giddiness. He had a high tension pulse, and a little albumen in his urine. He fell down in one of these attacks of giddiness. He was eating about four times as much as he ought to. By cutting down his food—chiefly his starches and sugars, to about one-fourth, and cutting off his alcohol, the whole of his symptoms disappeared. The cutting down of meat is not so important as reducing starch and sugar. Very primitive man ate more animal than vegetable food, and the only sugar he had was a little honey. Another type of case in which you do an enormous amount of good by cutting down the food is bronchitis. If an obese elderly person has bronchitis, do not hesitate to practically starve him.

I now want to say a word about the diet of workhouses, a very interesting subject. I have visited two or three workhouses, and find that these old people eat very well. In one of the workhouses they grind their own corn. I show you one small loaf, weighing ¼lb. of wholemeal, and one the same weight, consisting of one portion of wholemeal to two portions of white. Each person eats five of those every day, and with each meal they have a pint of tea and ½oz. of margarine—which is quite as nutritious as butter—twice a day. In the middle of the day, at Marylebone, they have ¼lb. of meat, or bacon, and 12ozs. of vegetables, consisting of 8ozs. of potatoes and 4ozs. of greens. There is also sugar and milk with the tea. Once a week there is stewed fruit, and once a week pudding. No alcohol at all. In answer to inquiries, I learned that they suffer very little from indigestion. In reply to my question as to whether they suffered much from constipation, I was told that among the 2,000 inmates they do not have to give more than 20 doses of aperient in the day. That means only 3½ doses per individual in the entire year, which is remarkable, and shows what a simple dietary and regular meals will do. I also learned that in later life, when the reproductive system is atrophied and the fires all burnt out, that the women are more catabolic than the men. I was fortunate in having this patient to see me this morning, and, as he well illustrates the prolonged activity of the digestive function, I asked him to come and show himself to you. I have had him under observation for a long time, and he will soon be in his 92nd year. We are all proud that he is a Britisher. Between eleven o'clock and coming here he has been almost continuously walking about London. He has been a head gardener 50 years. At the age of 80 he applied for fresh employment, but when they learned his age they would not take him. He has been at various places in the country, eating well of the same food as other people, and feeling well; but since he returned to London he has been having a little indigestion.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Arthur Whitfield, M.D., F.R.C.P., Professor of Dermatology in King's College, Physician for Skin Diseases to King's College and to the Great Northern Central Hospitals. Subject: "Psoriasis: Its Clinical and Microscopical Characters, Diagnosis and Treatment."*

CLINICAL LECTURES FOR 1908.

We have been favoured by promises of Clinical Lectures from the following Hospital Teachers and Post-Graduate Lecturers, to whom we tender our best thanks:—

Wm. Alexander, M.D., R.U.I., F.R.C.S., Lecturer on Clinical Medicine, University of Liverpool.

Sir C. Ball, F.R.C.S.I., Regius Professor of Surgery, Dublin University, Surgeon to Sir P. Dun's Hospital.

Hy. Gilbert Barling, M.B., Lond., F.R.C.S., Surgeon to the Birmingham General Hospital and Dean of the Faculty of Medicine.

Sir James Barr, M.D., F.R.C.P., Lond., Physician, Royal Infirmary, Liverpool.

John Bland-Sutton, F.R.C.S.Eng., Surgeon to the Middlesex Hospital and to the Chelsea Hospital for Women.

George L. Chiene, M.B., Ed., F.R.C.S., Assistant Surgeon, Royal Infirmary, Edinburgh, Senior Demonstrator of Surgery, University of Edinburgh.

E. Scott Carmichael, M.B., Ed., F.R.C.S., Assistant Surgeon Royal Hospital for Sick Children, Surgical Registrar, Royal Infirmary, Edinburgh.

Harry Campbell, M.D., Lond., F.R.C.P., Lond., Physician to the North-West London Hospital and to the West End Hospital for Nervous Diseases.

Albert Carless, M.B., Lond., F.R.C.S., Surgeon to King's College Hospital, Professor of Surgery in King's College.

Edred M. Corner, B.Sc., Lond., F.R.C.S., Surgeon in Charge of Outpatients, St. Thomas's Hospital, Senior Assistant Surgeon to the Hospital for Sick Children.

Sir J. Halliday Croom, M.D., Ed., F.R.C.P., Cons. Gynæcologist. Royal Infirmary, Edinburgh; Professor of Midwifery, University of Edinburgh.

J. Debove, M.D., Doyen de l'Académie de Medécine, Paris, Physician to the Beaujon Hospital.

John Dundon, M.B., F.R.C.S., Eng., and F.R.C.S.I., Professor of Materia Medica and Therapeutics, Queen's College, Cork, Surgeon Mercy Hospital, Cork.

Jakob Erdheim, M.D., Professor of Clinical Medicine, University of Vienna.

Wm. Ewart, M.D., Cantab., F.R.C.P., Lond., Senior Physician to, and Joint Lecturer on, Medicine, St. George's Hospital.

Patrick J. Fagan, F.R.C.S.I., Surgeon to St. Vincent's Hospital.

Robt. Alex. Fleming, M.D., F.R.C.P., Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School; Assistant Physician to the Royal Infirmary.

John Magee Finny, M.D., F.R.C.P.I., Past-President R.C.P.I. King's Professor of Practice of Medicine, School of Physic in Ireland' Physician to Sir P. Dun's Hospital.

Jas. S. Fowler, M.D., F.R.C.P., Physician, Edinburgh Royal Hospital for Sick Children.

Andrew Fullerton, M.D., F.R.C.S.I., Assistant Surgeon, Belfast Hospital for Sick Children, Assistant-Surgeon Royal Victoria Hospital, Belfast.

Arthur E. Giles, B.Sc., Lond., M.D., F.R.C.S.E., Surgeon, Chelsea Hospital for Women, and to the Prince of Wales Hospital.

J. Dundas Grant, M.D., Ed., F.R.C.S., Eng., Surgeon to the Central London Throat and Ear Hospital, and to the West-End Hospital for Nervous Diseases.

Geo. L. Gulland, M.D., Ed., F.R.C.P., Assistant Physician to the Royal Infirmary, Edinburgh, Physician to the Victoria Hospital for Consumption.

Alex. Haig, M.D., Oxon, F.R.C.P., Lond., Physician to the Metropolitan Hospital and to the Royal Waterloo Hospital for Children.

W. Sampson Handley, M.D., M.S., Lond., F.R.C.S., Hunterian Professor of Surgery, Royal College of Surgeons, Assistant Surgeon to the Middlesex Hospital.

Chas. J. Heath, F.R.C.S., Surgeon to the Throat Hospital, Golden Square, President of the West Kent Medico-Chirurgical Society.

Francis Thomas Heuston, M.D., F.R.C.S.I., Senior Surgeon. Adelaide Hospital, Consulting Surgeon, Coombe Lying-In Hospital and Rotunda Hospital, Dublin.

Peter Horrocks, M.D., F.R.C.P., Lond., Senior Obstetric Physician, Guy's Hospital, Lecturer on Obstetrics and Diseases of Women, Guy's Hospital.

Robt. Hutchison, M.D., Ed., F.R.C.P., Lond., Assistant Physician to the London Hospital and to the Hospital for Sick Children.

Theo. B. Hyslop, M.D., Ed., M.R.C.S., Resident Physician Superintendent of Bethlem Royal Hospital, Lecturer on Mental Diseases, St. Mary's Hospital.

A. Jaquet, M.D., Professor of Therapeutics to the Faculty of Medicine, Paris.

T. Percy Kirkpatrick, M.D., F.R.C.P.I., Physician and Clinical Registrar, Steeven's Hospital, Dublin.

Frederick W. Kidd, M.D., Gynæcologist to the Meath Hospital, late Master Coombe Hospital, Dublin.

Denis Kennedy, F.R.C.S.I., Surgeon, Jervis Street Hospital and Children's Hospital, Temple Street, Dublin.

Charles R. B. Keetley, F.R.C.S., Eng., Senior Surgeon, West London Hospital.

Chas. B. Lockwood, F.R.C.S., Surgeon to St. Bartholomew's Hospital.

P. W. Maxwell, M.D., F.R.C.S.I., Surgeon to the Royal Victoria Eye and Ear Hospital, Dublin.

G. E. Pugin Meldon, M.D., F.R.C.S.I., Surgeon, Westmorland Lock Hospital, Dublin.

Elie Metchnikoff, M.D., F.R.S., Professor at the Pasteur Institute Paris.

Thos. K. Monro, M.D., M.Ch., F.F.P.S., Glas., Physician and Clinical Lecturer, Glasgow Royal Infirmary, Professor of Medicine in St. Mungo's College.

Herbert C. Mooney, M.B., F.R.C.S.I., Ophthalmic Surgeon, Children's Hospital, Dublin, Assistant Surgeon and Curator of Museum, Royal Victoria Eye and Ear Hospital.

Sir John Wm. Moore, M.D., F.R.C.P.I., Representative on General Medical Council, R.C.P.I., Senior Physician, Meath Hospital, Past-President Royal College of Physicians of Ireland.

Alex. Morison, M.D., F.R.C.P., Lond., Physician, Gt. Northern Central Hospital.

Wm. Murrell, M.D., F.R.C.P., Lond., Physician to the Westminster Hospital.

Sir Thomas Myles, M.D., B.Ch., Dub., F.R.C.S.I., Surgeon Richmond Hospital, Dublin.

David Newman. M.D., F,F.P.S., Glasg., Surgeon to the Glasgow Royal Infirmary.

H. Oliphant Nicholson, M.D., Aberd., F.R.C.P., Ed., Assistant Physician to the Edinburgh Maternity Hospital.

D. J. O'Connor, M.D., F.R.C.P.I., Physician, Mercy Hospital, Cork Physician, Cork Lying-in Hospital.

R. W. Philip, M.D., Ed., F.R.C.P., Physician to the Royal Victoria Hospital for Consumption, &c., Senior Assistant Physician to the Edinburgh Royal Infirmary.

John Poland, F.R.C.S., F.L.S., Senior Surgeon to the City Orthopædic and the Miller Hospitals, Consulting Surgeon to the St. Pancras and Northern Dispensary.

D'Arcy Power, M.A., Oxon., F.R.C.S., Surgeon to and Lecturer on Surgery at St. Bartholomew's Hospital, Consulting Surgeon to the Victoria Hospital for Children.

A. Maitland Ramsay, M.D., F.F.P.S., Glas., Surgeon, Ophthalmic Inst., Glasgow.

Prof. A. W. Mayo Robson, F.R.C.S., Hunterian Professor Royal College Surgeons, Eng.

Robert J. Rowlette, M.D., Lecturer in Pathology, Queen's College, Galway, Pathologist Steeven's and Rotunda Hospitals, Dublin. President Dublin University Biological Association.

J. S. Risien Russell, M.D., F.R.C.P., Lond., Physician to University College Hospital and to the Hosp. for Paralysis and Epilepsy.

R. Rehn, M.D., Professor of Surgery in the University of Berlin.

Geo. H. Savage, M.D., Lond., F.R.C.P., Lond., Consulting Physician for and Lecturer on Mental Diseases, Guy's Hospital.

Cecil E. Shaw, M.D., Assistant Surgeon, Belfast Ophthalmic Hospital, Consulting Oculist Alexander Hospital, Lecturer in Ophthalmology, Queen's College, Belfast.

Sydney Stephenson, M.B., C.M., F.R.C.S.E., Ophth. Surgeon, Evelina Hospital.

J. Lindsay Steven, M.D., F.F.P.S., Glas., Physician and Lecturer on Clinical Medicine, Glasgow Royal Infirmary.

Wm. St. C. Symmers, M.B., Musgrave Professor of Pathology, Queen's College, Belfast.

Sir William J. Smyly, M.D., F.R.C.P.I., Ex-President Obstetrical Section Royal Academy of Medicine, Ex-President R.C.P.I., Gynæcologist to Adelaide Hospital, Late Master, Rotunda Hospital, Dublin.

Jas. W. Russell, M.A., Cantab., M.D., F.R.C.P., Lond., Physician to the Birmingham General Hospital, Consulting Physician to the Midland Ear and Throat Hospital.

Geo. F. Still, M.A., Cantab., M.D., F.R.C.P., Lond., Physician for Diseases of Children, King's College Hospital, Assistant Physician, Hospital for Sick Children.

Geo. A. Sutherland, M.D., Ed., F.R.C.P., Lond., Physician to the North-West London Hospital, Physician to the Paddington Children's Hospital, and to the City Orthopædic Hospital.

Edward H. Taylor, M.D., F.R.C.S.I., Professor of Surgery, Trinity College, Dublin, Surgeon to Sir P. Dun's Hospital, Dublin.

William Taylor, M.B., F.R.C.S.I., Surgeon to Meath Hospital, Visiting Surgeon, Cork Street Hospital, Dublin.

Nestor Tirard, M.D., Lond., F.R.C.P., Lond., Professor of the Principles and Practice of Medicine in King's College, Physician to King's College Hospital.

Wm. Turner, M.S., Lond., M.B., F.R.C.S., Surgeon to, and Lecturer on Minor Surgery at, Westminster Hospital.

William I. de C. Wheeler, M.D., F.R.C.S.I., Visiting Surgeon, Mercer's Hospital, Dublin.

Arthur J. Whiting, M.D., M.R.C.P., Lond., Dean of the N.E. London Post-Graduate College, Physician to the Prince of Wales Hospital, and Mount Vernon Hospital.

Arthur Whitfield, M.D., F.R.C.P., Lond., Professor of Dermatology in King's College, Physician for Diseases of the Skin to King's College Hospital.

Andrew Wylie, M.D., C.M., Assistant Surgeon, Central London Throat, Nose, and Ear Hospital.

Leonard B. Williams, M.D., M.R.C.P., Lond., Physician to the French Hospital in London, Assistant Physician to the Metropolitan Hospital.

Macleod Yearsley, F.R.C.S., Eng., Senior Surgeon to the Royal Ear Hospital, London,

ORIGINAL PAPERS.

INHERITED SYPHILIS. (a)

By R. Clement Lucas, B.S., M.B.Lond., F.R.C.S.,

Consulting Surgeon to Guy's Hospital and to the Evelina Hospital for Children.

I have had the honour of opening this discussion thrust upon me by the unanimous vote of the Council as a penalty for certain criticisms I ventured to make on former discussions to the effect that the length and learning displayed in the opening addresses—sometimes five or six in number—left neither time nor opportunity for subsequent debate. I ventured to think the opening should be more suggestive than dogmatic, and terse rather than discursive. As a consequence, I am here to represent a phrase rather than a faculty, and the burthen of presenting new ideas and new facts will rest almost entirely with those who follow.

To begin with, this discussion will open under quite different circumstances to what it would have done had it been held three, or even two, years ago, for it is now generally accepted that the spirochæta pallida discovered by Schaudinn and Hoffmann in 1905 is the true cause of the disease, and that mercury, formerly given empirically, is a direct antidote by causing destruction of the parasite.

The Name.—This leads me to say a word or two on the three terms applied to this form of the disease—(1) congenital; (2) hereditary; (3) inherited. Of these three I greatly prefer the third. *Congenital*, besides being objectionable in form and suggestion, is not universally true; *hereditary* suggests something that may be passed on indefinitely, of which there is no proof; whilst *inherited* implies only something derived from the parents which is detachable, like a fortune or misfortune, and this more correctly expresses the passing on of the spirochæte to the offspring.

(a) The Opening Address to a discussion before the Society for the Study of Disease in Children, November 13th, 1907.

The Micro-Organism.—The cause of syphilis, whether inherited or acquired, is the presence in the blood and tissues of the same organism, which can be demonstrated in the various secondary lesions, in the blood, and in the internal organs.

The spirochæta pallida is a protozoon of spiral form from 4 to 20 μ in length (about half to three times the diameter of a blood corpuscle), and ¼ μ in diameter, with a flagellum at either extremity. It is very motile, and its motility is of three kinds, a lashing, corkscrew, and a to-and-fro movement. It stains pale pink with Giemsa's fluid, whilst the coarser, highly refracting spirochæta refringens with which it is often associated, stains dark purple.

The Mode of Transmission.—The discovery of the cause of the disease necessitates the re-arrangement of our former views as to its transmission. To those who remember the revolution in thought caused by the discovery of the tubercle bacillus—how that the long-taught diathesis gradually receded into the background and the danger of contagion by inter-communication in houses and families grew into importance—will be prepared for some change of idea in reference to syphilis.

To my mind inheritance from the father alone is now put entirely out of court, and it follows that infection of a mother by her syphilitic fœtus can never occur. For how is it possible that a spirochæte which is highly motile, and whose length averages rather more than the diameter of a blood corpuscle, can penetrate an ovum 200th of an inch in diameter and multiply without destroying it? I lay it down as an axiom, to be demolished, if you will, by discussion, *that inheritance is invariably through the syphilised mother.*

This is supported by Colles's law, that a syphilitic infant cannot cause a chancre on the nipple of its mother when suckling.

It would seem that, when virulent, the spirochætes penetrate the chorion or placenta and occasion miscarriages, macerated fœtuses, or premature births: but when the virus is attenuated by time or treatment the placenta forms a complete protection to the developing fœtus, and it is the separation of the placenta at birth which allows the infection to take place through the umbilical vein. Hence the regularity of the secondary exanthematous stage from a fortnight to three months after birth. In these cases *the separation of the placenta is the first stage, and corresponds to the chancre of acquired syphilis.*

Colles's Law.—I alluded to Colles's law (which was first stated in 1837) in support of the argument that the woman was always first syphilised before the embryo or infant. The law is that a woman giving birth to a syphilitic infant cannot be inoculated with syphilis by the infant when she is suckling it—in other words, though the mother may have shown no definite signs of syphilis, she is immune; whereas the syphilitic infant put to the breast of a healthy woman may inoculate her nipple and convey syphilis to her.

Hitherto, Colles's law has been used as an argument in support of the view that the mother may get a mild form of syphilis from her syphilitic fœtus, whose syphilis is supposed to be derived entirely from the father. But the law of immunity will remain equally true if it be supposed that the mother is first inoculated by the father, a large dose of the protozoon causing an obvious eruptive syphilis, and a small dose a syphilis which misses the eruptive stage.

Syphilis in a man is generally admitted to be capable of transmission to a succeeding generation for a much shorter time than syphilis in a woman, and this supports the view I have stated—viz., that for transmission it is necessary that the woman be first infected.

Transmission by Milk.—The question whether the milk of a syphilitic female may infect a healthy infant at the breast has been discussed for two and a half centuries, since Ambroise Paré, in the seventeenth century, quaintly observed:—"Infants suckled by syphilitic nurses are infected by them, seeing that the milk is nothing but whitened blood, which being infected by the virus, the child fed with it imbibes the same qualities." Hunter, founding his argument on ineffectual attempts to inoculate the blood of a syphilitic person, came to the conclusion that not only the blood, but every secretion derived from it, such as milk, saliva, perspiration, etc., could not convey the disease. But his experiments were inconclusive and his deductions incorrect.

Pellizzari succeeded in inoculating the blood of a syphilitic person, and if Voss's experiment is to be trusted, milk has been directly inoculated also.

A remarkable case bearing on this subject I showed before the Royal Medical and Chirurgical Society in 1881, and it will be re-published in the January number of the *British Journal of Children's Diseases*. A woman, æt. 30, gave birth to a healthy child on December 11th, which she suckled. The following Easter her husband inoculated her with syphilis, but she continued to suckle the child. She consulted me three months later, when suffering from severe secondaries, squamous eruption, sore throat, condyloma, and loss of hair, but the child showed no sign of infection. The mother was then treated with small doses of mercury. She and the child were shown when the latter was 10 months old. He had continued to suckle, and remained plump and in perfect health, though the mother still had patches of circinated squamous syphilide on her arms. During the two years the mother remained under my care for treatment the child showed no sign of inherited syphilis.

The importance of this case rests on the fact that the mother had suckled her child for three months after her infection before any treatment was commenced, so that it cannot be argued that the infant was taking the antidote in the mother's milk with the poison, and so escaped a source of possible inoculation; but it proves that the milk of a syphilitic woman when received into the alimentary tract of an infant need not convey any infection to the child.

Transmission by Semen.—It is obvious, as the greater cannot be included in the less, that a spirochæte cannot be carried in a spermatozoon; but this does not exclude the possibility of the spirochæte being conveyed by the fluid parts of the semen

The early experiments of inoculation by Mireur failed, but if the recent results obtained by Finger on monkeys be correct, the semen of syphilitic men in the secondary stage is inoculable. It seems almost necessary that it should be so to account for the cases of inherited syphilis conveyed after the healing of the chancre. If the presence of the spirochæte can be with certainty demonstrated in the semen of men suffering from recent syphilis, much doubt would disappear; and, in the cases where no chancre could be traced in the woman, the probability of the infection being carried through the uterus, after the disintegration of its lining membrane at any menstrual period, would be apparent.

Transmission to the Third Generation.—Another question much open to discussion is whether syphilis inherited is capable of transmission to the third generation. If the tertiary symptoms, occurring ten or twenty years after inoculation, can be proved to be due to renewed activity of the spirochæte in certain situations, there seems to be a fair possibility of their being carried to a third generation. But the question is beset with difficulties, since you must prove the sexual purity of two persons up to the time of maturity, and these are generally persons in whom a tendency to vice is also hereditary; for it is known that a person the subject of inherited syphilis is not immune from re-inoculation after a certain period.

Hutchinson mentions eight cases that have come under his observations of persons who presented signs of inherited syphilis, and who married, but whose offspring showed no evidence of the disease.

On the other hand Edmond Fournier collected 116 cases, 59 of which he thought were to be relied upon as showing transmission to the third generation, and R. W. Taylor has published others.

Dr. D. M. Hutton brought a case before this Society, which is published in the first volume of our Reports, and is there criticised by Dr. Ashby and others.

My own experience is limited to one case, but it is of unusual importance, as both parents showed most obvious signs of inherited syphilis which were unmistakable. A blind man attended a school for the blind, where he met a blind woman for whom he developed a feeling of affection. They were both blind from interstitial corneo-iritis, and they both presented the typical physiognomy of the inherited disease, notched teeth and scars around the mouth. They married, and at the time the man came under my care, their first child was about two months old. The blind wife was brought up to visit her husband, and, seeing she was marked by the same disease, I sent for the infant, which presented no evidence whatever of syphilis, nor did it develop any symptom of inherited disease during the months I was able to keep it under observation. This case, in which there should have been double inheritance, showed, so long as I was able to watch it, complete immunity.

The Infant Mortality.—There is probably no disease responsible for such an enormous destruction of human life in its earlier stages as that caused by syphilitic parentage. But my experience shows that this mortality is greatest in those families where both parents have suffered from chancre syphilis and obvious secondaries. The severity of the infection and ineffective treatment, or lack of treatment, are the two factors which determine the mortality. I give two illustrations:—

CASE I.—E. S., had been married eleven years, and suffered three months after marriage from rash and sore throat. The first child was stillborn, twelve months after marriage, and was miscarried at the sixth month. The second child lived (the mother being at this time under treatment), but had severe snuffles and rash, is very delicate, and has recurrent sores and eruptions. The third, fourth, fifth, sixth, seventh, eighth, and ninth children were all born at full time, but all died from a few minutes to within two or three months of birth. The tenth child was brought up for treatment suffering severely from snuffles, stomatitis, and coppery shiny eruption. Thus two weak children only were living out of ten.

CASE II.—R. C., three weeks after marriage, suffered from sores on vulva followed by rash and sore throat, for which she had no prolonged treatment, a pale, cachectic-looking woman. The first child, ten months after marriage, was stillborn at the seventh month. The second child was prematurely born at the eighth month, and lived a day. The third child, born at full time, a fortnight later came out in large brown spots, and had snuffles, and was taken to Guy's and treated by blue ointment rubbed in over the abdomen. She still lives, and at the age of eleven shows no notching of incisors or evidence of her inheritance. The fourth child did not come out in an eruption till five weeks old. He died at six weeks. The fifth child, a boy, came out in an eruption at five weeks, and died at seven weeks. The sixth child was stillborn. The seventh child, prematurely born at the eighth month with an eruption upon her, survived a day. The eighth child, a girl, had a rash soon after birth, and died on the eighth day. The ninth, also a girl, was born healthy, but an eruption came out at the third week. She was treated, but died at eleven weeks. The tenth, a fine boy at birth, came out in an eruption three weeks after birth, and was brought up for treatment. He was suffering from symmetrical squamous syphilide of legs, feet, arms and ears, little on body, ulceration of mouth and buttocks, and severe snuffles. Again two living out of ten.

The Secondary Stage.—The trite definition that "syphilis is a fever diluted by time," given by the late Dr. Moxon, is applicable to the inherited as well as to the acquired disease.

I argued that the primary stage is the separation of the placenta and the infection of the infant through the umbilical vein. The secondary or exanthematous stage commences from the second week to as late as the third month. It is characterised by eruptions which may vary from slight brown macular syphilides to pompholyx, by snuffles, stomatitis, condyloma, wrinkled skin and wasting, enlargement of the spleen and liver. Then follow certain changes in the bones, in severe cases perhaps epiphysitis, giving rise to pseudo-paralysis, Parrot's nodes causing natiform skull and square forehead, cranio-tabes and bent bones.

It cannot be too strongly insisted on that the moist eruptions and ulcerations about the mouth and anus, as well as the vesicular skin affections, are charged with the spirochætes, and highly contagious.

From the second to the sixth year there is commonly a rest in the symptoms that are regarded as characteristic, but the tibiæ may become thickened from periostitis, or a joint may become swollen and painful, and resolve under mercurial treatment.

But now the characteristic physiognomy has been gradually formed, the flattened nose, the square forehead, the radiating lines from the mouth, the stunted figure and pallid face; and then, during the second dentition, we look for the three signs pointed out by our great observer, Jonathan Hutchinson, the notched incisor teeth, insterstitial corneitis, and syphilitic deafness. Associated with such signs, or occasionally independent of them, gummatous destruction of the soft or hard palate may occur, and ulcerations of the skin and cellular tissue. Destruction of the nasal bones, caries of the forehead and skull, of the long bones and dactylitis, may take place as the result of the inherited disease.

Moon's Molars.—The teeth Mr. J. Hutchinson described as so characteristic of the disease are the notched and narrowed incisors, especially the central incisors of the upper jaw. This defect is brought about by arrest in development of the central columella, of which each incisor has three. But I wish to draw special attention to the characteristic change brought about by the disease in the first molars described by the late Mr. Henry Moon many years ago, since this change has recently been re-discovered both in America and on the Continent. The diagram which I show is taken from the fourth edition of *Bryant's Surgery*, published in 1884, wherein the article on teeth is written by Mr. Moon. He figures and describes the syphilitic first molar as "reduced in size and *dome*-shaped, through the dwarfing of the central tubercle of each cusp." He also contrasts these teeth with mercurial teeth and syphilitic-mercurial teeth. The change in the molar is of some clinical importance, since occasionally it is characteristic when the incisors are normal.

Eyes and Ears.—The eyes may become affected at an early stage by a choroido-retinitis, which may leave permanent changes easily recognised by ophthalmoscopic examination; and iritis, though rare, may occur during the eruptive stage. Interstitial keratitis is most frequent between the ages of six and sixteen, but may occur much later, and rarely earlier. It is highly characteristic of the inherited disease.

Like the eyes, the ears are attacked by different affections in the early and late stages. During the eruptive stage, otitis media may commence as an extension from the inflammation of the naso-pharynx, whilst during the second dentition a progressive deafness of labyrinthine origin may cause complete loss of hearing. Specialists in these departments will, I hope, give us some new facts relative to the syphilitic manifestations in the eyes and ears.

Inherited Syphilis Attacking the Viscera.—Much work has been done in demonstrating the disease in the various viscera, not one of which appears to be exempt, and there is probably a large field still open here for further investigation. Enlarged spleen and liver, associated with rickets, may be proved almost invariably to be of syphilitic origin.

The disease attacks the various organs in two forms, as a small cell infiltration usually following the course of the vessels, which in its development and decline may lead to fibrosis and consequent atrophy, and as a gummatous tumour which is less common.

When the inherited disease attacks both testicles or both ovaries at an early age, and brings about their fibrosis and atrophy, a condition known as *infantilism* is produced at a period when the sexual characteristics should be pronounced.

The physicians present will, I hope, give us much new information on inherited syphilis of the viscera.

The Nervous System.—Much difference of opinion exists as to the frequency of nervous disease dependent on inherited syphilis. Whilst some are inclined to attribute every conceivable weakness, paralysis, or mental defect to this disease, others regard the nervous lesions dependent on it as infrequent. A certain proportion of epileptics, deaf mutes, and idiots, but not a large percentage, show signs of inherited syphilis. On the other hand, syphilitic endarteritis of cerebral vessels, gummata on nerves, and sclerosis of brain and spinal cord have been observed by competent observers.

One of the most interesting observations of late years is that some cases of hydrocephalus are dependent on inherited syphilis, and are curable by mercury.

The Need of Criticism in Diagnosis.—In conclusion, I wish to insist on the importance of weighing carefully all the evidence before determining that a particular affection is due to inherited syphilis. Every deformity from dislocated hip to cleft palate, all defects such as hernia, infantile paralysis of various kinds, and even nævi, have been described by various writers as dependent on inherited syphilis, and as if better to cover the anomalies, the term "parasyphilis" has been invented to add to the confusion. I need scarcely waste time in combating such crude generalisations as that "all rickets takes origin in syphilis," when any puppy taken from a litter and deprived of proper food and exercise will certainly develop this disease.

Equally crude statements have been made as to other diseases. We do not deny that persons whose constitutions have been weakened by disease are liable to produce degenerates in succeeding generations; but in future the most certain test of the disease being syphilis will be the presence of the spirochæta pallida in the part affected. This organism has an extraordinary persistency producing local symptoms after lengthened periods, but happily we have in mercury and the iodides drugs which control its development and bring about its destruction.

Metchnikoff has recently shown that some hours after direct inoculation the application of a calomel ointment to the sore is sufficient to kill the organism and prevent the occurrence of secondary symptoms.

Gentlemen, I have now finished my brief sketch of this interesting disease as it attacks the second generation. It is the merest outline, that you may fill in the substance. I ask for new facts and new observations, for now that the cause of the disease is definitely known, we have a fresh incentive for further investigation. There are many diseases still confused under a common name—just as gonorrhœa and syphilis, typhus and typhoid fever, were confused generations ago—that time will unravel. But as we gain more exact, more precise, and more definite knowledge of any one disease, we shall be the better equipped for appreciating the symptoms and distinguishing the effects produced by others.

EYE-STRAIN. (a)

By T. PERCY C. KIRKPATRICK, M.D., F.R.C.P.I., M.R.I.A.,

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With the appearance in 1864 of the great work of Donders "On the Anomalies of Accommodation and Refraction of the Eye," scientific ophthalmology may be said to have had its birth. In the *Philosophical Transactions* of 1793, Dr. Thomas Young had described the condition of astigmatism, but his work does not appear to have had much effect on the practice of ophthalmologists till the whole subject of abnormal refraction was placed on a sure and scientific basis by the work of Donders. The evil effects which follow from the fatigue due to excessive action of the ocular muscles in cases of abnormal refraction of the eye were clearly pointed out by Donders, so far as they affected vision, but it was not till some years later—1874—that Weir-Mitchell, of Philadelphia, suggested that the evil effects of this ocular fatigue, or eye-strain, were of much wider distribution. Since the appearance of Weir-Mitchell's papers, many writers have treated of this, and recently the subject has been brought prominently before the profession in a series of publications by Dr. George M. Gould, under the title of "Biographic Clinics." In spite of the amount of work which has already been done, it is quite evident that physicians are not yet satisfied as to the position which eye-strain is to ultimately assume among the recognised causes of disease.

During the past few years I have devoted considerable attention to this question, and I bring the results of my observations before the Academy, not because I believe they contain anything new, but in the hope that from the criticism of my fellow-members my deductions may be corrected or amplified.

There is one great group of diseases which does not appear to me to have taken an adequate share in the great advance which has characterised the history of medicine, both preventive and curative, in the latter half of the nineteenth century. I refer to those diseases known vaguely under the generic title of the "functional neuroses."

Much has been done, no doubt, by the gynæcologist, the rhinologist, the aural surgeon, and the dentist for the treatment of conditions formerly classified in this group; but, in spite of this, the number of persons affected appears to become greater year by year. It has been customary to give as an explanation of this the stress of modern civilisation, and the survival of the unfit, which has followed the great progress of preventive medicine. Both factors have probably contributed to the result, but so far from allowing this to paralyse our efforts to prevent and to relieve the suffering caused by the functional neuroses, it should, I maintain, stimulate us to greater efforts to complete the triumph of medicine by making efficient and happy citizens of those whom the success of preventive medicine has spared to the State. My observations on a number of patients have led me to believe that in the recognition and removal of eye-strain we have a very valuable means of reducing considerably the number of persons who suffer and have their efficiency greatly impaired by various disabilities at present known as functional. It is not possible for me to go into details of all the conditions and disabilities which may result from eye-strain; I shall merely, by the record of some few cases, endeavour to establish the general principle that it is the duty of the physician to look for and correct any abnormality of the eyes in every case of disease which does not readily and completely yield to treatment by other means. That this principle is not recognised at present, or, if recognised, not always acted upon, I have had ample evidence, although it does not appear to be in the least unreasonable. There are, I believe, few physicians who would not consider it a grave neglect to omit examination, and, if necessary, treatment of the teeth in such cases. Although many persons have diseased and unhealthy teeth without appearing to suffer from them, still the importance of removing that source of irritation and infection in every patient is fully recognised. Though this be so, it has been seriously urged against the adoption of the principle I have advocated that many persons with considerable refraction errors do not suffer in the least from the condition, and in others who do suffer the correction of the error brings no relief. To submit a patient to such a serious operation as the removal of the Gasserian ganglion for trigeminal neuralgia without first ascertaining that there is no ocular defect, or the result of its correction if present, appears to me to be quite as bad as to amputate his leg for a tumour without satisfying oneself that the condition was not due to syphilis rather than cancer. Before proceeding to deal in detail with the cases I should like to insist on the necessity of making the examination of the eyes thorough, and correcting as far as possible any abnormality that may be found to be present. This should be conscientiously done before any opinion is expressed as to the possibility or not of the abnormality present causing the symptoms. I know it is the practice of some ophthalmologists to neglect minor refractive errors provided the patient's vision is fairly good, and to assert that the error is so small that it cannot be looked on as a cause of severe symptoms. Such a position is not warranted, and every source of eye-strain should be removed before one asserts that the symptoms complained of are not due to it. Some writers have found that slight errors are more potent in the causation of symptoms than those of a more aggravated degree. This is quite intelligible when we remember that slight errors will probably interfere only to a very slight degree with vision, and consequently the eyes may be subjected to prolonged strain without the patient being aware of the fact. It is remarkable how often such patients will resent the suggestion that their eyes are at fault, asserting that they can see perfectly well, although on trial they at once feel the benefit of suitable glasses. This has been my experience with several patients.

(a) A paper read before the Medical Section of the Royal Academy of Medicine in Ireland, December 6th, 1907.

The first condition of which I wish to speak is the group of symptoms known as migraine or hemicrania. Migraine forms such a well-defined and easily recognised clinical entity and is so common that it is unnecessary for me even to enumerate its symptoms. The time at my disposal would be quite insufficient were I to endeavour to enumerate the various hypotheses as to its causation and the methods which have been recommended for its cure. Suffice it is to say that none of these hypotheses satisfactorily explain the condition; and most of us will agree with Osler's remark, "that in a very large proportion of the cases the headaches recur in spite of all we can do." It has long been recognised that various functional disturbances of vision form a prominent symptom in migraine, and it has been recently demonstrated that a large number of patients thus affected have some abnormality of refraction or muscle balance of the eyes. It has also been shown that many cases of migraine are immediately and permanently cured by the correction of such abnormality. I am not aware that anyone has yet published statistical tables of a large series of cases in order to enable us to estimate whether in all or what percentage of patients with migraine ocular abnormalities have been found, and the results that have followed the correction of such abnormalities; but a sufficient number of cases have now been published, where some abnormality has been found and the patient cured by its correction, to make it clearly our duty to look for such abnormality in every case of migraine. The compilation of such a table would, I believe, be an important and useful contribution to the work of our Dublin School of Medicine.

The following case well illustrates the connection between eye-strain and migraine: A young man, aged about 24 years, came to me complaining of well-marked migraine. He was a clerk by occupation; a teetotaller and non-smoker. On physical examination he appeared to be perfectly sound, and there was no family history of nervous disease. His eyesight was quite good, and between his migrainous attacks he was quite healthy. He stated that he had been subject to attacks of severe sick headache since childhood. These attacks came on quite suddenly, usually beginning with the feeling that the objects about him were moving from side to side. These ocular symptoms were soon followed by violent headache, and after some time he vomited; he was usually quite well again in from three to five hours after the attack began. These attacks came at irregular intervals, sometimes two or three in a week, and sometimes there would be an interval between them of two months. He was unable to account for the attacks by anything in his mode of life or diet, and often they came on when he was feeling particularly fit. He had been treated by many drugs prescribed by different physicians, but from none had he received any permanent benefit. I recommended him to have his eyes examined, and he consulted an oculist in town, who subsequently told me that the patient had 0.25 diopters of myopic astigmatism, and although he considered the error to be too small to cause the symptoms, he had ordered correcting glasses. My patient got the glasses and used them regularly, but in about a month came back to say that so far from being improved, the migraine attacks were more frequent than they had ever been before. I advised him to return to his oculist and ask if there was any change to be made in the glasses. The oculist reported that the glasses were perfectly correct, advised a further trial of them, and, though he did not say so, suggested that the result was just what he had expected. My patient found that the glasses appeared to make his migraine worse the longer he persisted in using them, and eventually decided to get further advice. The next oculist he consulted recognised the presence of faulty muscle balance, which he said was probably of more significance than the astigmatism, and ordered glasses for its correction. For a year after using these glasses my patient was quite free from all migraine—a longer period of freedom than he had known since the attacks first started. He then had one slight attack, not accompanied with vomiting, after which he again had some slight change in the glasses, and since then has been quite free from all signs of the disease. It would not, of course, be right to draw any definite conclusions as to the causation of migraine, but this at all events is clear, that in his case the correction of the eye-strain was the only method of treatment attended with any success. The case also shows the great importance of a careful and thorough examination of the eyes before we can conclude that they are not concerned in the production of the symptoms complained of. I now believe that the oculist the patient first consulted was right in so far that the astigmatism had little if anything to say to the migraine, but he missed what in my opinion was the essential feature of the case, the faulty muscle balance; and had not the patient sought further advice he would in all probability be still suffering from his periodic attacks of migraine.

I do not wish to be understood as maintaining that migraine is always the result of eye-strain—the information at my disposal does not warrant me in doing so—but I do maintain that the connection has now been so frequently established that it is one of our first duties in every case of the disease to see that all sources of eye-strain have been removed, and not to be satisfied with any incomplete examination of the eyes or protestations of the patients as to the excellence of their vision.

The connection between eye-strain and headaches, the so-called neuralgia, is now so well established that it appears almost unnecessary to dwell upon it here. I have found, however, that in spite of this knowledge, many physicians when dealing with cases of headache do not insist on an examination of the eyes unless there is obvious defect in vision, and further, that many oculists do not consider it necessary to correct slight refractive errors provided the vision is good. There are, of course, many patients who will not bear complete correction of refractive errors, at all events at the start, but there are others who do not resent the glasses though they do not find that their vision is improved by them, and many such patients are left uncorrected.

As an example of this I give you the history of the following case:—A young woman of about 22 years of age consulted me at the out-patient department of Steeven's Hospital some seven years ago, complaining of severe recurrent headaches. I examined her carefully and made a note in the register, "complaining of headaches, but I can find nothing else wrong with her." I treated this patient with purgatives and tonics for some time, but with no evident improvement, and the patient disappeared, as I suppose to seek treatment elsewhere. Some three months ago she came again to my dispensary and told me she had been in America in the interval; she was now complaining of some slight dyspepsia. On looking her name up in the book and seeing my previous note, I at once asked about the headaches, and she replied that while in America she had sought advice for her headaches, and had been ordered glasses, and since wearing them the headaches had completely disappeared. I greatly fear that there are only too many other patients whom I have left to suffer in a similar way from not having recognised the necessity of seeking the aid of the oculist. The following instructive case also illustrates the benefit of treating eye-strain and the difficulty one sometimes encounters. Some eighteen months ago I was called in a hurry to see a gentleman in town by his partner in business, who informed me that he believed the patient was going off his head, and had made some remarks which suggested suicide. As the usual medical attendant was out of town I was asked to see the patient with a view to getting him into hospital. I found the patient in a very restless and excited state, complaining of severe headache, and saying that at times he felt quite unable to control his actions. I had him at once removed to a private hospital, ordered complete rest and a full dose of bromides. During the next two or three days his condition improved greatly, and he expressed himself quite well except for some headache, which, however, he said he nearly always had. On making inquiries as to the cause of this headache he informed me that he had suffered from headache more or less continuously for the past fifteen years—at times it was better and at times it was worse—but very seldom was he quite free from it. He further told me that he had consulted many physicians, but got no relief in spite of the varied treatment prescribed. One physician, after careful physical examination, told him that he could find nothing wrong with him, and so it was useless to recommend medicine. The patient himself attributed the headache to excessive lawn tennis playing, at which game he had attained considerable proficiency some 15 or 20 years before. I suggested that probably his eyes were at fault, and that the glasses which he was wearing did not suit him. He indignantly repudiated the suggestion, and proceeded to demonstrate to me that his vision was exceedingly acute. I told him that it was not a matter of vision, and asked him to consult his oculist. On my pressing this matter again the next day he said to me, "As a personal favour, doctor, I must ask you not to mention this matter any more, for I know you are wrong, and I do not wish to fall out with you." The patient passed from under my care on the return of his usual medical attendant to town, and I informed this gentleman of my opinion, and asked him to use his influence with the patient to have his eyes examined. I heard nothing more from the patient for about six weeks, when one day he stopped me in the street and said he wished to thank me for my advice, for he had been to his oculist, had his glasses changed, and since that had experienced such freedom from his headaches and general improvement in his health as he had not known for 15 years. The sequence of events is so striking that one is strongly tempted to assume a causal relationship. This case does not, however, stand alone, for I have had several others in which the use of suitable correcting glasses has been followed by complete relief of more or less persistent headache that for years had resisted other forms of treatment. I have also, of course, had cases in which I suspected the eyes to be at fault, but on examination they were found to be perfectly normal. Such cases do not, and I think should not, in any way prevent the adoption of the general principle that I advocated to have every such patient's eyes carefully examined.

Some recent writers have attributed all sorts of chronic ill health to the presence of eye-strain, but as I have not myself had experience of such cases I do not purpose to consider them to-night. If one may express an opinion on *à priori* grounds, I should be inclined to doubt the causal connection in many such cases, but I am quite prepared to admit the presence of eye-strain may be an important factor in such cases, the origin of which was due to some totally different cause. It is quite possible, indeed I might say even probable, that the eye-strain itself may be the result of the condition of ill-health which has interfered with the nutrition and function of the ocular muscles, and when once established this eye-strain may help in maintaining that condition to which it was itself due. We have ample evidence of the importance of such vicious circles in many cases of disease, and it would seem illogical to exclude it here.

I fear I have no very plausible hypothesis to offer in explanation of the contention which I have put forward. It seems to me difficult to accept the explanation suggested by Donders that the excessive muscular action produces waste products the accumulation of which acts as a poison on the nerve cells and fibres. The very small bulk of the muscle involved appears to me to make such an explanation untenable.

Excessive stimulation of the muscles or the nerve centres, one would think, would be followed by loss of function of these muscles or nerve cells with consequent relief of the eye-strain rather than by symptoms in other and distant parts. At most one would imagine that a condition analogous to what we find in writer's cramp would result. While however we are compelled to speculate on the explanation of such conditions, we should remember how scanty our knowledge is of the intimate relations of the central nervous system, either anatomically or physiologically considered.

I have tried by the relation of these few cases which have come under my own observation to establish the importance of eye-strain as a factor in the production of disease, to impress on my hearers the importance of the removal of this eye-strain as a method of treatment, and to solicit their criticism for my own guidance. That I have found the adoption of these principles of advantage to myself, and I hope to my patients, must be an apology for detaining the Academy so long. I must tender my very best thanks to my friend, Dr. Mooney, for his kindness in devoting so much care and attention to the laborious investigation of the many refraction cases which I have sent him at the Royal Victoria Eye and Ear Hospital.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Three Cases of Fæcal Fistula.—Mr. T. P. Legg operated for fæcal fistula on three patients:—(1) The first was a young woman, æt. about 23, who some years before had had some operation performed in her right groin; since that time had had a fæcal fistula which constantly discharged large quantities of thin, watery, intestinal contents, with an acid reaction. She was in a deplorable state, her right thigh being excoriated and in an eczematous condition nearly as low as the knee. The lower part of the abdomen on both sides was in a similar condition. She was very much emaciated, and had practically to spend her whole time in bed, which was the only place in which the fistula leaked very slightly. The opening was situated in the upper and inner part of Scarpa's triangle, just below the middle of Poupart's ligament; it admitted a No. 8 bougie, which passed upwards and backwards. For some days she was kept in bed, and various diets were tried to diminish the amount of leakage, and to get the skin into a better condition by the use of various applications. At the operation a bougie was passed through the fistula, the opening of which was then closed by suturing over the end of the bougie, and a small collodion dressing was fixed over the sutures. The abdomen was next opened just through the middle of the right rectus; very few adhesions were found, and on passing the hand downwards to the lower part of the iliac fossa it was quite easy to feel the bougie passing into the ileum not far from its termination. The rest of the peritoneal cavity was packed off, and this adherent piece of ileum was separated from the bougie and drawn up on to the surface of the abdomen; there was no attempt at the formation of a spur, the hole in the bowel being about a third of an inch or more in diameter, and situated towards the anti-mesenteric border. It was closed by invagination, two rows of sutures being used; some narrowing of the lumen resulted. The abdomen was then closed completely, a small drainage tube being placed along the track of the fistula. (2) The second was that of a man, æt. 37, who was admitted with a large tumour of the right kidney and pus in the urine. The kidney tumour was removed, and in doing so a portion of the intestine must have been bruised during the separation of the adhesions, which were very abundant. Four or five days after the operation a slight fæcal discharge was noticed on the dressing, and a few days later it was quite easy to see in the lower part of the incision (which had been left open in order to pack it) a small opening into the bowel. The amount of intestinal contents which escaped varied, but caused considerable excoriation of the skin around. The reaction was acid, and flakes of milk and bile were easily recognisable in the discharge. As the fistula showed no signs of healing, an attempt was made to close the opening by separating the intestine from the incision and invaginating it by two rows of sutures ; for a time the discharge ceased, but again the fistula recurred, and another attempt was made to close it in the same manner ; this was again unsuccessful. As the patient was losing ground, and the amount of discharge was abundant, it was decided to more thoroughly explore the condition of the bowel by opening up the original wound. After separating the adhesions, the affected piece of intestine, which was the upper part of the jejunum, was found to have a well-marked spur, so that the proximal portion was almost entirely shut off from the lower part, and all the contents of the former portion of the bowel were unable to pass into the lower ; hence the failure of preceding operations. About 4 inches of intestine, with the spur, were excised, and the two ends united together by two rows of sutures. Most of the wound was sewn up, a small piece of gauze being left in to stop some oozing from the raw surface left by separating adhesions. (3) The third was that of an older man, nearly 50, who had been originally operated on for a large abscess in the upper part of the right groin. At this operation the abscess was found to originate in the right iliac fossa, and, as a sinus was left, the fossa was explored through an incision above and parallel to Poupart's ligament. The source of the abscess was apparently from the cæcum, which was much thickened. It was thought inadvisable to do more at this time, so the wound was packed and allowed to heal. During this process a fæcal fistula formed, with two openings, one just above Poupart's ligament, and the other at the upper and outer part of the thigh ; from the latter there appeared to have been more discharge than from the former ; the amount varied, sometimes it was absent, but the quantity was sufficient to prevent the patient from following any employment. He had also steadily lost flesh. In the right iliac fossa there was a definite amount of induration, and with a view of first, if possible, finding out the exact source of the disease and removing it, and, secondly, to perform some operation for the cure of the fistula, it was decided to open the abdomen. When this had been done, the cæcum and ascending colon were found to be very closely adherent to the parietes, and, except for being thickened uniformly, not otherwise obviously diseased, so it was decided not to attempt their removal. The fistulæ apparently opened on the posterior aspect of the bowel ; at any rate, they were not seen on the inner lateral aspect, which was clearly exposed. The termination of the ileum was free from adhesions ; it was divided about 6 inches from the ileo-cæcal valve, and both ends completely closed by two rows of continuous sutures. The proximal piece was then applied to the transverse colon, which was situated quite low in the abdomen, and a lateral anastomosis was made between these two pieces of intestine not far from the hepatic flexure. The abdomen was then completely closed, without any drainage. The fistulous tracts were scraped and packed, and a piece of gauze inserted. Mr. Legg, in his remarks, said that these three cases illustrated three different methods of treatment of fæcal fistula. The first case was the simplest method, and can generally be adopted when there is no spur, and the opening can be found ; sometimes it was easy to do this, especially when there were few adhesions, and those not dense, or it may be impossible, as in the third of these cases, or inadvisable, to attempt their separation. He thought that placing a probe or bougie along the fistula was a valuable guide to the situation of the track and of the opening in the bowel, as in the first case. In the third case not any assistance was really gained by having a bougie placed in the fistula, for it could not be felt inside the abdominal cavity. The second case illustrated the only way of curing a fæcal fistula when there is a spur, and in excising the intestine enough must be removed to get healthy bowel above and below to join together. In many of these cases the adhesions may be so close that a very careful dissection is necessary. The third patient illustrated the method of curing the fistula by "exclusion" of a portion of the bowel. In this particular operation the termination of the ileum, the cæcum, and a portion of the colon were excluded in part from the direct track of the intestinal contents. As the transverse colon was not divided, but only united to the ileum, any secretion from its mucous membrane, or any intestinal contents which happened to be in it, would be passed on by the natural peristaltic wave into the colon beyond the anastomosis. In this operation of "exclusion" of a portion of the intestine, the excluded portion must always have left some means of escape for its contents until such time as it ceases to secrete and shrivels, if it ever completely does so. Now, as the ileum was anastomosed to the transverse colon by a large opening, the only thing left to keep open the fistulæ was the secretion of the mucous membrane of the intestine with which they were connected, and when a piece of intestine is put out of use, its secretion diminishes to a very small amount. Therefore, these fistulæ would probably close, and at most might occasionally reopen if the intestinal secretion accumulated to any great extent. Incidentally these three cases illustrated the different effects of the intestinal contents on the skin. In the first and second cases there was widespread excoriation, due to the secretion and contents of the small bowel. The third patient in whom the contents of the large intestine escaped showed very slight alteration in the skin. The first and second patients also emaciated much more rapidly and to a greater extent than the third patient, the emaciation being most quickly evident in the second case, in whom the fistula was high up in the jejunum. Mr. Legg also pointed out that the contents of the small intestine being fluid, the narrowing which was present in the calibre of the bowel, as the result of the operation in the first case, was not likely to lead to symptoms of stricture, especially as the scar was placed in the long axis of the intestine. The result of the operation performed in each case was quite successful, and it was interesting to notice how rapidly the skin recovered in the first and second cases.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING.

CLINICAL MEETING, HELD DECEMBER 18TH, 1907.

The President, Dr. JAMES RITCHIE, in the Chair.

DR. ALEXANDER BRUCE showed—(1) a case of syringomyelia of the rare type associated with contraction of the muscles of the shoulders, elbow, wrist and fingers. The patient also had dissociated anæsthesia of the arm. (2) A patient with well-marked hemiatrophy of the tongue and lateral nystagmus. The girl was also subject to attacks of giddiness, in which she had a sensation of objects rotating to the left. There was also a history of numbness in the left arm. The nature of the case was obscure ; there was probably a lesion in the neighbourhood of the hypoglossal nucleus, extending forwards to implicate the centres for the external recti. (3) A case of neuritis of the median nerve, following cellulitis consequent on an injury to the palm of the hand. There was marked hyperalgesia, and the cutaneous distribution of the fibres of the median nerve was very distinctly mapped out by the disturbance of sensation. (4) A case of amyotrophic lateral sclerosis. (5) An aneurism of the internal carotid artery ruptured into the cavernous sinus, producing well-marked proptosis of the left eye, and giving rise to a loud buzzing murmur audible on auscultation over any part of the cranium, but loudest at the point where the tip of the sphenoid and temporal bone unite. (6) A patient who showed marked emotional disturbance, tremor of the right arm, narrowing of the right palpebral fissure and increased flow of tears from that eye. There was also unilateral sweating, limited to the right side. The case was regarded as of functional nature.

Professor **Chiene**, C.B., showed:—(1) A case of congenital wryneck. He had never felt satisfied with the operations performed for this deformity, and in the case in question had devised a new one, which consisted in the reflection of a flap of skin over the mastoid process, the dissection off the bone of the periosteum and attachment of the sterno-mastoid, and the suture of the upper part of the periosteum detached to the lower part of the mastoid process. The amount of periosteum detached was regulated by the amount of shortening of the muscle—in this case 2 inches. The result had been good; the scar was not in the neck, as when the lower end of the muscle was divided. (2) A case of loose body in the elbow-joint, following injury. He had operated as follows, the object being to preserve the integrity of the lateral ligaments:—A horseshoe-shaped flap was turned down over the elbow, and the triceps was split by a vertical incision. He was surprised at the free access to the joint which this gave, and suggested that similar incisions might be used for excision. There was no scar over the olecranon, hence it would be possible to begin passive movements very early. Mr. Chiene also demonstrated —(1) an instrument devised for measuring the length of the lower extremities; (2) a shield to wear over the mouth and nose when operating; (3) an improved support for flat foot, embodying the principle of supporting the transverse as well as the longitudinal plantar arch.

Mr. F. M. **Caird** showed a series of ten patients in whom the operation of pyloro-gastrectomy for cancer of the pylorus had been performed. The earliest case dated back to 1899, another to 1900; the rest were of more recent date. In all the history was much the same—vomiting, absence of free HCl, and movable pyloric tumour. Although the growth was often felt to be movable, there were usually troublesome adhesions, particularly to the pancreas. The operation generally performed was to suture the divided ends of stomach and duodenum, and then to perform a posterior gastro-jejunostomy. The operations were troublesome, and took from two to three hours for their completion. (2) A case of acute pancreatitis, treated by drainage. (3) A case of idiopathic dilatation of the colon. The patient was admitted with a greatly distended abdomen, showing conspicuous ladder patterns, and signs of chronic obstruction. An artificial anus was made, and subsequently the loop of bowel which had been drawn into the wound was resected, the ends of the colon being united by end-to-end anastomosis. The difficulty with the regular action of the bowels had been overcome, and there were no more ladder patterns, but the abdomen was still rather tumid.

Dr. R. W. **Philip** showed a series of patients illustrative of the cutaneous and ophthalmic reaction of tuberculin. The former was introduced by von Pirquet, of Vienna, and consisted in the inoculation into the skin of a small quantity of tuberculin. In tuberculous subjects a cutaneous reaction consisting of redness, papulation, and occasionally vesiculation, ensued. The ophthalmo-reaction had been introduced by Prof. Calmette, of Lille, and was tested by instilling into the conjunctival sac one drop of ½ to 1 per cent. solution of dried tuberculin prepared by precipitation with absolute alcohol. Tuberculous subjects showed within three to six hours injection of the caruncle, slight conjunctivitis, and occasionally a muco-purulent discharge. It was noted that sometimes patients with advanced tuberculous symptoms failed to react, just as they sometimes failed to react to injections of tuberculin.

Mr. **Alexis Thomson** showed:—(1) A patient, æt. 69, after a radical operation for carcinoma of the cæcum, performed in two stages. He demonstrated a new pattern of enterotribe, by which it was possible to compress the colon into a pulpy ribbon; then the softened part was invaginated, and the end closed as easily as after removal of the appendix. (2) A patient, æt. 53, operated on for acute intussusception confined to the small intestine, which, being irreducible, the entire segment of gut involved, including the sheath, had to be resected. Intussusception limited to the small intestine was rare. After removal of the gut he had slit it up in the expectation of finding a tumour which would have caused invagination to occur, but none was present. The patient had complained a great deal of abdominal pain and irregular peristalsis since the operation, and his future could not be looked upon without anxiety being felt lest repetition of the intussusception should occur. (3) A patient, æt. 29, who had sustained a gunshot injury of the upper arm six months before he came under observation, with smashing of the humerus and tearing of the musculo-spiral nerve. An operation was performed for ununited fracture of the humerus, when it was found that the extent of the destruction of the nerve rendered suture impossible. The distal end was therefore inserted into the median nerve above the elbow, and there had been considerable return of power. He proposed now to complete the bridge by grafting the proximal end of the divided musculo-spiral into the trunk of the median nerve.

Mr. **Hodson** showed patients:—(1) After operation for renal hydatid. (2) A case of Dupuytren's contraction after treatment by fibrolysin.

Mr. E. **Scott Carmichael** showed—(1) Boy, æt. 10, after acute suppurative cholangitis and cholecystitis following generalised streptococcal peritonitis. (2) Girl, æt. 6, after severe compound fracture of the skull and hernia-cerebri. (3) Girl, æt. 3, after resection of the cæcum and ascending colon for tuberculous stricture two years ago. (4) Boy with chronic arthritis of the wrist-joint of doubtful diagnosis.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

Meeting held Friday, Dec. 6th, 1907.

Dr. A. R. Parsons in the Chair.

DIPHTHERITIC FEVER.

Sir **John Moore** gave details respecting a remarkable outbreak of sore throat which had come under his observation in a large girls' school in Dublin during the autumn of 1906. Bacteriological examination proved the outbreak to be due to an infection with a form of the Klebs-Löffler bacillus diphtheriæ The resulting illness failed to present the typical features of classical diphtheria—it might be described as "Diphtheroid," and he had ventured to call it "Diphtheritic Fever." From October 2nd, 1906, to November 11th, following, 18 out of a total of 43 girls in the school were attacked—that is, 41.9 per cent. There were five distinct outbreaks. In the first, one girl sickened on October 2nd; in the second, one girl sickened on October 10th; in the third, nine girls sickened, two on October 19th, two on October 21st, two on the 22nd, two on the 23rd, and one on the 24th; in the fourth, five girls were attacked, one on October 28th, two on October 29th, one on November 1st, and one on November 2nd; in the fifth, three girls were seized, one on November 7th (for the second time), one on November 8th, and one on November 11th. After this last date no further cases occurred. Allusion should be made to two instructive sequels to this epidemic. The first is the fact that diphtheria was carried home to the country in two instances by the girls when, nearly two months after their illness, the school broke up for the Christmas holidays. The second is the fact that nearly twelve months afterwards a little epidemic of a precisely similar nature occurred in the school. On September 30th, 1907, three cases of sore throat occurred in the school—the patients were moderately feverish, with swollen tonsils, enlarged cervical glands, but little or no exudation. The result of a bacteriological examination, made by Dr. Boxwell on October 1st, was to find the milder form of the diphtheria bacillus present in considerable quantities in two of the three cases. In the third case—clinically the most severe—Dr. Boxwell failed to find it, probably because streptococci and staphylococci were so numerous that they crowded out, as it were, the Klebs-Löffler bacilli—a fact well-known in true diphtheria. Lastly, the symptoms which by their more or less constant presence make up the clinical syndrome of diphtheritic fever are:—

1. A more or less severe coryza.
2. A moderate tonsillitis, usually one-sided, and unattended by high fever or by much exudation.
3. Thickly coated tongue and foul breath, the tongue desquamating as in scarlatina.
4. A patchy or punctate rash on the roof of the mouth and buccal mucous membrane.
5. Swelling of the cervical lymphathic glands.
6. A roseolar rash on the skin (in 12 out of 18 cases—in four cases early in the attack; in eight cases on the fifth to the seventh day from the first symptoms, or invasion).
7. Distinct desquamation (in three cases), the peeling being particularly marked on the hands.

Dr. **Kirkpatrick** said that sometimes 10 or 11 recruits came into Steeven's Hospital in one day from the Constabulary Depôt, complaining of symptoms resembling those described by Sir John Moore. They usually got well in a short time. In no case had there been any suspicion of membrane, and bacteriological examination showed no trace of the diphtheria bacillus in many cases. The organism in the majority of cases was some form of coccus. The condition was looked upon as an epidemic of catarrh, and in no case had been seen the roseolar rash, or the cervical glands materially enlarged.

Dr. **Burgess** said the recruits mentioned by Dr. Kirkpatrick were brought up from the country, and were not used to the ordinary hygiene. They were put on swimming lessons, and kept in the water for half an hour or more. This chilled them, and they complained of sore throats.

Dr. **Day** said it was not necessary to have a membrane to diagnose diphtheria. He had pointed out in a paper some years ago that cases having soft tonsils, coated tongue, and enlarged glands had given the diphtheria bacillus on a swab. Diphtheria was much commoner in the city than people supposed, and there were two main predisposing causes—bad teeth and constipation. The latter would explain the outbreak after the holidays. He thought the only way to get people free from the diphtheria bacillus was to give them change of air and occasional injections of, say, 500 units of anti-toxin prior to discharge from hospital. Since the anti-toxin treatment had come in, paralysis had been postponed. It was necessary to swab cases before applying any antiseptic treatment to the throat, and it was also more advisable to touch the red injected parts than to swab whatever membrane was seen. If there was nasal discharge, it was preferable to swab it than the throat.

Professor **White** said it was well to remember that the diphtheria bacilli were exceedingly susceptible to desiccation; they died more quickly than any organism of the same degree of virulence that he knew. Hence, in most cases that were swabbed in the membrane, it was possible that they got little away except some dry necrotic material which might contain bacilli alive and capable of reproducing themselves, but which would have died in a few hours because there was probably no moisture put in the swab. That might be the explanation of negative results of swabs taken from cases of severe diphtheria.

Dr. **Boxwell** said he would like to exonerate Sir John Moore and Professor White for the use of the word "attenuated" in his report. It was he (Dr. Boxwell) who had used it simply to describe a type of organism which he had often found in mild cases of sore throat. It was somewhat smaller than the typical bacillus, and in appearance like what was described as Hoffmann's bacillus. Not knowing whether it was the real diphtheria organism or not, he had called it an attenuated form.

Professor **White** said it appeared that there was some doubt as to whether the bacilli in the cases were diphtheria bacilli or not. There was no doubt whatever that some of the cases were due to the true diphtheria bacillus. The bacillus varied extremely, and he confessed to a difficulty in distinguishing between the form spoken of as Hoffmann's and the shorter forms of the bacillus.

The **Chairman** instanced an outbreak at a school in which definite membrane appeared in some cases. It was pronounced to be undoubted diphtheria. One boy admitted having had a slight sore throat at home during the preceding holidays. On examination, diphtheria bacilli were isolated. His own practice was to have a culture made in cases of follicular tonsillitis. He would like to know if, in any of the cases which developed in the country afterwards, there was a bacteriological examination.

Sir **John Moore**, in reply, said that constipation was very prevalent at the time of the outbreak of diphtheria. The toilet of the mouth was carefully attended to from the outset. He had found quinine to be a powerful disinfectant of the mouth. In nearly all cases the rash appeared before the anti-toxin was injected. Although Dr. Boxwell had used the term "attenuated," he submitted that the country cases which followed were perfectly conclusive as to the infecting organism, although he had no information that the diagnosis was confirmed by a bacteriological examination.

EYE-STRAIN AS A FACTOR IN THE PRODUCTION OF FUNCTIONAL NEUROSES.

Dr. **Kirkpatrick** read a paper on this subject, which will be found under the heading of "Original Papers," page 11.

Mr. **Mooney** also read a paper on "Eye-Strain," in which he expressed the opinion that the relation between headaches and errors of refraction was not as fully realised by physicians as it might be. His paper appeared in our last week's issue.

Dr. **Drury** quoted several cases in which attacks of migraine had ceased after the adoption of glasses for the correction of eye-strain.

Dr. **Henry** said there could be no doubt that in a very considerable number of cases of neuroses the symptoms were due to some affection of the eyes, and in some cases astigmatism would be found to be the cause. His own experience was that the affection of the eye which had most effect in producing headaches was a small degree of mixed astigmatism.

Mr. **Story** agreed that mixed astigmatism was perhaps a more common cause of headaches than simple astigmatism, and he also believed that difference in muscular balance was perhaps of even greater importance in the production of migraine.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

Meeting held at the Faculty Hall, Dec. 20th, 1907.

The President, Dr. **Walker Downie**, in the Chair.

Before proceeding with the business of the evening, the **President** made a sympathetic reference to the passing of Lord Kelvin. He recalled an occasion when Lord Kelvin—then Sir William Thomson—lectured to this Society on the diffusion of liquids and gases. He also remarked on the wonderful mental activity exercised by the late Baron up to the time of his last illness, and the sense of loss felt in the City and University of Glasgow.

Some interesting papers were then read and discussed, and card specimens were exhibited illustrating various surgical conditions.

A group of nine cases of

PULSATION IN THE WALLS OF THE PHARYNX

were shown by Dr. **James G. Connal**. This group comprised persons of both sexes, whose ages ranged from 10 to over 60 years. The pulsations were easily seen when the patient's tongue was well depressed and a good light thrown into the pharynx. In some of these cases the pulsation was unilateral, and in others it was bilateral. The commonest situation of the pulsation was just behind the posterior pillar of the fauces. This condition, though not unknown to both anatomists and laryngologists, has hitherto received little attention. Dr. Connal was of the opinion that this condition accounted for the excessive hæmorrhage sometimes encountered in operations upon the pharynx, and should always be looked for before operating in this region. The arteries that may give rise to these pulsations may be either the internal carotid artery or the ascending pharyngeal branch of the external carotid artery; but no explanation was given as to how this abnormal phenomenon was produced.

Dr. **Connal** then read an account of a case of "Chronic Purulent Middle Ear Disease," with involvement of the lateral sinus. Before opening into and evacuating the contents of the lateral sinus, he ligatured the internal jugular vein, a proceeding that he thought was justified by the satisfactory result obtained.

This paper was discussed by Dr. Walker Downie, Dr. Love, Dr. Eddington, and Dr. Barr, whose remarks were largely founded on their own experiences of similar cases.

Dr. **Archibald Young** showed a man with

MULTIPLE EXOSTOSES OF THE RIBS

and of the long bones. The patient had well-marked rhachitic deformities, and the interest of the case lay in the correspondence of the situations of the bony outgrowths with the usual sites of rhachitic deformity. Thus a long osteoma projected from one of the ribs at a point near to its junction with its costal cartilage. Another appeared over the tibial spine. The former began to grow when the man was 19 years of age, the latter when he was three years older. A large nodule on the clavicle began to grow three years ago, when he was 30 years of age. The other deformities of the bones were those of rickets rather than distinct tumours, and it was pointed out that the time as well as the distribution of the exostoses had a definite relation to the period when rhachitic deformity occurs.

An interesting discussion followed, in which Dr. A. McLennan and Dr. Eddington took part, and an explanation of such conditions was given by Dr. Ivy McKenzie, who described the anomalous manner in which bone is formed in rickets resulting in patches of unossified cartilage, which, after resting for some time, may again take on growth and become ossified when the conditions for so doing are favourable.

DOUBLE TUMOURS.

Dr. M. **Logan Taylor** gave a demonstration of microscopic and museum preparations of "double tumours." By this term Dr. Taylor did not refer to tumours composed of two or more different tissues, such as adeno-sarcoma, nor to "mixed tumours," such as are found in the parotid gland, where several kinds of tissue enter into the composition of the tumour. He wished it to be understood that double tumour meant a tumour that during its life history passed from one distinct type into some equally distinct but different type, or in some manner gave origin to such a different type of tumour. Cases of this kind were given, such as where adeno-sarcoma was cultivated for 40 generations in mice the carcinomatous element largely predominated. In one series of these experiments it was found that up till the twelfth generation the carcinomatous elements were in excess, about the sixteenth generation there was as much sarcomatous as carcinomatous elements; and in the fortieth generation the carcinomatous elements had almost disappeared, and the tumour was nearly all sarcomatous. In another series of cases the sarcomatous elements equalled the carcinomatous in the sixth generation, greatly exceeded them in the tenth, became entirely sarcomatous in the fifteenth generation, and continued thus till the fortieth generation. Cases in man were also given. In a case of primary carcinoma followed by secondary deposits and dissemination, the secondary growths in lymphatic glands were adeno-sarcoma, and the tumours formed by dissemination were pure sarcomata. Another form of double tumour was illustrated by a case where a melano-sarcoma affected the eyeball, which was excised in consequence. Deposits of melano-sarcoma were found in nearly every organ of the body, and where these growths were found in the liver primary carcinoma of the liver had occurred. The next case cited was that of a patient with a sarcoma of the mediastinal glands growing through the sternum, and at the same time having an adeno-carcinoma of the thyroid gland. These two tumours, arising separately in the same individual, extended till they became contiguous. In the discussion which followed this paper, Dr. Walker Downie referred to a case of cancer of the uvula in which the disease was removed, and in which there was a sarcomatous tumour removed from the neck seven years later.

Drs. G. **Buchanan** and **Wilson** also referred to a case where an epithelioma was removed from the back of the hand, and the whole limb had to be amputated later on for growths of sarcoma high up in the arm. Many of the microscopical preparations made from some of these cases showed two kinds of tumour occupying different parts of the same section.

A short communication was made by Dr. **Ivy McKenzie** upon

THE SPIROCHÆTA PALLIDA AND ITS ÆTIOLOGICAL RELATIONSHIP TO SYPHILIS.

These organisms were demonstrated to be present in abundance in the lesions of congenital syphilis, which were shown under the microscope. It was stated that the evidence in favour of spirochæta pallida being the ætiological factor in syphilis is increasing, while the opposite view is held by fewer observers, as their objections are being gradually met and answered by careful researches on the subject. The evidence, however, is not yet so complete as could be desired, as the organism has not been cultivated outside the living body, and inoculation experiments in animals only give rise to an indefinite kind of disease, with little resemblance to syphilis.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Manchester, Dec. 20th, 1907.

The President, Dr. E. O. Croft, in the Chair.

Dr. **Walter** (Manchester) (1) mentioned a case of

HÆMATOMA OF BOTH BROAD LIGAMENTS,

occurring a few hours after a supra-vaginal hysterectomy on a patient, æt. 37, who was exhausted by prolonged metrorrhagia. The tumour grew from the posterior wall of the uterus, and extended laterally to the sides of the pelvis. Incising the uterus deeply, the myoma was enucleated from its attachments, but general oozing from the broad ligaments gave trouble. The pulse was 84 at completion of operation; four hours later, 96; at 6 p.m. it was 116, and a small amount of blood was coming through the vagina. At 8 p.m. the patient became collapsed, and complained of abdominal pain. Saline injections were given, ether administered, and the abdomen opened. Not more than 8 oz. of free blood was found in the abdomen, but both broad ligaments were distended with blood and clots. There was no bleeding apparent from the main vessels, nor had their ligatures slipped. The collapse, simulating extensive hæmorrhage, was the chief interest in this case, and may have been due to intense pain from over-distension of the ligaments in a patient already debilitated by previous hæmorrhage.

(2) Particulars were also given of a case of

ABDOMINAL DISTENSION,

arising the day after supra-vaginal hysterectomy had been performed on a single woman, æt. 40, who sought relief on account of excessive menorrhagia and retention of urine produced by a myoma. The operation took place on October 29th, in the Trendelenburg position. Three hours afterwards the pulse was 88, and the patient fairly comfortable. The day following the abdomen was slightly distended, and flatus could not be passed voluntarily. The pulse gradually rose, and in the evening was 130; vomiting and pain were marked, and nutritive enemata were no longer retained. On the third day symptoms were more pronounced.

and the pulse 152. It was decided to open the abdomen unless some improvement took place. At 8 p.m. one of the enemas took slight effect, and the pulse fell to 140, and the next day to 128. Hot fomentations and gentle massage aided the ordinary treatment by enemata and calomel. The obstruction was possibly due to kinking of the intestines when being replaced after Trendelenburg's position. Both cases made good recoveries.

Sir **William Sinclair** (Manchester) mentioned a *case of gonorrhœa* and sepsis of the uterus in a patient, æt. 28. Seven years married. Repeated operations of curettage, and the removal of the uterine appendages had been carried out with little relief before he saw her on account of constant abdominal pain. On November 15th he extirpated the uterus per vaginam, and steady improvement followed. He advocated conservative treatment from the outset in these cases.

Dr. **Lloyd Roberts** (Manchester) related two cases of *Cæsarean section* for pelvic deformity, and showed the full-term fœtus, placenta and gestation sac, successfully removed by abdominal section from a patient who had an extra-uterine pregnancy.

Dr. **Arnold Lea** (Manchester) narrated two *cases of diffuse adenoma occurring in fibroid uteri*, and drew attention to the features of pathological interest in this condition. Multiple polypoid projections of the endometrium, microscopically of a benign character, were present. The uterine wall was uniformly thickened to the extent of 2 inches in some places. The specimens and microscopical sections were also shown.

Dr. E. **Emrys-Roberts** (Liverpool) gave a pathological report on a case of *primary unilateral superficial papilloma of the ovary*, and expressed the opinion that the ascites present in such cases was the result of secretion by the epithelium covering the papillæ. Lantern slides were shown. The tumour was removed by Professor Briggs in the Hospital for Women, Liverpool.

Dr. **John Cameron** exhibited a number of dissections demonstrating the *supports of the pelvic viscera.* After pointing out that the muscles forming the pelvic floor in man were now recognised as vestigial structures, he directed attention to the fact that we must regard the fascia surrounding the visceral branches of the internal iliac vessels (the perivascular fascia) as forming the most important support of the pelvic viscera both in the male and in the female. He then went on to suggest that operative treatment for prolapsus uteri must be directed not to the pelvic outlet alone, but also to this perivascular fascia.

CENTRAL MIDWIVES' BOARD.

Meeting held December 19th, 1907.

Dr. Champneys in the Chair.

The principal matter dealt with by the Board was one arising out of a report from two of the Manchester Examiners as to the insufficient training of a candidate at the October examination. The question was debated for some time *in camerâ*, after which the following statement by the Chairman was communicated to the Press. In view of its importance this statement is given in full:—

"Drs. Stallard and Wallace, two of the Manchester Examiners, have reported as follows with respect to one of the candidates examined by them at the October examination:—'No 42 has only attended 15 cases personally (10 in hospital and 5 in district), although she was signed up for 20. Has not fully attended a course of lectures. Quite ignorant of fœtal skull and pelvis, and of normal body temperature. Does not know how to deal with post-partum hæmorrhage, and has hazy ideas on most subjects.' No. 42 was Elizabeth Christiana Myerscough.

"No candidate can be admitted to an examination of the Board unless she produces certificates—(*a*) of having attended and personally delivered 20 cases; (*b*) of having nursed 20 lying-in women for the 10 days following confinement; and (*c*) of having undergone a three months' course of instruction. The three certificates of training comprised in Miss Myerscough's schedule were each signed by Dr. Thomas G. Stevens, Master of the Coombe Hospital, Dublin, and she was admitted to the examination in virtue of these certificates. The candidate herself had signed the declaration that the certificates signed by Dr. Stevens were in all respects correct and true.

"The Secretary communicated with Miss Myerscough, and, after some difficulty, ascertained from her that her statement of having conducted 15 labours only was true. She added that the matron, although she knew she was entering for the Central Midwives' Board's examination, informed her that 15 cases would be sufficient. Her excuse for having signed the declaration was that she had no idea that the Board would be so particular. She stated finally that she did not wish any publicity to be given to her name should the matter be taken up by the Board.

"The Secretary then wrote to Dr. Stevens informing him of Miss Myerscough's statement to the examiners, and that she adhered to it, and asking him for his explanation of the circumstances. A reply was received from the Registrar of the Coombe Hospital which merely stated as regards the point at issue that Miss Myerscough was credited in the books of the hospital with having attended and watched the progress of not fewer than 50 cases, of which she had had personal practical experience. A further letter from the Secretary pointed out that this was no answer to his previous letter, and stated that what the Board wished to know was whether Miss Myerscough's statements were true, or whether she had, in fact, personally delivered 20 cases.

"To this a reply was received from the Registrar, of which the following are the material extracts:—

> "'The Master desires me to say that in signing the certificate he was aware that Nurse Myerscough had conducted 15 cases, but, being present and having had practical personal experience of such a large number extra, he considered he was entitled to sign the certificate, and that in doing so he complied fully with the spirit of the rule. . . . In conclusion, the Master desires me to say that if 15 conductions, as well as a large number of attendances of which the nurses have personal practical experience, are not considered sufficient by your Board, the hospital will at once make arrangements to see that each nurse in future conducts at least 20 cases.'

"Dr. Stevens accordingly admits that he signed a certificate stating that Miss Myerscough had, under his supervision, attended and watched the progress of not fewer than 20 labours, and had personally delivered the patient, knowing perfectly well that she had conducted 15 cases only.

"The signing of a false certificate, knowing it to be false, appears to fall within the class of offences included in Section 22 of the Midwives' Act, 1902. This section is as follows:—'Any person wilfully making or causing to be made any falsification in any matter relating to the roll of midwives, shall be guilty of a misdemeanour, and shall be liable to be imprisoned with or without hard labour for any term not exceeding 12 months.' This section is printed *in extenso* and in conspicuous type at the bottom of that page of the schedule which contains the three signatures of Dr. Stevens and the signature of Miss Myerscough to the declaration.

"Dr. Stevens' conduct in signing this false certificate is such that no words of comment are necessary. Such a flagrant breach of the law, however, requires drastic action by the Board, and I move accordingly:—

"(*a*) That the name of the Coombe Lying-In Hospital be removed from the list of recognised training-schools.

"(*b*) That Dr. Stevens be informed that no certificate signed by him will be accepted by the Board in future.

"(*c*) That Elizabeth Christiana Myerscough be informed that she will not be admitted as a candidate at any future examination of the Board unless she produces a fresh schedule showing that she has undergone a complete course of training elsewhere than at the Coombe Hospital.

"(*d*) That the facts and documents relating to the case be reported to the General Medical Council and to the Privy Council."

Other correspondence dealt with by the Board included letters from Mr. W. Schröder, Deputy Coroner for Central London, and Hon. Secretary of the Coroners' Society, asking the Board to furnish the Coroners of England and Wales with an annual copy of the Midwives' Roll, or in the alternative that the local supervising authorities of England and Wales should furnish copies of the local rolls.

The matter was referred to the Privy Council.

Letters from Dr. G. Sydenham were discussed, as they related to the term infectious disease as employed in the rules, whether they included such diseases as measles and whooping-cough. It was agreed that no definition could be made by the Board, and that Dr. Sydenham be referred to the rules as regards the necessity for disinfection, and to the local supervising authority as regards the method and cost of the same.

There was also a letter from the Clerk of the Council transmitting a copy of a letter from the Local Government Board enclosing a letter from the Executive Committee of the Rural Midwives' Association in regard to the question of the training of midwives, and the possibility of the grant of State aid towards the cost of such training. This was referred to the Standing Committee.

Dr. Rahim, of Commercial Road, had written to ask whether the midwife employed by him to do some of his midwifery cases could not be exempt from inspection, as it added to the work of a general practitioner. The request, however, could not be granted, as the woman practised as a midwife, and not as a maternity nurse.

The following motions, put forward by Dr. Stanley Atkinson, were carried :—(1) That in the case of a midwife struck off the roll upon consideration of depositions taken at a Coroner's inquisition, the Coroner be informed of the result. (2) That upon application being made for the restoration of the name of a midwife to the roll, the local supervising authority under which she practised be notified of the fact at once.

Dr. Wright, of Derby, was approved by the Board as a teacher *pro hac vice*. The Birmingham Maternity Hospital was approved as a training school. The following were appointed examiners to the Birmingham centre:—F. Edge, E. Malins, C. Martin, J. Wilson and Jordan Lloyd were to be asked to accept the appointment.

The date of the next meeting was fixed for January 16th.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Dec. 29th, 1907.

Prophylaxis of Gonorrhœa.

Quite recently Roux and Metchnikoff drew, for the second time, attention to the utility of calomel ointment (33 per cent.) as a prophylactic agent of syphilis, which if applied after coitus seems to grant immunity. Gonorrhœa being one of the commonest forms of venereal disease, and frequently followed by grave complications, it may be interesting to give a *résumé*, according to Tausard, of the different means recommended as preservatives against the affection.

Condoms are useful, but are liable to tear in use. The advice to micturate immediately after coitus is good, but it is not necessarily efficacious, as the microbes can localise themselves on the lips of the meatus and on the mucous membrane. Antiseptic lotions of the glans, with a solution of permanganate of potash, oxycyanide of mercury, or protargol, are better as precautionary measures. But these different methods are far from being infallible, and have been more or less replaced by injections, instillations, or ointments.

Welander advises an injection after coitus of a solution of protargol, 1—25. Frank utilises also protargol, but much stronger, 1—5.

Guiard employs permanganate of potash in very weak solution (1—10,000), of which from eight to ten injections are given successively, and the operation repeated two or three times in the day.

Zeissel uses a glycerine solution (1—5) of protargol, of which 5 or 6 drops are injected into the navicular fossa. In Germany specially prepared tubes filled with this solution can be found.

Tandler employs the same solution, but injects it by means of an ordinary drop tube.

Salmon and Rheusse prefer a solution of protargol and vaseline oil. They advise injecting a few drops before coitus, and after washing with a solution of corrosive sublimate the glans, follow this by an injection of protargol.

Tausard considers that a weak solution of protargol (1—50) is quite sufficient, and the strong solution, if frequently repeated, would set up irritation of the canal, terminating finally in stricture.

Pruritus of the Anus.

Pruritus of the anus is more of an inconvenience than a malady. It is met in gouty, arthritic persons, and accompanies hæmorrhoids, threadworms in children, and eczema of the region. The affection is, as all know, very tenacious and rebellious to treatment. A good method is to apply in the evening a very warm solution of phenic acid or poultices, especially if eczema be present. After the fomentations the following ointment gives some relief :—

Ess. of peppermint, 15 drops.
Lanoline, 1 dr.
Vaseline, ½ dr.
Olive oil, ½ dr.

Brocq advises also, suppositories :—

Cocain. ½ gr.
Morphia, ½ gr.
Cacar b., 1 dr.

If the itching is produced by ascarides, calomel ointment should be applied, and santonin with calomel given internally :—

Calomel, 1 gr.
Santonin, 1 gr.
Sugar, 10 gr.
For one powder, No. 3, one each night.

If the pruritus is associated with hæmorrhoids, the following ointment, applied morning and evening, will be found useful :—

Tinc. of benzoin, 2 dr.
Ext. of hamamelis, 1 dr.
Ergotine, 1 dr.
Phenic acid, 10 gr.
Lanoline, 5 dr.
Vaseline, 5 dr.

Some very obstinate cases will only yield to linear scarifications.

Acute Coryza.

Sulph. of atropine, 1-5 gr.
Cherry laurel water, 5 dr.
Water, 5 dr.

Pour a few drops into a teaspoon, and dip into it the end of a match covered with a little piece of absorbent wool rolled tightly around it. With this simple instrument the mucous membrane of the nose is touched every hour by the patient himself during the daytime. If by the third day no relief (which is unlikely) is obtained, the treatment should be discontinued. A few drops of tincture of aconite in some warm infusion taken at bedtime procures perspiration and adds materially to the effect of the local treatment.

A good means of relieving the painful sensation of nasal obstruction is to sniff up a few drops, three times a day, of the following solution :—

Solution of adrenalin (1—1,000), 10 drops.
Solution of cocaine (1—100), 5 dr.
Cherry laurel water, 5 dr.

Not to be employed in children.

GERMANY.

Berlin, Dec. 29th 1907.

From a decision given some time ago in a court of law, a landlord of a house in Germany that has been occupied by a medical man who has left that house and gone to another is bound, although no special contract has been entered into regarding the matter, to allow the departing tenant to put up a notice-board on the house, and keep it there for a certain specified period, announcing the fact of his departure and his new address.

A SOCIETY FOR THE CARE OF INFANTS.

A Society for the Care of Infants (Verein für Sauglingsfürsorge) has been founded in the Düsseldorf district of Germany. The Society commences with a capital of 500,000 marks and a valuable piece of ground. The current expenses will be borne partly by the city and partly by the district. An intimate connection will be established between the Verein and the Academy for Practical Medicine. The Director of the Klinik for Diseases of Children will also be the scientific director of the Society. Some of the buildings have already been erected. The President will be Professor Schlossmann.

At the Medical Society Hr. Carl Levin spoke on the morphology and biology of malignant tumours. He spoke of the great difficulties that had been encountered in the transference of malignant disease from one animal to another, and laid stress on the fact that even when this had been accomplished in the case of classes of animals nearly allied, the whole group of symptoms of malignant disease were but rarely met with. The speaker had succeeded in cultivating a mammary carcinoma of a rat through thirteen generations, anatomical carcinoma with metastases in the abdominal organs being produced in every case. The case was originally an adeno-carcinoma. In the third generation a cancroid suddenly developed at the inoculation point, and from that time onwards during the succeeding generations either a tumour of mixed form —adeno-carcinoma and cancroid—or one of the two forms developed singly. It was certain there was nothing of cancroid in the tumour originally. Either a metaplasia of the cancer cells took place subsequently, or the cancroid arose from the irritation set up by the cancer cells upon the epidermis. The stroma developed freely in patches in the carcinoma, with occasional accumulation of spindle cells, which increased without any interval of granulation tissue to be seen.

Contrary to the experience of other observers in the case of mice (L. Michaelis), in rats breed and descent made no difference as regarded either susceptibility or growth of tumour. The most susceptible were young rats five to seven weeks old. He had had only 10 per cent. of failures in his inoculations. If the animals were first inoculated with hæmorrhagic tumours difficult to transmit (Ehrlich), or the first inoculation failed from any other cause, further inoculations were also failures. He looked upon this as an acquired immunity. In the same way mice were not susceptible who had previously been inoculated with rat tumours, and inversely rats were not susceptible when they had been first inoculated with mouse tumours.

At the Aerztlicher Zentralverein in Olten, Professor Roux spoke on his experiences with

ILEOCÆCAL TUBERCULOSIS.

since the Tuberculosis Conference in 1905. The right iliac fossa he looked upon as the key for investigating the condition of the various organs (gall bladder, ovary, right kidney, bowel). He pointed out the possibilities of palpation of the cæcum where in case of disease tumour formation or infiltration was rarely absent. In all his cases the disease could be recognised by palpation; 14 patients suffered from pain in the right iliac fossa; in 7 cases there were plain signs of stenosis; whilst the remaining 10 only suffered from constipation. Most of the patients were between 20 and 30; only two had advanced beyond the 6th year. Heredity could be shown in 7 cases; in 2 it was doubtful; in the remainder there was no trace of it. All the patients were treated surgically. In 7 he found multiple tuberculosis of the bowel, mostly with participation of the serous covering. If there were adhesions they were always in the right iliac fossa—nowhere else; 7 patients were suffering at the time from advanced tuberculosis of the lungs; the others showed only slight changes there, or none at all. Diffuse, multiple ulcers were only met with in association with advanced disease of the lungs—cavities, etc. He had performed the radical operation in 13 cases. When the ileum was wide enough, end-to-end anastomosis could be performed; otherwise the other forms were preferable. In his operations he had always made use of the incision he had recommended for operations on the appendix. In order to get more room you could then turn in the sheath of the rectus. Of palliative operations the taking out of a portion was the best; entero-anastomosis, on the other hand, was of but little value, as it only relieved the stenosis and did not influence the disease. In his operations for ileocæcal tuberculosis there was one death. Early diagnosis was important, as it allowed early operation. For this palpation was always of the greatest importance. The family doctor should never omit to palpate the right iliac fossa, as it often afforded indications for operation when other symptoms failed to give the necessary clue.

AUSTRIA.

Vienna, Dec. 29th, 1907.

FISTULA GASTROCOLICA.

AT the "Gesellschaft" Eiselsberg gave a history of the treatment of a case of ulceration of the stomach terminating with a fistula into the colon. The first palliative operation was a colostomy or jejunostomy, the former into the ascending colon, while the radical operation of colo-colostomy with resection of the primary fistula had finally to succeed these palliative measures.

MORPHOLOGY AND ÆTIOLOGY OF SEXES.

Tandler and Gross next entertained the meeting with the results of their investigations into the secondary effects of sexual operations such as castration, etc. They exhibited a eunuch, æt. 28, along with another negro, æt. 28, from Zanzibar. The castration of the eunuchs is usually performed when the child is six or seven years old.

In the comparison nothing very striking could be observed about the head unless the ossification which was niversally affected. The larynx was small, resembling a boy of twelve, while all the internal genitals are equally backward, the prostate being very small. The general configuration of the pelvis was between a male and female. The epiphyses of the humerus, ulna and radius, etc., were all apparently jointed. Two crania of castrated negroes were shown to demonstrate the same inhibitory action in the calvaria as present in the long bones. The pelves had the same defects. They next presented the bones of sheep that had been castrated along with those that had not been castrated. They also showed the pelvis of a man, æt. 54, with epiphyseal junctions of the pelvis, who presumably suffered from agenesia of the testes. From these facts Tandler and Gross reason that the bones never reach perfect ossification till the function of the glandula genitalis is fully matured.

Tandler and Gross are of opinion that this secondary effect is not only an inhibition or checking of the growth, but rather a perversion of the phylogenesis in the several organs. The genital glands of the sheep were neither masculine nor female, but rather a peculiar asexual form. For example, the larynx is neither male nor female in character, but rather an immature condition of the organ. The castrated pelvis has the same immature appearance, resembling neither one sex nor the other. The thymus in the castrated remains longer than in the normal state, thus indicating the immature condition of the individual. The great increase of the hypophysis after castration was early observed by Fichera, and needs no further description than by saying it is a peculiar symptom in castration.

Schüller said that besides the peculiar formation and proportionately large size of the castrated skeleton the peculiar structure of the bone itself was diagnostic of castration which could be detected with the assistance of the Röntgen rays. Redlich had recently published a case of "Giant Growth in the Infant" where the Röntgen rays revealed the presence of diffuse atrophy in the skeleton. These cases all prove to us that besides the thymus and hypophysis of bone being affected, the marrow of the bone is adversely affected by any interference with the cellular glands in other remote parts of the body.

Cramps and Convulsions.

Benedikt raised the question of locating cramps in the nerve system. The function of the nerve on the muscle was threefold—(*a*) shortening of the muscle, (*b*) an extension or broadening of the muscle to bring the body into the upright position, and (*c*) the fixation of body.

We now know that the cerebellum and medulla oblongata are responsible for the power of erection or elevation, and that all cramping arises from muscular shortening. In the case of paralysis agitans the cramping centre is apparently in the region of the quadrigemina. In chorea major the cramp assumes the character of a wave movement, while in the minor form it appears in irregular contractions. From this Leyden assumes the centre is located in the pulvinar or cerebrum, while the minor is in the cerebro-spinal axis. Isenschitz said that clinicians did not consider chorea major and chorea minor two separate diseases, and why they should have two morbid centres would be difficult to explain.

Rhachitis.

Goldreish exhibited an eight-year boy with tardy development of the permanent teeth. He was scarcely 93 ctms. instead of 119 ctms. with all the signs of rhachitis. At his age the four incisors and first molars should be appearing, and he considered the delay due to the rhachitis. He believed that phosphorus therapy would be successful in this case. Escherisch thought the rhachitis was very slight and the retarded teeth due to hypothyreoidism or some other congenital anomaly. Kasowitz was opposed to this view, and believed that rhachitis was the sole cause in the retardation of the teeth.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SERIOUS POSITION OF MEDICAL TEACHING IN CONNECTION WITH GLASGOW UNIVERSITY AND THE ROYAL INFIRMARY.

Considerable interest is being taken at present in medical and other circles in Glasgow and the West of Scotland with regard to the future relations of the Royal Infirmary and its Medical School, on the one hand, and the utilisation of the Royal Infirmary by Glasgow University for teaching purposes on the other. Briefly, the facts are as follows:—When Glasgow University was transferred to Gilmorehill in 1874, the then managers of the Royal Infirmary considered it essential, in the interests of the Infirmary, that it should possess a Medical School of its own, and the "Glasgow Royal Infirmary Medical School" was finally established, in the face of the strongest opposition from the University authorities. In 1889, at the instigation of the Royal Infirmary managers, the School was constituted a College (St. Mungo's College), so that the affiliation clause of the Universities Act of that year might be applied towards the affiliation of the Medical School to the University. But affiliation has all along met with the strongest opposition from the University authorities. In spite of this, St. Mungo's College was for a number of years a flourishing medical school in connection with the Glasgow Royal Infirmary. In more recent years, partly owing to the increased facilities for complete medical education in England and Wales generally, but more particularly owing to the operations of the Carnegie Trust acting unfavourably with regard to extra-mural students of medicine, the number of students in attendance has diminished, and for some time it has been evident that some form of reconstruction or affiliation was necessary if the school was to be continued on a permanent basis. Suggestions for the affiliation of St. Mungo's College to the University have met with very negative encouragement on the part of the latter, although no definite scheme of any kind has as yet been propounded to the University Court. On the other hand, suggestions emanating from University quarters have been made that the wards of the Royal Infirmary should be utilised for the purpose of affording additional clinical facilities for University students, while as a *quid pro quo* the University might appoint a certain number of teachers in the Infirmary as University lecturers, these lecturers to be examiners in virtue of their appointment, and to have in this respect equal status with the University professorial staff. While, of course, there are arguments on both sides which can only be finally settled by the arbitrament of time, there are some features which show a distinct analogy with the cases of the London Medical Schools, and differ materially from the cases of Birmingham, Manchester, Liverpool, and other centres which have been cited in favour of what is euphemistically termed "co-ordination" in medical teaching. The Royal Infirmary is the largest general hospital in Scotland, the number of beds occupied being somewhere between 600 and 700, and therefore seems *a priori* to have a good case for the possession of a Medical School of its own. The Western Infirmary, where at present practically all University students get their clinical teaching, contains somewhere between 400 and 500 beds. The other essential point is that the Royal Infirmary is about three miles from the University, while the Western Infirmary is practically in the University grounds. Now it is clear that students cannot be expected to waste hours of valuable time daily in travelling between the two Infirmaries, and as the University has no power to compel its students to go outside the Western Infirmary for their clinical teaching, the only practical remedy appears to be that the Royal Infirmary should continue to maintain a complete Medical School of its own. This, indeed, seems to be fairly generally recognised in Glasgow, and the two stumbling-blocks are the financial difficulty and the actual though unacknowledged hostility of the University to affiliation. On the general question of the interests of medical education, it does not seem too much to imagine that Glasgow and the West of Scotland ought to be able to accommodate at least two complete Medical Schools; and, to secure really effective competition, these schools should be on terms of affiliation. No surprise need be felt that the University probably does not look upon the matter in this light. The annual meeting of the qualified contributors to the Royal Infirmary, which takes place in a few weeks, and which may decide the future destiny of the Infirmary with regard to its Medical School, will be awaited with very great interest in many quarters.

Notification of Births Act in Scotland.—A representative deputation of the Glasgow medical profession was received by the Health Committee of the Glasgow Corporation on December 24th, in view of the coming into force of the Act on January 1st. In a memorandum the deputation state that whilst they have entire sympathy with the object of the Bill—namely, the reduction of infantile mortality among the poorer or less informed members of the community—they are of opinion that the means by which this is sought to be attained in the Notification Act in the form in which it has emerged from Parliament are in certain respects of a highly objectionable character. The provisions of the Act involve, in many instances, an unnecessary invasion of the homes of the citizens, and they place the family doctor in the position of a spy and informer in relation to his patients. Under the oath which has been imposed upon members of the medical profession from time immemorial, every medical man, upon his entrance into the profession, declares that he will not knowingly or intentionally do anything to the hurt or prejudice of persons committing themselves to his care and direction, "for any consideration or from any motive whatever," or divulge any secret committed to his charge. The requirements of the Act, if pressed indiscriminately, will in certain instances involve consequences of the most distressing character. There will be cases—not, unfortunately, very uncommon—in which young girls in respectable families would come within the purview of the Act under circumstances of shame and anguish. It may be taken for granted that members of the medical profession in such cases may not be deterred by any fear of the imposition of penalties from fulfilling the obligations of the medical oath. In conclusion, the medical profession of Glasgow, believing that the Corporation will act with discrimination in administering the Act, propose in case of each birth in connection with which they are called in, to place in the hands of the father or other responsible person a simple form of notification, with directions for its transmission to the Medical Officer of Health. They respectfully invite the Corporation, without adopting any resolution on the subject, to accept such notification as falling within the scope of the exemption clause of the Act, which is that no person shall be liable to a penalty if he has reasonable grounds to believe that notice has been duly given by some other person. The deputation were thanked and assured that the Committee would fully consider their statements.

OBITUARY NOTICES of the late Sir Patrick Heron Watson and of Professor Annandale, will be found in another column of our present issue.

LETTERS TO THE EDITOR.

MALIGNANT ANTI-VIVISECTION FANATICISM.

"VIVISECTION.

"To the Editor.

"Sir,—Instead of unseemly riots by medical students, and heartless jesting about one poor, helpless, pitiful little martyr to so-called science, let them do all in their power to make an end of the vivisection of dogs, which is carried on to such an appalling extent in the laboratories and medical schools.

"Most of these young men have, no doubt, had—and loved—dogs of their own. How, then, can they endure to witness the vivisection of other dogs, bound down, and maimed, and mutilated in the most terrible and revolting manner before their eyes?

"If all medical students would adopt the noble and manly course of refusing to attend classes where dogs are used for demonstration of lectures, and of declining to have anything to do with the cruel, vile, base and degrading practice of vivisection, they would gain infinite credit and honour for themselves and for the profession they intend to enter, which is now so very deeply disgraced by the foul blot of animal torture.—I am, etc.,

"C. A. M. BAILEY,
"Hon. Secretary, National Canine Defence League."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The above is an extract from a letter taken from the local paper of this date, December 20th. I am informed that letters of this kind are sent out wholesale to the provincial Press, and find a place in most of them. The letter constitutes a malignant and atrocious libel on physiological workers, on students of medicine, and on the whole profession. You will notice the false statements, particularly that which speaks of students "witnessing the vivisection of dogs bound down, and maimed, and mutilated in the most terrible and revolting manner before their eyes." The whole thing is calculated to inflame the minds of the public against the profession, to excite suspicion, distrust, and hatred of medical men. I repeat the query of your correspondent whose letter appears in your last issue, "Is it necessary that the profession should take all this lying down?" The papers that print these calumnies have their columns full of quack puffs, many disparaging doctors, and trading upon the fears of simple and ignorant readers—such an advertisement as you will see is printed below the letter I send. Vast numbers of poor people are to be found with organic pathological mischief, or malignant disease, gradually passing beyond the reach of remedy, whilst reliance is being placed upon worthless heal-alls and nostrums of one kind or another. The amount of human suffering and misery to which the anti-vivisection propaganda is giving rise in these islands alone exceeds a thousandfold the pain inflicted in the whole of the physiological laboratories throughout the civilised world. It is impossible for single individuals to combat this evil; local practitioners certainly cannot do it. Their appearance in the public Press at once lays them open to the imputation that they seek a personal advertisement. This is at least enough to deter me from such a course, and hence my appeal to you, Sir, for guidance and help. Is no organisation of the profession possible to deal effectually with the evils I write about? Ought we not, for the sake of humanity, and for our own sakes at least, to show fight in the cause of justice and truth?

I am, Sir, yours truly,
A SURREY DOCTOR.

Near Reigate, December 20th, 1907.

TREATMENT OF ARTIFICIAL ABSCESS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—On page 614, of THE MEDICAL PRESS AND CIRCULAR, December 4th, 1907, in your "Special Correspondence from France," reference is made to a certain method of treatment by artificial abscess, made by injection of 20 drops of sterilized turpentine. I beg to inform you that I have been using for this purpose a much better medium, pure culture of yeast cells; made according to the process of Prof. Christian Hansen, of Copenhagen, Denmark.

I am *curing* leprosy by this means; that is, my cases are steadily progressing favourably; all lesions are healing. 2 c.c. of these cultures ice cold, fresh from the single cell (unbudded) cultures, are injected mixed with vaccines, procured in the following manner. A first injection is made with the yeast cultures; beneath a prominent leproma this abscess is aspirated, and the contents dried, washed, sterilized, then emulsified to more 2 c.c., with strong camphorated oil. The second abscess, beneath a leproma produced by this, is again aspirated, and thus the treatment is continued. The area of inflammation is sometimes excessive, almost erysipelatous in character; and I note that, following this extended irritation thus set up, the best results are obtained in healing the open lesion of leprosy. The good effects of each vaccination by this method continue about 12 days, when a new abscess with yeast culture cell, leucocytes and dead bacilli, must be created. I find this a good method of training the leucocytes to kill the leper bacilli. The yeast cells remaining in these abscess cavities, by methylene blue staining, are shown to be dead; the enzymes by testing on sugar solutions are found to be still living. Chaulmugra oil will kill yeast cells and not enzymes, and this is our best remedy against leprosy. Thus the improved condition resulting from the one remedy must be in some way like that of the other. If the leucocytes can kill the yeast cells when thus drawn to an infected leprosy area, may they not at the same time act inimically against the leper bacilli? Evidently they do, for the cases in which I have used the method are continuing to improve rapidly.

ALBERT S. ASHMEAD, M.D.

New York, December 20th, 1907.

THE HEREDITY OF SYPHILIS

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to your report of my remarks on congenital syphilis and the question of the "heredity of syphilis," may I be allowed to call the attention of your readers to the masterly and exhaustive critical examination of this subject, especially as regards Colles's law, by Matzenauer? Matzenauer's "Die Vererbung der Syphilis" (Wien, 1903) is deserving of study by all medical men interested in the matter. The same author's "Die Vererbung der Syphilis: Ist eine paterne Vererburig erwiesen?" and the discussion which took place before the Imperial Society of Medicine in Vienna in 1903, are also well worthy of study ("Wiener Klin. Wochensch.," 1903).

I am, Sir, yours truly,
GEORGE PERNET.

London, W., December 30th, 1907.

OBITUARY.

PROFESSOR ANNANDALE, OF EDINBURGH.

PROFESSOR THOMAS ANNANDALE, whose sudden death on the morning of December 20th caused such universal grief in professional and social circles, and came as a great shock on the many friends who had seen him at work as usual on the day previous, was born in Newcastle in 1838, and had just entered on his 70th year. He was educated in his native town, and studied medicine first at Newcastle, subsequently at Edinburgh University, which he entered in 1856. From his student days he evinced a remarkable aptitude for surgery, combining dexterity, resourcefulness, and boldness in a remarkable degree—faculties which, along with his marvellous precision and neatness in operating, served him well until the end, and seemed rather to be sharpened than blunted by the passage of years. Though not trained in the pre-anæsthetic school, he was yet sufficiently near it to have acquired from those who practised then the art of rapidity in operating, on which so much of the success of earlier surgery depended. He graduated with honours, and received a gold medal for his thesis on injuries and diseases of the hip. At the same time he became a member of the College of Surgeons of England, and in 1860 served under the late Professor Syme as house surgeon. Syme undoubtedly was the teacher who most guided Annandale's bent, and many were the references the latter used to make to "my old master, the late Mr. Syme." So impressed was Syme by his young house surgeon's surgical instincts that he made him his private assistant, and in this capacity Mr. Annandale acquired a very large and varied experience of surgical practice. Mr. Syme died in 1870, and five or six years before that, Mr. Annandale, who had meanwhile been awarded the Jacksonian Prize by the English College of Surgeons, was appointed assistant surgeon to the Royal Infirmary. In 1863 he began to lecture on systematic surgery, and in 1871, when he became full surgeon, he gave this up for clinical surgery. When Lord Lister left Edinburgh for King's College in 1877, Mr. Annandale was elected to succeed him in the Chair of Clinical Surgery. It is a striking coincidence that his chief rival in the competition for that chair was Sir Patrick Heron Watson, whose death followed so closely upon the heels of that of Mr. Annandale. For the remaining 30 years of his life his whole energies were thrown into the conduct of the class of Clinical Surgery.

Professor Annandale taught his students many lessons, and not least of these was courtesy. It is impossible to conceive of him as anything but unvaryingly polite to his patients, from the humblest to the highest. His constant good humour and fund of anecdote enhanced the attractiveness of his teaching, and never detracted from his dignity. His relations with the students were of the happiest character, and his influence among them for good was all the greater that it arose from example and from the innate kindliness of his disposition, and was never enforced by prosy moralising. Professor Annandale was a brilliant operator. He was at his best in operations which demanded neatness and dexterity, and was especially successful in dealing with extensive malignant disease of the mouth and jaw. Various plastic operations, too, were his *forte*. In certain directions his powers of diagnosis were so remarkable as almost to merit the adjective "intuitive." Among his chief literary contributions works on diseases of the fingers and toes, on diseases of the breast, and on surgical appliances and minor surgery may be mentioned.

He was Surgeon-General to H.M. Bodyguard for Scotland, the Royal Archers, and took a prominent part in the social life of Edinburgh. All his old students will feel that, through his death, the University is poorer by the loss of a brilliant surgeon and a courteous gentleman.

SIR PATRICK HERON WATSON, OF EDINBURGH.

It cannot be said of Sir Patrick Heron Watson, as it was of Professor Annandale, that he actually died in harness, for although he was in active work until comparatively recently his health had been failing for some years, and within the past week his malady—angina pectoris—underwent a change for the worse, so that his death on December 21st was not wholly unexpected. Sir Patrick Heron Watson was the son of the Rev. Chas. Watson, D.D., parish minister of Burnbeland, and was born in Edinburgh in 1832, being at the time of his death within a few weeks of the completion of his 86th year. Educated at the Edinburgh Academy and University he graduated at the age of 21, and two years later, in 1855, became a Fellow of the Royal College of Surgeons. Watson determined to join the Army Medical Service, and went immediately after graduation to Woolwich, where his abilities were so speedily manifest that at the desire of the powers in authority he conducted a class of operative surgery for over a year. Becoming an assistant surgeon in the Royal Artillery he embarked for the Crimea, where he was first delayed from going to the front by an attack of typhus, and later, while his battery was guarding the Traktir bridge, he was debarred from active service by dysentery. Soon afterwards he was invalided to Scutari, when he heard the doctors discussing his case say "The man is too ill to survive the night." On his return to Edinburgh Dr. Watson began to build up what was probably the largest medical and surgical practice which has ever existed in Scotland. He taught surgery in the extra-mural school, he became assistant surgeon to the Royal Infirmary, he practised ophthalmic surgery in the Eye Infirmary, and he was likewise surgeon to Chalmers Hospital. He edited an edition of "Miller's Surgery," at the time the standard surgical text book. For various reasons, while Patrick Heron Watson's name was a household word throughout great part of Scotland, it has been but a tradition to many generations of students. He attained fame and an outstanding position in the medical world at an age when most men are only beginning to win their spurs—he retired from the infirmary after completing his tenure of office as senior surgeon at the age of 47; thirty-five years ago, when he was conducting a most extensive practice, specialization was in its infancy, and his opinion was sought after in medical and surgical cases, in which for the next twenty years his position as a consultant was undisturbed. His determination not to specialize militated against his obtaining that official recognition and position in surgery which his undoubted abilities and powers so well deserved.

Sir Patrick Watson filled many public offices and received many dignities. He was twice President of the College of Surgeons, being elected for the second time on the occasion of the quatercentenary. He was a curator of patronage of the University of Edinburgh, a Fellow of the Royal Society, and a member of the General Medical Council for many years. He was an LL.D.Edin., and Hon. Fell. of the Royal College of Surgeons of Ireland. He was one of the honorary surgeons in Scotland to H.M. Queen Victoria, and held the same honour at the hands of our present sovereign. In July, 1903, he received the honour of knighthood. He was universally respected, and was a quite unique figure in the medical world. However eminent physicians and surgeons we shall have in the future, it is certain that changing times will prevent any one man from filling the place left empty by Sir Patrick Heron Watson's death.

SIR ALFRED B. GARROD, M.D., F.R.S.

We regret to announce the death of Sir Alfred Baring Garrod, which occurred on Saturday last at his London residence, 10, Harley Street. Deceased was educated at King's College Hospital, graduating as M.D. of the London University in 1843. He became a Fellow of the Royal College of Physicians in 1856. Dr. Garrod was early placed upon the medical staff of King's College Hospital, and was Professor of Materia Medica and Therapeutics and of Clinical Medicine in the College. His attention was very early directed to the study of gout, and he endeavoured to confine the name to a specific condition in which the presence of lithate of soda in the blood could be demonstrated by the crystallisation of this salt upon a fibre of thread placed in a small amount of blood serum. This direction of his energies soon opened the way to a large and lucrative practice, and increased opportunities only added to his endeavours to solve the many problems connected with gouty and rheumatic conditions. Dr. Garrod was Physician Extraordinary to her late Majesty Queen Victoria, a Vice-President of the Royal College of Physicians of London, and in 1891 received the Moxon gold medal awarded by the College for research in clinical medicine. He was a Fellow of the Royal Society, and received the honour of knighthood in 1887. He was the author of many books and memoirs connected with the forms of disease to which his attention was chiefly devoted, but he had retired from practice for some time before the occurrence of his last and fatal illness, dying at the ripe age of 88 years.

LIEUT.-COLONEL MAITLAND, M.D.ED.

WE regret to announce the death of Lieut.-Col. J. Maitland, of the Indian Medical Service, retired, late Principal of and Professor of Surgery at the Madras Medical College, and Senior Surgeon at the Madras General Hospital. Colonel Maitland died at Bournemouth at the age of 55. He graduated at the University of Edinburgh in 1874, joined the Indian Medical Service in 1876, and was appointed to the General Hospital, Madras, and a Professor at the Medical College in 1882. He took the M.D. degree in 1888, and after filling various appointments in Madras and at the Medical College and General Hospital, was in 1896 appointed Professor of Surgery, and in 1903 Principal of the Medical College and Senior Medical Officer at the General Hospital. Lieut.-Col. Maitland was a honorary Fellow of Madras University, and was the author of "Elephantiasis and Allied Disorders," and of papers on "Filarial Disease," "Some of the Less Common Manifestations of Filariasis," etc.

I. HAWKER SOPER, M.R.C.S.ENG.

WE regret to record the death of Dr. I. Hawker Soper, of Plymouth, formerly of Blaina. Dr. Soper, who was in his 76th year, had been in failing health for some time, and on December 22nd he passed away as the result of senile decay. Dr. Soper from his early days was intended for the medical profession, and was a student at the old South Devon and East Cornwall Hospital. Having completed his studies, he went to Blaina, Monmouthshire, and started a practice which, by his skill and industry, proved to be a large and lucrative one. Fourteen years ago Dr. Soper retired from practice and removed to Plymouth to reside. Of an energetic and benevolent disposition, the deceased soon found scope for his activity, and he was especially interested in all movements for the benefit of the poor. His eldest daughter is the wife of Mr. Bramwell Booth, the chief of the staff of the Salvation Army.

GEORGE J. SEALY, M.R.C.S.ENG., L.S.A.

WE regret to record the death, under most tragic circumstances, of Dr. G. J. Sealy, a well-known medical man, residing at Oak Hill House, Weybridge, on the 24th ult. He was galloping on horseback by the side of the Thames, from Shepperton to Chertsey, a groom following, and was going at a good pace, when suddenly the bank gave way at the bend near the windmills. Both horse and rider were pitched into the river, which at this point is very deep. The deceased, who was booted and spurred, sank immediately, and the horse started to swim. The groom never saw Dr. Sealy again, the swift stream carrying him away. The horse swam to the bank. It is believed that the recent heavy floods have softened the earth embankment, and thus rendered it unsafe.

REVIEWS OF BOOKS.

OPERATIONS OF GENERAL PRACTICE. (a)

THE idea of this book is quite a good one, namely, to describe in detail those operations which may frequently be undertaken in general practice, in order that practitioners who but seldom resort to surgical measures may have encouragement to do so. The authors truly say "Most operative surgery is easy when the operator has mastered the technique of surgical cleanliness, and has some opportunity of practising the art." It is the facility with which most surgical operations may be performed, the kudos that attends success, and the proportionately high fees chargeable which determine most capable men who start in practice to do their own surgery. Unhappily when work is confined to a small circle, when the principle of averages has not the opportunity of operating, sooner or later he is apt to find that, even if he has escaped the odium of being "fond of the knife" and not being "much good at medicine," he is brought up by some untoward calamity, which in hospital practice has been put down as bad luck, but which may do him infinite damage in the neighbourhood. People expect deliberate operations to go without a hitch, and surgeons are paid on a scale which allow them, so to speak, to insure the risk of failure. It is a little amusing that the junior of the authors of this book, who appears to have just emerged from the house-surgeon stage, should join the seniors in sagacious reflections on the general practitioner, such as: "With the advance of medical and surgical knowledge a better educated and more highly skilled practitioner has come into existence," and again "the good work done in these (cottage hospitals) indicates that he should have further facilities to enable him to draw a line between his possibilities and his limitations." One cannot help remembering that many of these gentlemen who are thus encouraged were probably house-surgeons before the junior author was acquainted with the potentialities of stereoscopic vision. However, if we pass to the business of the book we can certainly congratulate the authors on the lucidity, completeness, and practical character of the descriptions, and also on the judiciousness of their choice of subjects. We notice much small and graphic detail which must be of great help to a man who is performing an operation alone for the first time, and who does not wish his unfamiliarity with detail to attract the notice of attendants. The point that calls most particularly for criticism is the little, or comparatively little, importance attached by the authors to local anæsthesia, especially with eucaine and adrenalin. To the general practitioner for whom this book is specially intended, the advantage of taking anæsthetist and anæsthetic in the waistcoat-pocket is extraordinary, and there are very few of the operations here mentioned that cannot be done under local anæsthesia. However, the practitioner who is acquainted with the blessings of local anæsthesia, and uses this volume to aid him in ideas and technique, may find his way happier and blither than it would have been even two years ago.

MINOR MEDICINE. (a)

THERE is no doubt that since the abandonment of the "apprenticeship" method of commencing medical education, neo-practitioners have to learn what practice is after qualification instead of before. The consequence is a very distressing bewilderment when confronted with the myriad ailments not falling into any particular category that patients complain of. The author has put together what may be described as "post-graduate notes" in order to assist young practitioners in their dilemma. The list comprises affections as alien to each other as bilious attacks and balanitis, sea-sickness and scabies, the removal of cutaneous stains and the treatment of dysuria—in fact, we are initiated into the mysteries of symptomatic therapeusis. The work is eminently practical, and its utility is enhanced by a liberal provision of prescriptions, which, after appearing in the text, are collected for facility of reference at the end, under their respective headings. There are useful hints as to diet in various functional disturbances and morbid states—altogether a very handy work of reference in dealing with the minor ailments of life.

(a) "Operations of General Practice." By Edred M. Corner, M.A. M.C., M.B.Camb., B.Sc.Lond., F.R.C.S., Surgeon in charge of Out-Patients at St. Thomas's Hospital, and the Sick Children's Hospital, and H. Irving Pinches, M.A., M.B., B.C.Camb., M.R.C.S., L.R.C.P., Clinical Assistant, Sick Children's Hospital. Oxford Medical Publications. London: Henry Frowde, and Hodder and Stoughton. 1907. Price 15s. net.

(a) "Minor Medicine." By Walter Essex Wynter, M.D., B.S. (Lond.), F.R.C.P., F.R.C.S.; Physician to the Middlesex Hospital, etc., etc. London: Sidney Appleton. 1907. Price 6s. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Ascites from Cirrhosis of the Liver treated by Operation.—Ketchen and Thomson (*The Practitioner*, December, 1907) discuss the very important question of the indication for this form of treatment of cirrhosis of the liver. The writers divide the cases of cirrhosis of the liver into two well marked clinical classes. The first class includes those cases in which ascites is an early symptom, which occurs before there are any signs of general poisoning of the system. The cases belonging to this class generally show marked improvement after being tapped. In the second class are cases in which the ascites is a late symptom, occurring when the general systemic disturbances are well marked, and in such cases if the fluid is withdrawn death frequently occurs before a second tapping becomes necessary. It is now generally recognised that the ascites in both classes of case is the result of peritonitis. The writers believe that in the first class of case this peritonitis is an entirely local condition, running coincidently with the changes in the liver but not dependent on them. The peritonitis and the cirrhosis both appear to be due to the same cause. In the second class of case the peritonitis appears to be due to a toxæmia which has resulted from the destruction of the liver cells and the consequent loss of the filtration function of the liver. Cases in the first class are as a rule greatly benefited by the operation of omentopexy, probably not so much on account of the anastomosis established between the portal and systemic veins as because of the increased arterial supply to the liver. The nutrition of the cells at the surface of the liver suffers from the obstruction to the hepatic arteries, and the new blood supply from the omentum to a certain extent counteracts this. In the second class of case operation does not delay, but rather favours, a fatal termination. For a clinical diagnosis between these two classes the writers rely on the general symptoms of the patient and the evidences for or against the presence of a general toxæmia. If the patient has been tapped several times successfully, his general condition remaining good, it is likely that an omentopexy will be beneficial. K.

The Medical Treatment of Gastric Ulcer.—Stockton (*Amer. Jour. of the Med. Sciences*, December, 1907), in an address delivered at the seventh triennial Congress of American Physicians and Surgeons, discusses this very important subject. He distinguishes two fairly well marked types of case: (1) that which as a rule starts in young chlorotic women, a type of case which is usually more common and which is usually acute. (2) The second type of case more usually occurs in elderly men, or at all events in men past middle life, and in its onset is usually chronic and in its course is more persistent. The difference in the history between these two types of case suggests a difference in their etiology, but the sameness in the processes enforces a belief that in most respects they are the same disease. Dr. Stockton has carefully examined both before and after gastroenterostomy the gastric contents of a patient who for years had been in the habit of swallowing knives, screws, nails and glass. He has found that though there were injuries to the gastric mucosa and some irritation, yet there was fair digestion of ordinary food, and injuries of the mucous membrane were rapidly recovered from. It has also been found that many serious cases of ulcer have occurred in stomachs having a gastric juice of very low acidity and feeble digestive power. These facts would point to the presence of some other factor in the causation of gastric ulcer than merely local injury and excessively acid gastric juice. This factor he finds in the lowering of the internal cellular resistance in some focus or foci of the gastric mucosa. The suggested explanation of these foci is that there is a want in the antibody in the cells of the mucosa which should normally antagonise the digestive ferments of the stomach, this want being further attributed to a tropho-neurosis similar to that causing herpes facialis. From this explanation Stockton draws his indications for treatment, which he believes should in the first instance be medical. A calm nervous system in a well-conditioned body is the state to be aimed at, and this state is to be attained by different means in different cases. One patient does better with complete gastric rest and abstinence from food for some days, while another does best with the rather full feeding recommended by Lenhartz. In all cases the treatment must be continued for a considerable period after apparent cure, making careful study of the stools for the presence of occult blood. From the medical point of view Stockton considers that the function of surgery in gastric ulcer is to relieve secondary results rather than to cure the ulcer itself. K.

Paralysis Agitans.—Berkely (*New York Med. Journal*, November 23) considers the therapeutical results from the administration of the parathyroid gland to cases of paralysis agitans. He draws attention to the fact that a properly identified gland must be used. Nothing much in the way of favourable results can be hoped for except from relatively small doses continued through a long period of time. These patients are nervously unstable, which fact must be borne in mind in drawing conclusions. Berkely has notes of 30 cases with the following results: Two patients declined to continue treatment; two have not been heard from; five denied benefit; three showed temporary improvement only; 18 were progressively benefited during the entire period of treatment. D.

The Influence of Food on Tuberculosis.—Weigert (*Berlin Klin. Woch.*, October, 1907) claims that clinical and physiological observations and experiments show that there is a direct connection between the water content of the organism and its power of resistance against infection. The greater the fluid content the less is the resisting power of the tissues. In animals fed on carbohydrates the fluid content is at its maximum. It is a demonstrable fact that different forms of food affect the composition of the organism. The author, working on these lines, fed five pigs on fat, and five others on carbohydrates. The animals were then infected with tuberculosis, and it was found that the fat-fed pigs reacted in a much lesser degree to the infection than those fed on carbohydrates. Weigert suggests that, taking these results into consideration, the diet in human tuberculosis should be largely fat and should contain little carbohydrate food. D.

Delirium and Delirious States.—Swift (*Boston Med. and Surg. Journal*, November, 1907) considers the fundamental attribute of most deliriums a disturbance of consciousness, using that term to imply the condition of mind under which external stimuli produce cerebral changes of some sort, of which the subject immediately becomes cognisant, and which he is accustomed to regard as ideas, feelings, etc. He discusses fever delirium, delirium tremens, the cause of delirium, the differential diagnosis, the treatment and prognosis. In regard to treatment, a continuous warm bath, he states, is generally preferable to soporific drugs as a quieting measure. The patient is kept in a bath at from 92 to 95 F., until restlessness subsides, when he is put to bed. This method of treatment is particularly useful in delirium tremens, but must be used with caution in asthenic conditions. Heart stimulants, such as alcohol, strychnine, and digitalis, may be indicated, but in alcohol delirium or in the presence of polyneuritis alcohol must be avoided. In threatened delirium tremens during enforced abstinence, Swift is inclined to side with those who believe that small doses of alcohol are beneficial. It may be distinctly beneficial in senile delirium. Regular nourishment—by the tube, if necessary, is important. The prognosis depends on the presence or absence of an underlying incurable cause. D.

Diagnosis of Cancer of the Stomach.—Brown (*Lancet-Clinic, Cincinnati*, November, 1907) reports two carefully reasoned cases which emphasise the fact that, with all the advantage of laboratory findings as an aid or a check to careful clinical examinations, stomach conditions are by no means easy of diagnosis. In the first case, the age, history, epigastric pain, absence of hydrochloric and presence of lactic acid, evacuation of blood with a stomach tube, and apparent constriction of the cardiac orifice, progressive emaciation and cachexia, apparent hour-glass constriction on X-ray examination, and secondary progressive anæmia, notwithstanding the absence of tumour and coffee-ground vomit, pointed clearly to gastric carcinoma; while the autopsy disclosed pulmonary tuberculosis, acute miliary tuberculosis, pulmonary œdema, atrophic gastritis, chronic interstitial nephritis, and ulcerated tuberculous enteritis. In the second case, all the symptoms, the blood findings, the occult blood in the stools, seemed to point to pernicious anæmia; and the absence of any detectable tumour, coupled with the presence of free hydrochloric acid in the gastric contents, did not divert the consideration to gastric carcinoma. Yet at autopsy a scirrhous carcinoma was found on the posterior wall. Brown concludes by pointing out that, valuable as the laboratory findings are as aids or checks, they are not infallible, and cannot replace a careful anamnesis and systematic physical examination. D.

New Local Anæsthetic.—Thibault (*Journal Arkansas Med. Soc.*, Little Rock, September, 1907) speaks highly of the value of quinine infiltration as a local anæsthetic. He describes an interesting series of personal experiments on himself, which arose out of his use of quinine hypodermically for the cure of malaria. After making several injections with first a 4 and then a 2 per cent. solution of quinine and urea bichlorid, he answered the objections that the results were an instance of pressure anæsthesia by infiltrating spots on each side halfway between the umbilicus and ensiform process, two inches from the median line, on the right side using the 2 per cent. quinine and urea injection, and on the left side a normal saline solution. At the end of five minutes there was no sensation in either place, but while sensation quickly returned over the area infiltrated with the saline solution, the anæsthesia on the right side was tested at intervals of one hour for six hours without producing any pain. He has since tried all the soluble salts of quinine, and found them to be good local anæsthetics when injected in 1.5 per cent. or stronger solution. He has used this local anæsthetic in amputation of a finger, removal of a large fatty tumour half a pound in weight, incision of a large carbuncle, divulsion of the sphincter for the removal of a fish-bone. He concludes:—(1) It is efficient in 1 to 2 per cent. solutions; (2) healing is as rapid as with any other local anæsthetic; (3) it is safer than any other local anæsthetic of any like equal efficiency; (4) solutions can be kept in stock and boiled repeatedly without deteriorating; (5) it is efficient when applied in 15 to 20 per cent. solutions to raw surfaces on cotton pledgets; (6) the anæsthesia lasts from one to six hours. D.

Great ravages are being caused at Mecca, Medina, and Yambo by the cholera outbreak. The deaths number over a hundred daily.

Medical News in Brief.

The Public Health Acts Amendment Act, 1907.

The Local Government Board has sent round a circular to the councils of municipal boroughs and urban and rural districts on the subject of the Public Health Acts Amendment Act, 1907, which comes into force on January 1st. The object of the Act is to enable sanitary authorities outside London to obtain when requisite, and without incurring the trouble and expense involved in promoting Bills for local Acts, various additional powers which are based upon provisions in local Acts passed in recent Sessions of Parliament.

The Board's purpose in the circular is to draw attention more particularly to those provisions of the Act which prescribe the procedure for applying enactments in it to any particular locality, and which are contained in section 3. Under that section the Board are empowered, upon the application of a local authority, by Order to be published in such manner as the Board direct, to declare any part or any section of the Act to be in force in the district of the authority, or where they are a rural district council in any contributory place in their district, and also to declare any enactments in any local Act which appear to the Board to contain provisions similar to or inconsistent with any such part or section to be no longer in force in that district or contributory place (section 3 (1)). The Board will be ready to give attention to applications under the Act, but they think that such applications should not be made unless the local authority are satisfied that the powers sought are really needed.

Coventry Medical Men and the Dispensary.

Dr. Pickup and Dr. Orton have written a letter in reply to Dr. McVeagh on the profession and the local dispensary, and on the position of Dr. McVeagh in relation to his colleagues in the division. Drs. Pickup and Orton say, *inter alia*: "Dr. McVeagh's bonhommie and genial presence, as well as his mature years, have long endeared him to the medical profession in Coventry, and it was a matter of great regret that circumstances compelled the members to place him in the same category as the three medical men who filled the vacancies in the Provident Dispensary. At various times and at various meetings Dr. McVeagh has expressed his dissatisfaction at the management of the dispensary as strongly as any of his late colleagues, and he frequently stated that he was willing to leave the dispensary could he afford to do so. Efforts were made by the division to raise a fund to compensate him for any financial loss he might sustain, but as nothing less than a guarantee of £200 a year for life would satisfy him, such efforts proved abortive."

Death under Chloroform.

Mr. Troutbeck held an inquest at Lambeth, on December 24th, on the body of Edward Edwin Boyd, a milk-carrier, who died under chloroform in St. Thomas's Hospital. The widow said that an operation was performed on her husband in the hospital on the 16th. She went to the hospital on Sunday, and had only spoken to her husband for three minutes when she was told to leave the bedside. He had told her that the doctors were going "to do him a bit of good." The doctors were waiting at the foot of the bed when she was sent away. About two hours later, when she was still in the hospital, she heard of his death. "I blame the doctors for his death," she said. "He was too weak to stand it. He was too near death at the time. I think he was slowly murdered." Dr. Nightingale, the house surgeon, said there was no chance of saving his life unless an operation was performed. Had he not undergone an operation he would have died that day, but an operation gave him a chance of life. Dr. Ronald E. Todd, who administered the anæsthetic, said he gave chloroform and ether. About 15 minutes after the patient had been under its influence he became very feeble, and the usual means of restoration were applied, but without success. Dr. Trevor, the pathologist of St. George's Hospital, agreed that the second operation was the only chance of saving the man's life. The Coroner said that Boyd himself was quite aware of the situation in which he was placed, and consented to an operation. He excused the wife's language, because she was under great emotion. A verdict in accordance with the medical evidence was returned, and the jury concurred with the Coroner's remarks.

Death under an Anæsthetic at Bridgwater.

THE Deputy-Coroner for the borough held an inquest, on December 23rd, concerning the death of Eliza Ellen Coles, æt. 36, whose death had taken place at the hospital. The evidence showed that the deceased suffered from internal pains, and under medical advice was removed to the hospital, where on Sunday an anæsthetic was administered in the presence of the whole medical staff for the purpose of making an examination of the patient, but just before the stage of unconsciousness the deceased suddenly changed colour, which implied that something was radically wrong. The deceased had also stopped breathing, and the medical staff tried artificial respiration and other means for quite an hour to restore animation, but without avail. Dr. Penrose Williams deposed to having made a post-mortem examination, which showed that one of the heart muscles was atrophied, and that was sufficient to cause the deceased to go off under an anæsthetic. The cause of death was heart failure, due to the administration of the anæsthetic, in conjunction with the nervousness inseparable from the circumstances of undergoing the same. The jury returned a verdict in accordance with the medical evidence.

The Notification of Births Act.

AMONG the legislative measures passed during the last Session of Parliament, the Notification of Births Act will come into operation to-day (New Year's Day). The Act was framed with a view to decreasing the waste of infant life, especially in the larger centres of population. By its provisions the Medical Officer of Health has to be informed within 36 hours of the birth of a child, so that he may, where necessary, advise as to the rearing and nursing of the infant. It is not a compulsory measure, but several Metropolitan parishes have already made preparations to use its powers to the full. Our Glasgow correspondent also refers fully in another column to the Act as it affects the profession in Scotland.

A Coroner's Predicament.

A SINGULAR incident occurred at an inquest held at Lewisham on December 27th, on the body of a child named Cutler, aged three months. Dr. John Wood said he had made a post-mortem examination, but had failed to discover the cause of death. The Deputy-Coroner said, as Dr. Wood could not find any evidence as to the cause of death, it would be necessary to call in another medical witness. A messenger was despatched for Dr. F. S. Toogood, who later on reported that he had made a post-mortem examination, and had seen the child's mother. Having regard to the history of the case, he was of opinion that the child had died of convulsions, although the mother had not seen it, and that death was due to this cause, followed by failure of the heart's action. A verdict of "Death from natural causes" was then returned.

Medical Men's Claim.

A CURIOUS claim was brought before His Honour Judge Granger, at the Redruth County Court. Drs. J. H. Tonking and William Blackwood, of Camborne, sued Miss Ada E. Roach for £38 12s.

Counsel for the plaintiffs said he understood the defendant and her father had been in communication with His Honour on the matter. Miss Roach, who was formerly a governess at Camborne, was taken ill and removed to the Redruth hospital and operated upon for a perforated stomach. It was an urgent case, and Drs. Tonking and Blackwood, assisted by other surgeons, performed the operation, which was a most difficult one, and fortunately successful. Some 70 visits were paid to Miss Roach, and the account was for £38 12s.—20 guineas for the operation and the balance for the visits, etc. Defendant's father had paid everybody else, but had refused to pay the plaintiffs, holding that the fees were excessive. In his letter, to which Dr. Tonking took strong exception, on account of the manner in which the claim was disputed, Mr. Roach admitted that a moral tribute of praise was due.

Dr. Blackwood bore out the advocate's statement. The operation was performed on May 7th. Mr. Roach, who was a naval pensioner, living at Plymouth, endeavoured to get a Plymouth doctor down for the operation, but the last train had left Plymouth, and a motor could not cross Torpoint. If a Plymouth doctor had performed the operation, he would have charged 30 guineas and expenses.

His Honour agreed with that view, and remarked that the operation was successful, and no doubt very well done. He gave judgment for Drs. Tonking and Blackwood for the full amount claimed, with costs.

Royal Academy of Ireland.

THE following resolution, passed by the Council of the Royal Irish Academy, has been forwarded to the Secretary of the Royal Commission on Vivisection, now sitting:—

"The Council, fully recognising the vital importance of experimental investigations carried out on living animals, believes it is desirable that licences to perform such experiments should continue to be granted to qualified workers.

"The Council believes that the restrictions at present regulating the granting of licences are adequate.

"The Council would desire to see licences granted by the Home Secretary on the recommendation of:—

"(1) The head of any of the Universities of Great Britain and Ireland.

"(2) The head of any of the medical licensing corporations.

"(3) The head of any of the chartered scientific societies.

"(4) The head of any of the veterinary colleges."

The Norwegian "Smoked Process" in Dietetics.

WE have received from the Stavanger Preserving Company, the well-known inventors of the "Norwegian Smoked Process," some samples of tomato purée and of "Crossed Fish" sardines. The goods are neatly packed in tins, and the sardines are preserved in the finest virgin olive oil. The delicacies prepared by this firm are well worth a trial by those who are unacquainted with them, and we recommend them to make the experiment.

New Tabloids.

MESSRS. BURROUGHS, WELLCOME AND CO., from their ever-active laboratories, are always furnishing fresh weapons against disease or old weapons in new guise. Three of their latest preparations are capsules of calcium iodo-ricinoleate (each containing 3 grains), capsules of terebene (each containing 5 minims), and capsules of sandalwood oil (each containing 5 minims). All are of the "Tabloid" brand, and, we need hardly add, of the same superior class and finish which have long characterised the drugs bearing that *cachet*.

MARTINDALE'S TUBERCULIN TEST (CALMETTE).

A GREAT deal of attention has been drawn to the remarkable observations of Calmette. It was shown by that authority that where tuberculosis, either medical or surgical, existed in man, its presence could be detected by the ophthalmo-reaction obtained by dropping tuberculin in liquid form into the eye. The usefulness of so simple and speedy a test to the medical practitioner is obvious. Messrs. Martindale supply the tuberculin in a convenient tube, the end of which is broken off, and a drop or two of tuberculin placed on the conjunctiva. If there be no tuberculosis there is no reaction. If, on the other hand, tuberculosis be present, the lower conjunctiva and caruncle commence to redden within three hours, and the reaction attains its maximum between the 6th and the 13th hours. The test is safe, rapid, and apparently free from fallacies. A full account is given by Mr. Sydney Stephenson in the *Ophthalmoscope* for September and October, 1907.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3, and pro rata for smaller spaces.

Dr. A. H.—We would be glad to have a fuller report of the case before deciding.

Massage.—We fear we cannot trespass on the domain of the nursing-home proprietor unless a *prima facie* case of improper conduct is made out. This, we understand, was not so in the present instance?

THE COMPLETE CATECHIST.

The Quack Doctor's Catechism.

(For the instruction of unqualified medical practitioners in those arts by which alone success is to be attained in this irregular branch of the profession.)

Question: Who are you?

Answer: A quack doctor.

Q.: What is a quack doctor?

A.: An individual of very limited medical knowledge, but of unlimited assurance, whose boast it is to be able to cure all manner of diseases—particularly those which are pronounced to be incurable by the qualified Faculty.

Q.: Have you many unique and sovereign remedies?

A.: Yes. I have as many of them as there are diseases known to Medical Science.

Q.: Are they all different?

A.: All.

Q.: Wherein do they differ?

A.: Mostly in the colouring matter with which I tint the water in which they are mixed.

Q.: Are these various unique remedies expensive?

A.: Absolutely—yes. Relatively—no.

Q.: Of what class of persons do your patients chiefly consist?

A.: Of the poor, the ignorant, and the uneducated.

Q.: How do such persons manage to pay the high prices you demand of them?

A.: They pinch and save and deny themselves the very necessaries of existence in order to do so.

Q.: Do you ever feel sorry for these poor creatures who, relying on your promises of cure, thus pinch and scrape to save up money for the treatment?

A.: I never feel in the least sorry for them. It would be ridiculous, on my part, to do anything of the kind.

Q.: Why so?

A.: Because no wise man is ever sorry for any simpleton whose simplicity puts golden guineas into his (the wise man's) pocket.

Q.: Do patients who have little or nothing the matter with them write to you thanking you for the marvellous good you have done them, and bearing eloquent testimony to your skill and capacity?

A.: They do.

Q.: What use do you make of these letters?

A.: I print them in my advertisements, and exploit them for all they are worth.

Q.: Do patients, on the other hand, ever write to you complaining that your remedies have proved absolutely useless, and demanding the return of their money?

A.: Frequently.

Q.: What use do you make of these letters?

A.: I give them to the caretaker to light my office fire with.

—*Truth*.

Medical Economist.—Your letter is unavoidably held over till our next.

Edinburgh Student.—In reply to your queries, you will find Moorhead's "Surface Anatomy" and Buchanan's "Manual of Anatomy" the best for your purpose. The latter differs materially from the work referred to by you, in that it is systematic and practical, including Embryology.

THE *STANDARD* AND MEDICAL BUTCHERY.

Under the above heading we commented in our issue for December 18th upon a most discreditable advertisement which was appearing in a prominent position in the *Standard* newspaper. The announcement was that of a certain quack, who styled himself "Professor," and was of the most insulting character to the medical profession. We expressed regret that an advertisement of such an outrageous nature should have found admission into the columns of a hitherto respectably conducted newspaper, and it affords us satisfaction to know that it has now been stopped.

Dr. Arany (Karlsbad).—Your paper is marked for early insertion.

THE VALUE OF WIRELESS TELEGRAPHY.

The value of the wireless system of telegraphy was shown at Dover on Sunday last, when a passenger on the mail packet "Marie Henriette," crossing from Ostend, put his shoulder joint out of place, and was in great pain. A wireless message was sent from the vessel to Ostend, and thence to Dover, for a doctor to meet the boat, and on arrival at the Admiralty Pier the passenger was promptly attended to.

Dr. L. G.—Certainly, with pleasure

Mr. C. J. H. and **Dr. W. S. L.**—Letters greatly appreciated.

Appointments.

Aubrey, R., L.R.C.P. and S.Edin., District Medical Officer of the Bath Union.

Cassidy, M. A., M.A., M.B., B.C.Cantab., M.R.C.P.Lond., M.R.C.S.Eng., Resident Assistant Physician at St. Thomas's Hospital.

Cotton, R. H., M.R.C.S., L.R.C.P.Lond., Second Resident Assistant Medical Officer at the Infirmary for Medical Relief Districts 1 to 4 of the Parish of Lambeth.

Harris, Dudley Raymond, L.R.C.P.Lond., M.R.C.S., *pro tem* Medical Officer for the Falmouth Workhouse.

Hutt, C. W., M.R.C.S., L.R.C.P.Lond., Senior Resident Assistant Medical Officer, Chorlton Union Workhouse.

Peace, P. C., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer at North Evington Workhouse, Leicester.

Titterton, J. T., M.B., C.M.Edin., District Medical Officer of the St. Germans Union.

Vacancies.

Sheffield University.—Demonstrator in Anatomy. Salary, £150 per annum. Applications to W. M. Gibbons, Registrar.

Cardiff Infirmary.—Medical Man required to take Charge of the Electrical Department, which includes X-Rays and Finsen Light. Salary, £150 per annum. Applications to Leonard D. Rea, Secretary and General Superintendent.

Sussex County Hospital, Brighton.—Third House Surgeon. Salary, £50 per annum, with board and residence in the Hospital, with washing. Applications to the Secretary.

The Middlesex Hospital, W.—Resident Medical Officer. Salary, £200 per annum, with residence and board in the Hospital. Applications to F. Clare Melhado, Secretary-Superintendent.

North-Eastern Hospital for Children, Hackney Road, Bethnal Green, E.—House Physician and Two House Surgeons. Salary at the rate of £60 per annum, with board, residence, and laundry. Applications to the Secretary. (See Advert.)

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Assistant Medical Officer for the New Crossley Sanatorium. Salary, £100 per annum, with board, apartments, and laundry. Applications to C. W. Hunt, Secretary, Hardman Street, Deansgate, Manchester.

Monkwearmouth and Southwick Hospital, Sunderland.—House Surgeon. Salary, £100 per annum, with board, lodging, and washing. Applications to the Secretary.

Chesterfield and North Derbyshire Hospital.—Senior House Surgeon. Salary, £120 per year, with board, apartments, and laundress. Applications to the Secretary.

Taunton Union.—Medical Officer. Salary, £75 per annum, together with 10s. for each case of Midwifery. Applications to W. F. B. Dawe, Clerk.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—A Casualty Medical Officer. Salary, £200 per annum, with lunch. Applications to Stewart Johnson, Secretary. (See Advert.)

Nottingham Children's Hospital.—Lady House Surgeon. Salary, £80 per annum, with board, residence, and washing. Applications to A. F. Kirby, Secretary, Albion Chambers, King Street, Nottingham.

Borough of Burslem.—Education Committee.—Lady Doctor. Salary, £150 per annum. Applications to A. T. Sheldon, Secretary, Education Offices, Burslem.

Births.

Sibley.—On Dec. 27th, at The Mansions, 70, Duke Street, Grosvenor Square, London, the wife of W. Knowsley Sibley, M.A., M.D., of a daughter.

Gutch.—On Dec. 27th, at 30, Fonnereau Road, Ipswich, the wife of John Gutch, M.D., B.C.Cantab., of a daughter

Marriages.

Pasmore—Screech.—On Dec. 21st, at Holy Trinity Church, Sloane Square, Edwin Stephen Pasmore, M.D., M.R.C.P., Medical Superintendent, Croydon Mental Hospital, Warlingham, Surrey, to Gertrude Eva, second daughter of the late John Screech, Esq., of Yelverton.

Thomson—Finlay.—On Dec. 24th, at Kohat, Captain Alexander Guthrie Thomson, 58th Rifles (Frontier Force), Indian Army, to Annie Wilhelmina, second daughter of Dr. W. A. Finlay, Trinity, Edinburgh.

Colbourne—Wilbey.—On Dec. 21st, at St. Mark's, Hamilton Terrace, London, Harold Brehmer, eldest son of Louis Colbourne, M.D., Beckenham (late of Buenos Ayres), to Blanche Kirsten, youngest daughter of Jules Edward Wilbey, of Maidenhead.

Deaths

Garrod.—On Dec. 28th, at 10, Harley Street, London, Sir Alfred B. Garrod, M.D., F.R.C.P., F.R.S., Physician Extraordinary to her late Majesty Queen Victoria, in his 89th year.

Respiratory Inflammations.

There are many reasons why Angier's Emulsion is so extensively employed in bronchitis and the various inflammatory affections of the respiratory organs incidental to the winter months. The first and most potent of these reasons is the universally attested clinical fact that the remedy quickly relieves these conditions. Equally true is it that the Emulsion exerts its curative influence in both the acute and chronic forms of bronchitis. Cough is checked, bronchial irritation allayed, and expectoration facilitated. No other remedy has such sedative demulcent and lubricating effects, while its stimulating influence on nutrition overcomes the oft-present element of systemic depression. It is no exaggeration to state that Angier's Emulsion is not only the simplest but likewise the best treatment for acute and chronic inflammatory affections of the respiratory organs.

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"A non-toxic and trustworthy antiseptic in all ages, differing entirely from simple solutions of formic aldehyde in nature and in action being much more powerful, devoid of any irritating properties, and which on solution by the saliva sets free that disinfectant in a nascent form."

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"In ten cases of **Diphtheria** the treatment by Formamint Tablets was employed as a substitute for local treatment by disinfectant gargles, and in some of the milder cases anti-toxin was dispensed with. In all cases the improvement was rapid."—(*British Medical Journal*, January 13th, 1906, Epitome, page 8.)

"A proved antiseptic and bactericide, non-toxic in action, far more efficient than gargles or mouth washes, particularly suitable for children and entails no pain, and its portability is of considerable convenience."—*Medical Magazine*, March, 1907).

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXVI. WEDNESDAY, JAN. 8, 1908. No. 2.

NOTES AND COMMENTS.

Goose-oil. THE curious dietaries and remedies which poor and ignorant mothers provide for their infants are the subject of many comments at health lectures and the like, and they go a long way to show the necessity for the schools for mothers which are being established some centres. We do not, however, remember to have seen mentioned before a delicacy which a mother spoke to using at Wolverhampton the other day, namely, rancid goose-oil. In our ignorance we must acknowledge to not knowing the beneficial results which are supposed to spring from the internal employment of this uncommon article of materia medica, but it seems that it was kept in the home of the woman in question, and when her three-day-old infant had a "wheezing on the chest" she proceeded to seek relief for him by the exhibition of the oil. The desired effect not being produced, half a teaspoonful of gruel was administered, but the infant still ailed, and whether from inherent delicacy or from the mixture of the goose-oil and gruel, or from a combination of these adverse circumstances, it eventually gave up the ghost. The mother had been attended in her confinement by an old woman who was not even a certificated midwife, but it did not come out whether she advocated the administration, or whether the mother relied on her own intuitive therapeutic promptings. Goose-grease is a well-known country panacea for external injuries, such as bruises, abrasions, and sprains, and in its way it is certainly as efficient as most of the four-and-sixpenny boxes of ointment that are advertised, but the idea that goose-oil turned rancid is good for any internal complaint, especially of a newly-born infant, is staggering. The question arises whether supersitition darker than this existed in the darkest period of the Middle Ages, and whether compulsory primary education, far from curing popular beliefs and traditions, has not merely turned them into other and perhaps more harmful channels.

Guinea-pig Barometers. OUR contemporary, the *Indian Medical Gazette*, always affords interesting and instructive reading for homesters, and in the December number we find an ingenious paper by Captain R. D. Saigol, of the Indian Medical Service, on "Rats and Guinea-Pigs as Plague Barometers *versus* Rat Destruction." Captain Saigol reviews the various methods aimed at the pestiferous rodent, from the keeping of tame cats to feeding him with bacteria-infected food, and the writer points out how little impression any of these measures can really make on the infinite number of rats in India. He justly observes that if plague itself, which is to rats the most fatal of all diseases, will not exterminate them, it is not very hopeful that any other poison or disease will. He then suggests that rat-proof houses should be built and cleanliness observed, and that in such houses cages of guinea-pigs or rats should be kept. He argues that if a plague-infected rat gained admission to the house, its fleas (*pulex cheopis*) would prefer, on quitting their host, to go to the juicy guinea-pigs or succulent rat rather than to the comparatively insipid human. Not only would the guinea-pig, or caged rat, act as a flea-filter, but if it were infected in turn its death would be an indication of threatened plague and preventive steps could be taken. Moreover, the course the plague was taking at any time could be easily followed by the deaths of the domesticated rodents. The plan likes us much. We can picture paterfamilias tapping the "barometer" before he goes out, and discussing rat "snaps" and guinea-pig "waves" with his neighbour in the railway-carriage; but, from a youthful experience of white mice which were not kept for hygienic indications, nor under particularly hygienic conditions, we can only be thankful that we of temperate climes have not got to provide each of our rooms with a cage of rats. The remedy is a drastic one.

Whitaker manque. THE infallibility proverbially associated with the name of Cocker is as nothing to the exact, stupendous omniscience which we moderns attach to the name of Whitaker. Indeed, if the compiler of that annual were to receive ten per cent. on the bets settled by reference to his pages, he would probably be in a position to give up the task of compilation altogether. But even Homer nods, and Whitaker, having stepped on to the slippery slope of medical custom, has come, slightly, to grief. A medical man was suing a recalcitrant patient, and the defendant alleged that the charge was excessive. "Whitaker" was brought forth as his authority, and the scale of doctor's fees there given quoted as authoritative. We do not profess to understand how the judge admitted "Whitaker" as evidence at all, except on the principle that if one wishes to err it is better to err in good company; however, the evidence was listened to, and part of the statement read out ran as follows: "All engaged in the profession are supposed to be equal in point of skill, and therefore entitled to charge alike, the tariff depending chiefly upon the residence of doctor and patient." Now the scale given is really a very fair one, and it is a pity that it was not left without comment, as it would give people a guide as to approximately what to expect a medical man in the ordinary way to charge. But to say that all men are "entitled to charge alike" means either that no one is allowed to charge more than his neighbour, or that the "sixpenny doctor" may charge a hundred and fifty guineas for bisecting a duchess's cook because she lives in Belgravia. As a matter of fact, the former is obviously untrue, and the latter is ridiculous. Medical charges are fixed by custom; districts vary enormously, and the fees received by eminent practitioners outside London are much smaller than those acceptable to West End practitioners of no greater skill.

Noblesse oblige.

As showing, however, how the traditions of the profession appeal to foreigners, it is interesting to note that the German High Court held that it was illegal for the medical practitioners to band themselves together and establish a definite code of fees for professional services. The reason given for this weird decision was that the Court held that medical practitioners are actuated by a desire to serve their fellows and not to seek their own interests, and therefore, they do not expect to be paid in full for their work. It is comforting to know that doctors are so highly thought of in Germany and that their generosity is so proverbial, but in a matter-of-fact community such a decision will only mean that a great many unscrupulous scoundrels will never adequately requite their medical attendant for his services. The German Court was good enough to add that doctors stood above the level of men of business pursuits, and the establishment of a fixed fee would lower their dignity. But high position, even if accorded, is a poor recompense for an empty stomach, and we agree with the philosopher who observed that, however undignified it might be to do certain things, there was nothing more undignified than poverty. It is quite true that medical men can never hope to obtain a full recompense for their work, but they like to decide for themselves who shall be the objects of their charity. It is one thing to act on the principle of *noblesse oblige*, and another meekly to allow oneself to be swindled.

LEADING ARTICLES.

THE PUBLIC HEALTH ACTS AMENDMENT ACT.

The new Public Health Acts Amendment Act, which now becomes operative, marks an important advance in national health administration. The general effect may be described as equalising to a great extent the powers of rural and urban sanitary authorities throughout the United Kingdom with those hitherto enjoyed by the London Council as regards the health of the community. Part I. of the new Act authorises the extension to all parts of the United Kingdom, exclusive of London, all or any parts or sections, by an order of the local Government Board or the Secretary of State. In future, therefore, the Central Board may declare any section or sections of the Act to be operative wherever they may deem such a step desirable. It is worthy of careful note that appeals to Quarter Sessions may be made by persons aggrieved by any order under the Act. Part II. affects streets and buildings. A deposit of plans can be declared by a local body to be inoperative if the work be not commenced within a period of three years from the date of the deposit. Powers are given for regulating the width, access and other conditions of streets and roads. As regards urgent repairs to private streets to obviate danger to passengers, the local authority may require the owners to execute the same forthwith. Under Section 20 owners may be required to make good damage to any public road or footway due to excavations or the works on their private property. Part III. deals with sanitary provisions, and adds to the list of circumstances constituting a nuisance. A nuisance is legally defined as that which destroys the whole comfort of life of the public. The third part of the Act refers to rain-water pipes and closets, expenses, payments for works for the common benefit of two or more buildings belonging to different owners, and the removal of urinals. The local authority can require the owner to provide and maintain urinals in any inn, public-house, refreshment-house, or place of entertainment. If a medical officer has grounds for distrusting the drains of any building, he may apply the smoke or coloured-water test, and the owner can be required to remedy the defect. If local authorities are required to remove trade refuse (other than sludge), they must do so, charging a reasonable sum, to be settled, if necessary, by a court of summary jurisdiction. There is given a power for local bodies to provide ambulances. Part IV. deals with infectious diseases. It forbids a person knowing that he is suffering from such to engage in any occupation which risks the spread thereof. Infected clothes may not be sent to a laundry, and filthy articles in dwelling-houses may be purified or destroyed. Dairymen can be compelled to state their sources of supply. Children suffering from infectious diseases may not be sent to school without a permit from the local medical officer, and the principal of a school where such disease has been must send a list of the scholars to the local authority. Another provision, of importance chiefly in Ireland and in the Irish quarters of English and Scotch towns is the forbidding of "wakes" over the bodies of persons who have died of infectious disease. It is to be hoped that this provision will not bring the Act into conflict with deeply-rooted tradition and prejudice, not to mention the religious feelings of a number of his Majesty's subjects. The Act makes the owner and every guest liable who take part in a "wake" over the body of a person suffering from infectious disease. Part V. introduces common lodging-house legislation. A court of summary jurisdiction may cancel the registration of a common lodging-house keeper on a first offence against any provision of the Public Health Acts, and not merely on a third conviction, as under Section 88 of the Public Health Acts, 1875. Part VI. of the Act of 1907 deals with recreation grounds. The rest of the ten sections deals with police, traffic, registration of servants, and other matters of less direct interest to medical men. On the whole, this may be regarded as the most comprehensive and detailed extension of public health that has taken place for some time.

THE LOCAL GOVERNMENT BOARD AND STRAIT JACKETS.

For many years past we have from time to time urged the necessity for some greater measure of central control of our Poor-law system, but so far the long-wished-for day of reform has not arrived. The appearance of a fresh scandal now and then disturbs the public conscience, and the lay Press is provided with a nine-days' wonder, after which things settle down into the old groove. A typical occurrence of the kind has been recently investigated by Mr. Arthur Downes, the Local Government Board Inspector. The subsequent report, couched in his usual lucid and able style, furnishes some suggestive reading. The subject of the inquiry was the death of a Dane, aged 39, who died in the observation ward of the Hampstead Workhouse, after having been there for seventeen hours, seven of which were spent in a strait jacket, without having been seen by a medical man. Read in the light of this bald statement the incident takes one back to the worst days of the old *régime* of Bumbledom. A man is brought into a workhouse in a state of maniacal excitement: there is no padded room, and he is consigned to the tender mercies and skilled judgment of an attendant, who claps him forthwith into a strait jacket. The medical officer is either summoned late or is otherwise engaged; anyway, the upshot of this sordid story is that the unfortunate man dies without medical advice. It is needless to point out in the columns of a medical journal that prompt medical attention is absolutely necessary in such cases, and that the majority recover more or less completely under appropriate treatment. That part of the matter is not emphasised in the condensed copy of the Inspector's report at hand. It is enough to know that such an occurrence is possible under what is commonly described as the humane modern conditions of the Poor-law. Unfortunately there is no reason to flatter ourselves that the incident is isolated and exceptional. Years ago we dwelt on deaths in padded rooms in London workhouses, and we asked for a full investigation of this point by the Local Government Board. We have little doubt that were such returns available the public would be provided with a sensational exposure of no common order. What is possible in the largest and wealthiest city in the world, however, is much more likely to happen in other parts of the United Kingdom, notably amongst the poorer and less densely populated districts. In the Hampstead case the report can hardly be regarded as adequate, at any rate, by those who are anxiously awaiting the coming of a new spirit into Poor-law control. The attendant is mildly censured for having failed to summon a medical officer, and his subsequent conduct is to be reported upon in three months' time. The master is blamed for not having seen the man after admission. It is further urged that all officials concerned should be informed as to the official regulations laid down for the treatment of lunatics. In our opinion, the Local Government Board cannot absolve itself by a perfunctory report of this kind. We presume that the main defects of the Hampstead Workhouse Infirmary, including the non-resident medical officer, the absence of a padded room, and the system for the reception and control of lunatics has long been within the knowledge of the Board's inspectors. We presume, further, that repeated official reports have been submitted to headquarters drawing attention to these defects. If this has not been done the inpectors have failed in their duty; if this has been done and steps have not been taken to secure an immediate remedy, then the responsibility lies with the Board. What is the use of a central authority which does not enforce the provision of elementary accommodation in workhouses and workhouse infirmaries for all medical emergencies? Of late years much has been heard about the coming Poor-law reform. Here is a field in which there is no need to wait for a future; the work is ready to the hand of the labourer. If the Local Government Board is unable to insist upon proper accommodation for acute mental cases in Poor-law institutions, then the Board itself must be in no less urgent need of reform than the workhouse system, whose duty it is to guide, govern, and control in such a way as to render it an efficient State service.

CURRENT TOPICS.

The State Regulation of Laundries and Notification of Births.

AMONG the laws that have come into force with the New Year is the Factory and Workshops Act of 1907, which was introduced by the Home Secretary in the House of Commons on behalf of the Government. By the provisions of this Act all laundries in which persons are employed for wages, and which are carried on for purposes of trade, are brought under the Factory Act, 1901, as regards regulating the hours of employment of women and young children in such establishments. The implicit—if not the explicit—effect of the Act is to bring laundries connected with charitable institutions under the control of Government inspection. In order to meet objections raised in certain quarters a special provision is made, by section 5, sub-section 2. par. d, whereby the private interrogation of inmates of reformatories is excluded, except on the authority of the Secretary of State. Another law that becomes operative is the Notification of Births Act, devised with a view of reducing the present high rate of infantile mortality. In districts where the Act is adopted, notice of birth must be given in writing to the medical officer of health within six hours, either by the father (when residing in the house at the time), or of the person in attendance upon the mother, under a penalty of 20s., recoverable on a summary conviction. The legislation applies to the birth of any child which has issued forth from its mother after the expiration of the twenty-eighth week of pregnancy, whether alive or dead. So far as London is concerned, the medical officer of every metropolitan borough is directed to send a weekly list of notifications of birth to the County Council. One serious defect in the Act is the omission to provide for payment of the services of the medical attendant when called upon to sign the certificate of birth, while, at the same time, he is subject to pains and penalties for non-complance in the matter. The graver objections we have discussed.

The Progress of Cremation.

CREMATION, like many other desirable reforms, moves but slowly in the estimation of the public. The reasons for this tardiness of advance are mainly sentimental, but, in spite of all objections, there is little doubt that the movement in favour of this form of burial is slowly but surely gaining ground. Several of the large cities have availed themselves of the powers conferred by the Cremation Act to erect crematoria. One noteworthy fact is the attitude of the clergy, which nowadays in some, if not in all of the churches, is favourable to this most ancient of rites. At the opening of the Birmingham crematorium, a few years since, Bishop Knox said that in spite of sentimental objections cremation was not only preferable from a sanitary point of view but was also a most reverent and decent treatment of the bodies of the dead, and one that was in entire accordance with Christian belief. At a recent meeting of the Manchester Crematorium Company it was reported that the number of cremations during the past year had reached 104, the largest hitherto in any one year, making a total since the opening of the crematorium of 1,119. From a sanitary point of view the arguments in favour of the disposal of dead bodies by fire burial are simply overwhelming. The contingency of the destruction thereby of the evidence of possible poisoning was carefully guarded against in the Cremation Act, 1902, which demands a statutory declaration and an independant confirmatory medical certificate.

Chloroform and Burglary.

Notwithstanding the length of time chloroform has been before the British public, there appears to be still a good deal of popular misunderstanding as to its particular properties. The most common error is probably that of the novelist and playwright, who attributes an instantaneous action to chloroform, somewhat akin to the rapid intoxication familiar on the opera stage. From time to time chloroform figures in the accounts of burglaries with the persistency and eke the elusiveness of the famous sea-serpent which is the pride of journalistic mythology. The latest romantic story of the kind comes from a village near Pontypool, where a young Welsh servant-girl was found one morning stark naked and tied to a bedstead. Her statement was that she awoke to find standing at her bedside two men who made her show them where the silver was kept under threat of death. At this stage of the proceedings she was too terrified to scream out. After the silver was looted, one of the burglars took the girl back to the bedroom, stripped her, and tied her to the bedpost. It was then that the chloroform appeared for the first time in the condensed drama, for the burglar, possibly by that time convinced that there was a danger of the girl becoming so startled as to scream and thereby alarm the household, placed a handkerchief saturated with the narcotic drug over her mouth, and departed. Most of the silver appears to have been found in the back yard. On general grounds it may be pretty safely asserted that the use of chloroform in burglary is hardly yet within the range of practical politics, a belief which is rather confirmed than otherwise by the internal evidence of the Pontypool incident.

The Central Midwives' Board and the Coombe Hospital.

The somewhat remarkable statement emanating from the Central Midwives' Board, which we published in our last issue, relative to the training of midwives at the Coombe Hospital, reminds us very strongly of the reports of certain police-court proceedings, which occurred recently. A man was prosecuted for driving a motor-car to the public danger, and also for attempting to bribe the policeman who stopped him on the road. He was convicted, and fined sixty pounds. A short time afterwards another man was prosecuted for driving a horse and trap to the public danger, and also for attempting to bribe the policeman who stopped him on the road. He was convicted, and fined forty shillings. There is no one who will try to justify bribery, but, even so, there are few who will consider that bribery committed in connection with a motor-car is thirty times a worse offence than is bribery committed in connection with a horse-drawn vehicle. Similarly, there is no one who will justify the signing of incorrect certificates, but there are few, in Ireland, at any rate, who will not be led by the rather non-judicial statement issued by the Central Midwives' Board, to think that perhaps a similar offence occurring in England would not have been punished in quite a similar manner. The Central Midwives' Board has itself resorted to so many quibbles with the object of placing the semi-illiterate "handy-woman" on the roll of trained midwives, and has so persistently tried to exclude the highly-trained Irish maternity nurses, that it is no wonder if it is has made those with whom it comes in contact casual and inaccurate.

Football Mortality.

There are few genuine sports which are entirely free from bodily risk. Even golf, which is probably the safest of all, has its victims, though they are not many. The most engrossing of all sports, such as fox-hunting, mountain-climbing, and big-game shooting, undoubtedly depend for much of their fascination on the element of risk associated with them. That a sport has its dangerous moments, therefore, does not necessarily condemn it, but, nevertheless, there are limits to the risks which it is justifiable to undergo. In these countries we are accustomed to regard football as a comparatively safe game, and we allow our boys to play it without let or hindrance. We hear of a broken collar-bone or an inflamed knee now and then, but permanent injuries and fatal accidents are very rare. In America, however, things are far otherwise, and the game of football stands for something quite different from what we understand by the name. A couple of years ago the high mortality from football injuries in the States attracted so much attention that, by the force of public opinion, the rules underwent certain modifications. The result was at the time gratifying, as the numbers dropped from 22 deaths and 96 serious injuries in 1905, to 10 deaths and 63 serious injuries in the following year. During the 1907 season which has just ceased—for the American football season lasts only a few weeks of the beginning of winter—there were 14 deaths and 58 serious injuries. It would appear, therefore, as if the promised improvement had failed to appear, and as if the changes in the laws had not been sufficiently radical. The problem has, therefore, yet to be solved. Our experience in these countries shows how, under strict rules, football may be played with safety, and there is no reason why an equally strict code of rules should not render it safe in America. Otherwise, it is likely that the game will have to be totally prohibited in schools and colleges.

Medical Lectures to the Public.

It is only within the past few years, and as a part of the modern sanitary campaign, that it has come to be recognised as permissible for medical men to address themselves to the public in the form of lectures on medical subjects. There is no doubt, however, that instruction given in this way may do good public service, and if controlled by certain definite limitations, we can see no objection to medical men taking their natural place as leaders of the public on matters relating to health. A usual limit imposed by the good sense of the profession is that detailed references to curative methods are to be excluded. The anti-tuberculosis movement in Ireland has given us so far the best example in these countries of instruction being systematically given to the public on sanitary affairs by members of the profession. It is true that some annoyance has been caused by the fact that a few of the lecturers took little notice of the limit we have mentioned as usual, and made perhaps somewhat unnecessary references to their own therapeutic successes, but, on the whole, the courses of lectures, which have now been running for some months, have been unexceptionable in tone, and productive of good results. In America an interesting step has just been taken by the medical faculty of the University of Harvard. During the next four months, on Saturday nights and Sunday afternoons, a member of the faculty will address the public on some medical subject. The subjects cover a wide field, but they seem admirably chosen, and, for the most part, unhackneyed. Among others are "The modern crusade against typhoid fever," "The sick child," "Rational infant-feeding," "The relation of the hospital to the community," "Mental hygiene and the prevention of insanity," and "The development and maintenance of good teeth." These are subjects on which the public requires instruction, and we shall watch eagerly to see whether this venture of Harvard will prove a success.

The Prevention of Sleeping Sickness.

It is to hoped that the recommendation made by the International Conference on Sleeping Sickness, held in London last June, will not be allowed to drop out of sight, but will become the basis of some international action. Most of the members were not invested with full powers to allow of their signing a definitive convention, and accordingly the Conference was adjourned to November 1st. Lord Fitzmaurice, who presided, said that the disease had decimated the Congo, had worked no less havoc in Uganda, and had appeared elsewhere. Accounts were given of the measures to combat the disease which had been taken by the various Governments. It was recommended that a central bureau should be established in London with branches in each of the countries represented. It was also suggested that efforts should be made to prevent natives from passing from contaminated districts. Cutting down the jungle has had good effects in driving away the tsetse fly, which inhabits the edges of lakes and rivers where there is forest. The fitting of screens to European houses and steamers and the wearing of veils and gloves were also recommended.

Medical Opinion and Vivisection.

Although there is no difference of opinion in the medical profession as to the necessity for experiments on animals in the course of research, yet it is quite possible that this unanimity may not be sufficiently impressed on the Royal Commission at present inquiring into the subject. We are glad to note that the Royal Academy of Medicine in Ireland has taken the step of putting into the form of resolutions the opinions of its members as regards experiments on animals, and of forwarding these resolutions to the secretary of the Commission. We publish them in another column, and it will be seen that the Academy thinks that the present regulations are sufficiently strict, while it urges that licences should be more easily obtainable than at present. They should be granted, it is suggested, on the recommendation of the heads of universities, medical and veterinary colleges, and chartered scientific societies. The changes urged by the Academy are sensible and practicable, and we hope that other responsible medical societies will also consider the question, and forward their views to the Royal Commission.

PERSONAL.

The Companionship of the Order of the Indian Empire has been conferred on Major J. N. Macleod, I.M.S.

Major Robert Charles Macwatt, I.M.S., has been made the recipient of the Kaisar-i-Hind Medal (First Class).

Mr. Malcolm Morris, F.R.C.S.Ed., has been appointed by the King a Knight Commander of the Royal Victorian Order.

Public testimonials were presented to Dr. George Petrie Hay, of Forres, on his retirement from the practice of his profession at the end of last year.

Sir James Crichton-Browne will take the chair at the inaugural meeting of the Society for the Destruction of Vermin, to be held at the Hotel Metropole on Friday next.

Sir John Tweedy will take the chair at the second annual dinner of past and present students of the Royal London Ophthalmic Hospital at the Trocadero on January 29th, at 8 p.m.

The Khedive has conferred the Grand Cordon of the Medjidieh on Sir Horace Pinching, K.C.M.G., who recently retired from the post of Director-General of the Public Health Service of Egypt.

Dr. J. Agar Matson has been appointed by the Lord Lieutenant to be a member of the Board of Governors of the Westmorland Lock Hospital, in the room of Dr. J. Magee Finny, who has resigned.

Dr. Laveran, who was recently awarded the Nobel Prize for Medicine, intends, we understand, to present a portion of the £7,600 he received to the Pasteur Institute, in order to encourage the work of scientific research.

Dr. W. D. Stoney Johnstone, M.B., Ch.B., Edin., and Dr. Victor M'Allister, M.B., B.Ch., B.A.O., R.U.I., ex-House Surgeon Mater Misericordiæ Hospital, Dublin, have been appointed Assistants to the Master of the Coombe Hospital.

Dr. George Turner, Medical Officer of Health for the Transvaal, will shortly retire under the Civil Service age limit, and will return to England. He is said to have saved Cape Colony something like six millions sterling stamping out rinderpest.

A Clinical Lecture
ON
PSORIASIS: ITS CLINICAL AND MICROSCOPICAL CHARACTERS, DIAGNOSIS AND TREATMENT.

By ARTHUR WHITFIELD, M.D., F.R.C.P.,

Professor of Dermatology in King's College, Physician for Skin Diseases to King's College and to the Great Northern Central Hospitals.

Gentlemen,—I have chosen the subject of Psoriasis for my lecture this afternoon because it is in this country so common a disease that it has a great practical importance, and it not infrequently presents difficulties in diagnosis and treatment.

The time at my disposal will hardly be sufficient for a very detailed description of the clinical characteristics, which, after all, are only too familiar to us all, but I hope to be able to pick out certain points which may be of interest and use to you.

Psoriasis is perhaps the most uniform of all the skin eruptions, if one studies the evolution of the process. It is true that certain differences are at first sight very striking, but on close examination one finds that these differences are only produced by the preponderance of one or more characteristics which are always present.

The earliest lesion of psoriasis is a scaly papule, and one may say that for practical purposes the lesion of psoriasis always remains a scaly papule. Whether the redness which is always present precedes the scaliness or *vice versa* is a point upon which I should not like to offer any opinion, never having seen either of these two features alone. The first characteristic to which I will draw your attention is the fact that this primary papule undergoes in most cases what we may call an essential extension. By this I mean that the actual lesion increases in size by gradual extension of its border, and without necessarily the aggregation of fresh lesions. By keeping this fact always in your mind you will at once remove many of the difficulties of distinguishing this eruption from that of other dry and scaly skin diseases.

Next I wish to point out to you the characteristics of the scale. This is, as I have already stated, present when the essential lesion is first noticed, and consists of several layers of apparently dry horny layer, and may be either silvery in its undisturbed condition, or it may be yellowish at first, and only take on its silvery characters when roughed up by means of scratching. It is always hard and gives a marked sense of resistance to the finger when felt. As the lesion extends peripherally new scales are formed beneath the original one, so that the centre of the scale is thicker than the edge, a condition well seen in the photograph I now show you of a case of acute psoriasis in a boy of about twelve years. You will also notice on close examination that the edge of the scale is apt to be less firmly attached than the centre, so that if you wish to detach the scale it is best to work from the periphery towards the centre. This is in sharp contradistinction to what occurs in tinea circinata and in pityriasis rosea, diseases which are often confounded with psoriasis, but in which the scale is always frayed out towards the centre, so that in attempting to remove them one naturally works from the centre towards the periphery. If one starts then from the periphery with a blade of a pair of scissors and attempts to lift the scale of a psoriasis papule, one finds that it is easy to lift off a coherent mass of scales thicker in the middle than at the edge, and after removing this mass one finds exposed a glossy surface showing on examination with a hand lens, minute red points shining through it. These points are, as I shall show you, the apices of dilated and congested papillæ. If now you pass the finger over the lesion thus denuded of its scale you will find that it imparts scarcely any sense of resistance to the finger, and if felt at all gives the impression of a succulent œdema rather than of new formation, an important point, as upon it rests the differential diagnosis between psoriasis and a scaly syphilide. I show you here two photomicrographs to demonstrate these points, and you will see that in comparing the histology of psoriasis with that of syphilis that in the former there is a comparatively small accumulation of cells limited to the papillary body, whereas in syphilis even as in this case of the most superficial variety, there is a well marked accumulation of cells round the vessels extending to a considerable depth in the corium.

I may also point out to you in this place what has been considered by some a characteristic feature of psoriasis, namely, the presence in the scale of small collections of leucocytes, the so-called "dry abscess" of psoriasis. For the rest of the histology I need not bother you with many details, but there are one or two points to which I may allude. These are the changes in the papillæ which have overgrown and become distended at their apices so that they have become club-shaped, extending much nearer to the horny layer than usual, and accounting for the red points which I have already mentioned; the diminution, or more commonly complete absence of the granular layer and the retention of the flat nucleus in the cells of the horny layer.

If after satisfying yourself that there is no "infiltration" or accumulation of cells in the skin by palpating the denuded lesion, you proceed to gently scratch the shining surface, you will find after a few seconds that you produce minute pin-point hæmorrhages which are derived from these individual congested papillæ. It is important that the scratching be very gentle, as if roughly done, the hæmorrhage may be produced in a number of eruptions and the diagnostic significance is lost.

So much, then, for the essential characteristics of the psoriasis lesion. We may now seek to inquire what may be the further development of it, and what peculiarities it may show. We have already ascertained that peripheral extension is usual, and we may now see that this may occur to form a large more or less circular sheet of eruption, or it may, by the occurrence of central resolution, produce large rings and polycyclical figures of which I show you two well-marked instances. In some cases the scale may be comparatively slight, so that it is transparent, and scarcely noticeable until roughed up by scratching, and the base may be very red and actively inflammatory; in others the scale may reach enormous dimensions, being heaped up to a conical mass strongly suggestive of rupia. To this form has been given a special name—"Psoriasis rupioides." It is very easily differentiated from rupia by lifting off the scale as there is no ulcer beneath it.

As regards the localisation of psoriasis, let me caution you against placing too great reliance on distribution for the purpose of diagnosis. In one of the gyrate cases which I have already shown you the chief incidence of the attack fell on the flexor surfaces, and I now show you two scalpy syphilides which both occurred only on the extensor surfaces. In my experience those cases of syphilis which most closely counterfeit psoriasis are the very ones in which the rash affects the extensor surfaces. In acute psoriasis the distribution is apt to be generalised, and it very frequently attacks both the back and front of the trunk in much the same manner as does the early syphilitic eruption. It is an open question as to how psoriasis begins. Some authorities believe that there is usually one initial lesion which is followed by a general outbreak, while others hold that the first outbreak is generalised at once. I have traced the course of a good many cases, and in my experience the latter view is the correct one.

There are two special localisations to which I should like further to allude, namely, the palmar and plantar surfaces and the scalp. Palmar and plantar psoriasis is a term which is still, unfortunately, often applied to designate a scaly syphilide, and indeed any scaly eruption of the palms and soles. I may point out that in acute generalised psoriasis the palms and soles are not so very rarely affected, and therefore palmar and plantar psoriasis should be reserved for these cases, for a disease is either psoriasis or syphilis. It is never both. I am quite aware that the diagnosis may be difficult, and perhaps impossible, but we shall certainly not learn by cloaking our ignorance under the term syphilitic psoriasis. The head is interesting from another point of view, namely, the difficulty of distinguishing between psoriasis and pityriasis capitis or as it is sometimes termed, seborrhœa sicca. Both are dry scaly diseases, and both are characterised by peripheral extension. So great is the clinical difficulty that there are still great authorities who maintain that the eruptions are different phases of the same disease. If, however, one will take the trouble to examine the scales in a rough manner by a microscopical examination which takes at the outside five minutes this difficulty at once disappears. The psoriasis scale, even when taken from the scalp, shows no organisms present at all, whereas the scale from pityriasis is crowded with examples of the bottle bacillus and other organisms as you see in this slide.

In the diagnosis of psoriasis from ringworm, the microscopic examination of a scale in potash is, of course, the ultimate test, but the exactness of the circular outline, the almost invariable presence of minute papulo-vesicles around the margin of the ring, and the arrangement of the scales with their loose border pointing inwards, to which I have already referred, will usually be enough to allow you to recognise a circinate ringworm on the glabrous skin, and the additional presence of broken hairs will aid you in scalp cases.

As regards the etiology and pathology of psoriasis, I have little to say. We know that the disease is commoner in cool climates, in the winter months; that it has a distinct tendency to run in families; and that it is occasionally associated with a joint trouble resembling, if not identical with, sub-acute rheumatoid arthritis. One or two doubtful instances of infection have been reported, but the disease is certainly not very contagious. Beyond this we know nothing, and all theories as to the causation are mere speculation with which I shall not bother you.

We may now turn to the practical point of treatment.

As regards internal treatment, the drug with the most general reputation is, of course, arsenic. Now, among the experts opinion appears to be considerably divided, some regarding it as of great, though uncertain value, while others do not hold it in high esteem.

My own opinion is that it is often of extreme value, though I admit that one cannot tell in which cases it is likely to succeed. It is generally said that in acute outbreaks it is liable to aggravate the disease, and this I quite admit to be the case in some instances, but I have found that most cases that are even moderately acute and irritable do well with it, and therefore if I have a patient whom I can take into my confidence, I often give it in irritable cases. It is quite easy to knock it off if it increases the symptoms. The great point is that one should give it in full doses—up to fifteen minims of the liquor three times a day, such a dose being naturally reached by gradual steps. If you like, you may use atoxyl in doses of a half to one grain three times a day, but this is a drug which occasionally causes a good deal of colic and purging, so that you must be cautious in your use of it. Another drug highly recommended by some is salicin in full doses. After trying it in very many cases, both consecutively taken and selected as acute, I have never seen any action at all.

Thyroid extract will occasionally cause the eruption to melt away in an almost magical manner, but here again high doses are required, and one can never say which is the case in which it is likely to be of benefit. Lastly, potassium iodide does undoubtedly cause the disappearance of the rash in certain cases, and it is not always necessary to give it in the heroic doses which some recommend.

As to the question of bathing in psoriasis, it may be said that in almost all cases it is beneficial. In irritable cases a prolonged soaking in an alkaline bath (washing soda, ¼ lb. to a thirty gallon bath) often relieves the itching in a very gratifying way, and of course helps in the removal of the scales. In indolent cases one may also assist the removal by scrubbing with soft soap.

After all, we must admit that the local treatment is more uniformly successful, and the most efficacious drugs in their order of efficiency are probably the following:—Chrysarobin, tar, pyrogallol, resorcin, mercury, salicylic and carbolic acids. A nice cleanly way of using chrysarobin is to paint on a coat of a 10 per cent. solution in chloroform, and after it has dried cover it in with waterproof strapping. Or one may use it dissolved in collodion, but this stains more and is less efficient. Tar may usefully be incorporated with the highly superfatted soft soap sold under the name of " Mollin," as it is then more easily washed off, or in mild cases the liquor picis carbonis, either used neat or diluted, may be painted on. One can nearly always safely begin with a 10 per cent. solution.

For the scalp a useful formula is half a drachm of resorcin in an ounce of white precipitate ointment. This must be made with paraffin, or it decomposes at once, and in any case it does not keep well, so that it should be ordered in small amounts.

In the extremely irritable cases, it is often recommended that the treatment at first should be limited to soothing lotions such as the following Glycerini, glycerini plumbi subacetatis aa, ℥ j., aq. ad oj., and this is certainly fairly efficient in removing the scales, but I have usually found that the alkaline bath, followed by a calomel (3 per cent.) ointment is more efficacious.

Lastly, there are the cases where one or more patches prove resistant to almost all forms of treatment, although there does not seem much tendency to the appearance of new ones. In these the X-rays will often be found of signal service. It is best to give a nearly maximum dose once every fortnight, though if the apparatus for accurate measurement is not at hand, very small doses may be given four or five times a week. It is of the utmost importance that the dosage be either carefully measured, or limited to the smallest amount at each sitting, as I have seen the most deplorable effects from over-exposure and burning in connection with this disease.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Andrew Wylie, M.D., C.M., Assistant Surgeon, Central London Throat, Nose and Ear Hospital. Subject : " Tubercular Laryngitis."*

ORIGINAL PAPERS.

THE PROPOSED CHANGES IN THE

TEACHING OF PRACTICAL MIDWIFERY. (a)

BY SIR WILLIAM SMYLY, M.D.,

Ex-President of the Royal College of Physicians of Ireland.

I HAVE been invited to open a discussion to-night upon the recommendations of the General Medical Council with regard to education in midwifery; and especially as regards the applicability of those recommendations to the teaching of midwifery in Ireland.

In the first place, then, I would call your attention to the circumstances which have led up to this action on the part of the General Medical Council. The commencement was, without doubt, the discovery by Semmelweis of the true nature of puerperal fever, by Pasteur of its causation, and by Lord Lister of how it could be prevented; in consequence of which this scourge has been practically banished from our lying-in hospitals. It was naturally anticipated that a similar result would follow in private practice, but this anticipation has so far not been realised. Hegar was, I think, the first to call attention to this lamented fact, and he attributed it to the increased number of operations. So that what had been gained by antiseptics had been lost through meddlesome interference. In these countries Dr. Boxall showed that, from the returns of the Registrar-General, it appeared that not only had there been no improvement in regard to the mortality from septic infection in childbed, but actually the reverse. The numerous papers and voluminous correspondence in medical and other journals, which this statement provoked, produced a profound impression in England, the outcome of which has been the Midwives Act, and the efforts of the General Medical Council to improve the education of students in midwifery, which we have now to discuss. Unfortunately, in this country the matter has aroused but little interest, and those who have shown any interest in it have been so divided in opinion that Ireland has been excluded from the Midwives Act, to our great injury and loss. Having failed, then, to secure any improvement with regard to midwives, I most sincerely hope that we shall not be found equally remiss with regard to our medical practitioners, for, as Dr. Boxall has shown, the state of affairs with regard to puerperal mortality is worse with us than it is in England.

The recommendations of the General Medical Council must be considered in two aspects: first, from the educational side, and secondly, as regards examination. From both these aspects the Council has been hampered by trying to reconcile what is desirable with what is possible. In England the opportunities for the teaching of practical midwifery are of the most meagre description. In London, for example, there is only one lying-in hospital open to medical students, and even there, where the course is strictly limited to three months, a very small proportion of the students can be provided for; and when every available source of practical instruction has been exhausted, a large body of the students still remain unprovided for. This is evident in the replies sent by the teaching bodies to the enquiries of the General Medical Council. Middlesex Hospital, for example, clearly states "that the difficulties in carrying out the recommendation that students should previously have attended the indoor practice of a lying-in hospital or the lying-in wards of a general hospital are at the present time insuperable." University College, in reply to the question, " Is it, in your opinion, possible at the present time to arrange for every student to attend for one month the practice of a lying-in hospital or the lying-in wards of a general hospital before attending or conducting twenty labours?" answered "No," and added: "The committee further thinks that a month is a longer period of time than is actually necessary to devote to attendance in a lying-in hospital or ward, and that a fortnight would be sufficient." Under such circumstances the Medical Council found itself forced to make very moderate demands upon students with regard to the practical study of midwifery, and their modest recommendations are, in my opinion, not only the best that could be recommended in England, but would seem to be too good to be carried out in practice there.

But when we consider their application to this country, with its great lying-in hospitals, with their ample supply of material, and large and efficient staffs of highly-trained teachers, it would seem to be an absurd retrogression to adopt any of the recommendations of the General Medical Council, for I have not the slightest hesitation in stating that six months' attendance on the practice of one of our large maternity hospitals is far more likely to produce experienced obstetric practitioners than would the adoption of any of the recommendations of the General Medical Council.

How is it, then, that, in spite of superior advantages, our results, as pointed out by Dr. Boxall, are so bad? I cannot here refer to the handy woman, but must confine my remarks to our medical students; and, in so far as the fault can be brought home to them, I fear it is the old difficulty with regard to a horse which has been brought to the water. Our ancestors asserted that this difficulty was insurmountable, and that we could not make him drink. But surely, in the twentieth century, that is not so, and the difficulty could be overcome either by forcing the fluid down his throat, or by developing a thirst that would compel him to drink of his own accord. And similarly with our medical students; we can either compel them to attend a certain number of patients or demonstrations, or we can arouse in them a desire to study practical midwifery. The former is the method at present in vogue; we compel the student to attend a certain number of confinements, a few of which he personally conducts, and that is all. Now, in considering the practical value of this method, let us imagine for a moment its adoption in the practical teaching of medicine or surgery. Supposing, for example, that the only practical work in these departments consisted in the examination of a score of people, the majority of whom were in perfect health; what would be the result as regards the returns of the Registrar-General when these gentlemen entered upon practice? With regard to obstetric practice, we have in this country ample provision for supplying skilled practitioners, and if the result is otherwise, it must be because they do not avail themselves of those opportunities. In fact, they seem to have no appetite for such study.

(a) An Address delivered before the Obstetrical Section of the Royal Academy of Medicine in Ireland, introductory to a general discussion on the subject, see page 43.

This brings me to the second method—the creation, namely, of a desire to study practical obstetrics and gynæcology. To the student, the all-important thing is to pass his examinations; to the ambitious to pass with distinction, but to every man, to pass. And he has a right to believe that his course of study and examination has been so planned and arranged for him that by following it he will find himself at the end in the best position to ensure success in his professional life. Now, what is that position, so far as it is indicated by the examinations in practical clinical work? It is that the diseases of the eye are the all-important group. In all others, excepting obstetrics of less account, and that of no practical importance whatever, a theoretical knowledge of midwifery is of course required, but, so far as practical work is concerned, he might, so far as his examination goes, have ignored it altogether.

Now I think that in this respect the recommendations of the General Medical Council are deserving of the highest praise, and I hope will be carried into practice. They advise that a genuine clinical and practical examination should be instituted by all qualifying bodies.

Well, now, what are we going to reply to these suggestions? As to the value of a practical clinical examination, no one can have a second opinion; but as to the possibility of carrying it out, there is ample room for discussion. There are certain inherent difficulties which have to be surmounted. I say have to be surmounted, because I earnestly beseech of you, now that an opportunity has been afforded, such as we have never had before, to improve the practical teaching of midwifery and gynæcology, not to turn your backs upon it and think it a thing impossible. It has been done in Edinburgh, where they have more students and less material than we have in Dublin. Can we not do what they have done? Those who are responsible for the conjoint examinations of our Royal Colleges have asked for suggestions. I can myself give them two, and I daresay, and hope, that better ones may be brought forward to-night, but my suggestions are these:—

1. If it is thought desirable that every student should have a practical examination in midwifery and gynæcology—for, observe that the Council does not suggest the former only—then by all means let us agree and try to carry it out; there would be no lack of material. But the chief objection I have to this plan is a want of proportion. Why should every student be examined upon one organ, be it the uterus or the eye, and not on all? If every student is to have a practical clinical examination upon the female pelvic organs, why should not the same rule hold good with regard to those of the male? If this is to be the rule, then should he not in every case be examined practically upon the diseases of the brain, of the spinal cord and nerves, the heart and vascular system, the respiratory, the digestive, the lymphatic, urinary systems, muscles, bones, and everything else? This is a *reductio ad absurdum*, but to my mind the absurdity lies in the present arrangement, where every student is examined upon the eye and its diseases, and none of them upon the female pelvic organs. Can anybody tell me why every student is examined upon the eye?

2. My second suggestion, which I think is the more reasonable and practicable, is that the female pelvic organs, with their varying physiological and pathological conditions, should be placed on the same level as other organs, and that a student should feel that, as regards practical work, his knowledge of them will be as useful in passing his examinations as would be a similar knowledge of the other organs of the body, and that he should be as liable—but not more so—to a practical examination upon one as another. At present men are examined on two or more medical and surgical cases; would there be any great difficulty in a certain number of candidates being selected by ballot to be examined clinically on one obstetric or gynæcological case, instead of one of the medical or surgical, and in some cases to substitute these subjects for ophthalmology? But these are only suggestions of detail; the all-important point is, are we to have a clinical examination, or are we to continue in the old groove which has resulted in discredit to our profession and disaster to lying-in women?

DIFFICULTIES ENCOUNTERED IN THE DIAGNOSIS OF CHEST DISEASE.

By JOHN HAY, M.D., M.R.C.P.Lond.,

Assistant Physician Liverpool Royal Infirmary; late Physician to the Stanley Hospital and to the Hospital for Consumption and Diseases of the Chest.

The following cases of disease of the chest have come under my care during the last two years, and exemplify a few of the difficulties not uncommonly met with in the diagnosis of abnormal conditions within the chest wall. The morbid conditions of the chest present in these four patients, and to which I shall refer in detail, were:—(1) actinomycosis; (2) sarcoma of the lung and mediastinum; (3) concealed empyema; and (4) pulmonary syphilis.

Case I.—Actinomycosis of the lung simulating pulmonary tuberculosis; embolic pyæmia; death. Girl, æt. 16. She came as an out-patient to the Chest Hospital on September 2nd, 1905, suffering from dyspnœa, cough and anæmia. Dr. Owen, who was then stipendiary medical officer, saw her, and made a diagnosis of pulmonary tuberculosis. She looked ill, and suffered from some cough, with expectoration. The cough was not severe, nor was the sputum large in amount. She had been ailing for six months, and had steadily lost weight. Her appetite was good, and her bowels regular. One noticeable feature in her condition was a pulse-rate of 160 per minute. On her next visit I carefully examined her. She was markedly anæmic, very short of breath, and was bothered with a rather troublesome, ineffectual and painless cough. Her heart was beating quite regularly at 170 to the minute. The heart was dilated, and there was a systolic murmur at the base.

On examining the lungs, I found some impairment of percussion note over the apices of the right upper and lower lobes. The breath sounds were altered, and, anteriorly, medium-sized râles were audible at the apex. The rest of the chest seemed to be normal. I agreed with Dr. Owen that the girl was suffering from consumption affecting the apices of the right upper and lower lobes, and that the tachycardia and tachypnœa were the result of a profound toxæmia. My advice to the mother was to put the girl to bed and to call in some medical man.

On October 19th I again saw the girl, on this occasion with Dr. Loughrey. She was propped up in bed, very pale and restless, suffering from marked dyspnœa which tended to occur in paroxysms. Her pulse-rate was still about 160. On examining her chest, I found the physical signs much as before; the local condition had apparently not altered. There was, however, one remarkable change in the appearance of the patient. Numerous small subcutaneous swellings were scattered here and there over the body; some of these had broken down and were discharging pus and blood. The edges of the openings were bluish red and indolent in appearance. There was a swelling situated over the spinous process of the seventh cervical vertebra, and many others on the hands, arms and legs. The left knee-joint contained fluid, and pus was oozing out from under the nails of some of the fingers and toes. A small collection of pus was situated on the tip of the nose. The ordinary signs of inflammation were absent. At first it flashed through my mind that this was a case of tubercular pyæmia, but something about the character of the edges of the openings suggested that the case was one of actinomycosis, and on carefully examining the pus I concluded that this suspicion was justifiable. Later in the day I examined the pus microscopically, and demonstrated the ray fungus with the club-shaped bodies at the circumference. On carefully questioning the parents, I found that the patient had been in the habit of eating large quantities of raw oatmeal and sugar, and I suppose that she had become infected in this way, for there is abundance of evidence to show that the parasite grows on grain, more especially, however, on barley.

CASE II.—Sarcoma, originating in the root of the lung, involving the left bronchus, encircling the aorta, paralysing the left vocal chord, infiltrating the left auricle; death by rupture of the heart. Man, æt. 29, complained of shortness of breath and cough. Family history good. His work, that of a marine engineer, was not very heavy. He did not admit to syphilitic infection or to excess in alcohol. For four months he had been afflicted with a troublesome cough. Latterly the expectoration had been profuse, and for two weeks before admission stained with blood. He had recently lost a stone in weight. There was no history of sweating, and his appetite was good. Pain in his left side gave him much trouble, and there was in addition slight pain at the base of the right lung.

He was admitted to the "Chest" Hospital, and examination revealed the following physical signs: impaired movement of the left side of the chest, with diminution of breath sounds, vocal fremitus, and vocal resonance; very slight impairment of note over the same area, but fairly well-defined dulness towards the base. Numerous râles were audible, more especially at the left base. The sputum was largely composed of mucus. It was frothy, viscid, tenacious, and bloodstained. It did not contain any tubercle bacilli. His cough was hoarse, husky, and rather lacking in explosive qualities. On examining the larynx, the left vocal chord was found fixed in the cadaveric position and normal in colour. When admitted the radial pulses and the pupils were equal, but in ten days' time the left radial pulse was found to be smaller than the right. On examining the precordium, the cardiac dulness was about normal, but the percussion note was impaired behind and to the right of the manubrium. The heart sounds were not materially altered, with the exception of a definite systolic bruit over the aortic area. No abnormal pulsation of any kind was noted, and tracheal tugging could not be elicited. He swallowed without difficulty or discomfort. His condition became steadily worse. The dyspnœa increased and occurred in paroxysms which were apparently relieved by amyl nitrite. The hæmoptysis persisted, the temperature remained normal, and the gnawing pain grew worse. It became increasingly difficult for him to lie down in bed. The dulness at the base of the left lung became more distinct, and I noticed that the skin over the site of the left lower lobe was slightly œdematous. He remained in this unhappy state for a few days, and was then suddenly attacked by extreme dyspnœa, increasing cyanosis, and great distress, which lasted about half an hour and terminated in death.

At the autopsy the pericardial sac was found distended with about a pint and a half of fluid arterial blood. There was a firm mass in the superior mediastinum in the region of the aorta. This extended into the posterior mediastinum, and completely surrounded the transverse portion of the aorta, growing up around its branches in the superior mediastinum. It completely encircled the innominate artery, the right subclavian and right carotid arteries, also the left carotid and subclavian arteries. The innominate veins and superior vena cava were lying on the anterior surface of the malignant mass, but not involved in the growth. The trachea was not infiltrated, and at its bifurcation the growth left the post-mediastinum and, encircling the left bronchus, narrowed its lumen and passed into the left lung. A most interesting condition existed in the pericardial sac. On its parietal layer a warty excrescence about the size of a shilling was found in the upper part of the posterior wall to the left, at which point the tumour was distinctly felt behind the pericardium, which had become infiltrated. The valves were not diseased. The wall of the left auricle was infiltrated by a spongy mass, spreading from the point of entrance of the left pulmonary veins, which in this case entered by a common orifice along the lateral wall to within half an inch of the auricular appendage, and for one inch along the posterior wall.

The auricular septum was not affected, nor had the growth passed the auriculo-ventricular groove. In the diseased area of the left auricle a perforation was found situated immediately posterior to the point of entrance of the left pulmonary vein. This perforation admitted the tip of the little finger. The first portion of the aorta was dilated and lengthened. The left lung showed thickening of the pleura and old adhesions everywhere, except at the base. It was dark red, collapsed, and deeply injected. The lower portion of the upper lobe was invaded by the tumour, which branched in all directions and was of a creamy colour. The centre of the mass had undergone fatty necrosis, and was semi-fluid. The root of the lung was composed mainly of tumour, which had infiltrated the lymphatic glands in this region. The œsophagus had escaped, though some of the lymph glands in its neighbourhood were involved.

Microscopic examination of the neoplasm proved it to be a small, round-celled sarcoma, which was actively invading the wall of the left auricle. For the careful description of the neoplasm, and the microscopical sections, I am much indebted to Dr. Halliday G. Sutherland, pathologist to the Hospital for Consumption and Diseases of the Chest.

In reviewing the facts of this case, it is of interest to note the points which might mislead in forming a diagnosis. The systolic bruit over the aortic area, the dulness behind the manubrium, the diminution in the volume of the left pulse, and the paralysis of the left vocal chord, constituted a "symptom complex" strongly in favour of aneurysm. On the other hand, the short history, the age of the patient, and the denial of syphilitic infection, the absence of pulsation and of diastolic shock, together with the presence of hæmoptysis, suggested mediastinal tumour. With mediastinal tumour, however, one would have expected involvement of the veins rather than interference with the arteries.

CASE III.—Small centrally placed empyema not discovered by frequent exploratory aspirations; diaphragm perforated by the pus which pointed below the costal margin; operation; death. Woman, æt. 35, admitted to the Stanley Hospital on May 11th, 1906, suffering from pain in the chest, pyrexia, and cough. She had been confined five or six weeks previously, and during the labour had lost a considerable quantity of blood. She recovered and was about again. Ten days before admission she fell ill with a shivering attack and a pain in her left side, but did not at once take to bed. When I saw her she was extremely pale. Six days before admission a herpetic eruption had appeared on her nose. Her temperature on admission was 102° F., pulse 108, respiration 40 per minute. She was hoarse, and complained of a stabbing pain in the left side of her chest on taking a deep breath. She stated that she was free from any cough. Her mouth was in a dirty state and her tongue pale and dry. The abdomen was not abnormally distended or tender; there was no unusual vaginal discharge.

Examination of the chest, made two days after admission, showed lessened movement on the left side and impairment of percussion note from the seventh rib down, the dulness being more marked at the extreme base and extending round to the left mammary line. Vocal fremitus and vocal resonance were both diminished. The breath sounds over this dull area were faint and bronchial in character. Anteriorly under the left breast a pleuritic rub could be heard. The apex beat of the heart was not displaced. As the outcome of this examination I diagnosed the presence of fluid, probably purulent in character. I inserted a large needle into the chest, first through the eighth and then through the ninth left spaces, about the level of the angle of the scapula, and was surprised and mortified with the result, which was negative, for I had just demonstrated the physical signs as those indicating the presence of fluid.

She had a rigor on May 12th, the day after admission, during which her temperature ran up to 104.4deg. F. There were two more rigors three days later. Although I was unable to locate the pus, I felt certain that the patient was suffering from septic absorption, and thought that she might receive benefit from the injection of anti-streptococcic serum. This was injected in doses of 10 c.c. daily, but without much, if any, benefit being observed.

On the 18th the spleen was found to be enlarged, and a rub could be heard over Traube's area. As the spleen was enlarged and the temperature persisted, and as the exploration of the thorax had proved negative, the possibility of typhoid fever presented itself; accordingly the blood was examined for the "Widal," with a negative result. A leucocyte count was made, which demonstrated a moderate leucocytosis. This, with the negative "Widal," made it very improbable that we were dealing with a case of typhoid fever. Her sputum at this time was frothy and viscid, and composed chiefly of mucus.

By the 21st the patient said she felt somewhat more comfortable, the tongue was cleaner, and her pain was less; the temperature, however, continued between 99 deg. and 102 deg. On the 22nd I again explored, and this time drew off 8 oz. of clear yellow fluid, slightly blood-stained towards the end of the aspiration. The fluid was alkaline, and loaded with albumen, and had a specific gravity of 1,020. On May 25th I again made an attempt to strike the pus, using a large needle and exploring three different portions of the left chest, and again the result was negative.

The temperature persisted, ranging from 99 deg. to 102 deg. F. There was a frequent pulse and rapid breathing. Her spleen was still easily felt projecting below the costal margin. By the end of May her condition was getting desperate, so I asked a surgeon to see her, and requested him to open the left chest and look for the pus. He declined, because its presence could not be demonstrated by an exploring needle. After this the condition of the woman became steadily worse.

On June 5th I detected some bulging under the left costal margin near the middle line, and this time on inserting a needle struck pus. An anæsthetic was at once administered, and about a pint of foul-smelling pus was drained from beneath the diaphragm. This, however, did not save her life, for she died the next day. At the autopsy we found that the primary condition had been a small empyema centrally placed, and at no point in contact with the chest wall (see fig. 1). It was situated in front of the root of the left lung, its internal boundary being the pericardial sac, its outer the visceral pleura and lung; below it was limited by the diaphragm, while above, the pericardial sac and lung met at an angle. The wall of the empyema was thick and tough. The pus had eroded the diaphragm, and formed a localised sub-diaphragmatic abscess which finally found its way to the surface below the left costal margin.

In this patient we have a good example of the great difficulties which sometimes offer themselves in diagnosing and locating small empyemata. Unfortunately the woman was debilitated as the result of a heavy and exhausting labour when she first took ill, and was in a poor condition to withstand any prolonged septic absorption. The duration of the illness was five weeks from the first shiver to the day of the woman's death. The recent delivery, the rigors, the continued temperature, the normal position of the apex beat, the enlarged spleen, the extreme anæmia, and the failure on three different occasions to strike pus, all added to the difficulties. It was a most distressing case to watch, and I publish it in the hope that its narration may be of help to others. Possibly a more favourable result might have ensued if we could have had the assistance of the Röntgen rays.

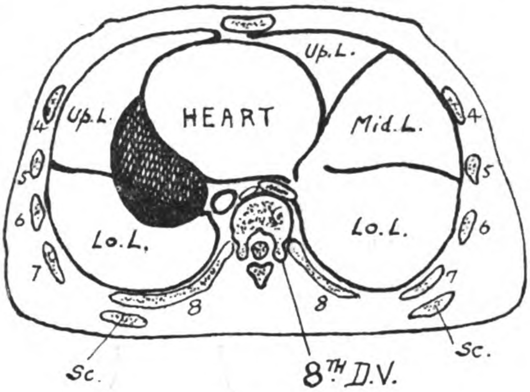

FIG. 1.

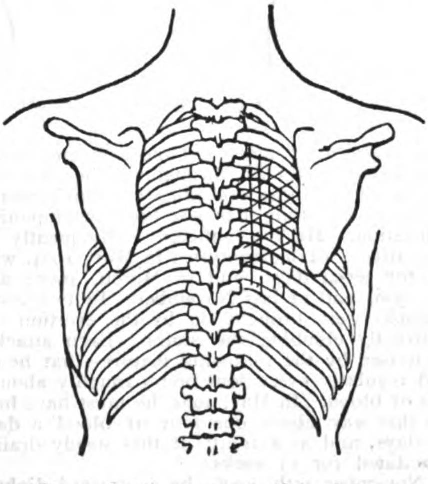

FIG. 2.—Chart showing area of slight dulness. Breath sounds diminished over same area. No adventitious sounds. Vocal resonance somewhat increased.

CASE IV.—Pulmonary syphilis. Fibrosis about the roots of the lungs; marked dyspnœa; cough; recurring hæmoptysis; few physical signs; cardio-pulmonary murmur audible at the open mouth. Man, æt. 36, complains of pain in the right side of the chest, great shortness of breath, and recurring attacks of blood-spitting. He worked as a monumental mason from the age of 14 to 23, with the exception of the two years when he was 18 and 19. When a mason his work consisted in dressing marble and limestone. Later he became a constable. When 27 he contracted syphilis. He consulted Dr. Logan five months after the primary sore, on account of a very bad throat, and was under continuous treatment for six months.

The history of the present illness dates back to five years ago; at that time he had been working very hard, and was feeling run down. His description of the onset of the attack is that, as he was cleaning some windows and reaching up, he felt a peculiar prickling sensation over the second intercostal space, just to the right of the sternum; this was at once followed by a rush of blood into his mouth.

The next morning he coughed up a clot which, on being floated out on water, was seen to be a "perfect cast" of a thick tube with two branches spreading from it; the thicker portion of it was of the calibre of a cedar wood pencil. Previous to this hæmoptysis he had not suffered from any cough or indication of chest disease—in fact, he tells me that he used to sing the bass solos in "the police minstrels." He recovered entirely from this attack, was free from cough or pain, and resumed his usual work. However, at the end of a year, he began to suffer from cough and dyspnœa on any exertion, and on this account had to give up singing. The cough and dyspnœa have persisted, becoming gradually more and more severe; and it is a remarkable fact that, throughout the illness, with the exception of those occasions on which there was hæmoptysis, coughing has not been accompanied by expectoration. He has suffered subsequently from several attacks of hæmoptysis: in May, 1904, when it lasted for seven days, and in March, 1905; also in April, 1906, and in last November. In two instances the attacks were brought on by the exertion caused by hurriedly climbing the stairs. Each attack was characterised by the following feature—that he expectorated regularly every four hours roughly about four ounces of blood. In May, 1904, he must have brought up in this way about one pint of blood a day for seven days, and as a result of this steady drain was incapacitated for 13 weeks.

On November 15th, 1906, he contracted diphtheria, and was in hospital for 23 days. In December he suffered from a peculiar pain about the region of the right nipple; the pain passed up into the neck and down into the right arm, lasting for days. He felt as though his "funny bone" had been struck. Since November 11th, 1906, he has been free from hæmoptysis. On February 5th, 1907, he again experienced severe pain in his chest, as described above; which extended into the armpit and down into the arm. Under treatment he is steadily gaining weight, and has put on five pounds in the last month. During the attacks of hæmoptysis the treatment has been opium and potassium iodide, and potassium iodide alone for the last few months between the attacks; under this treatment the dyspnœa has considerably diminished, and he feels much more comfortable. It is interesting to note that the potassium iodide was ordered before there was any suspicion that he was suffering from a syphilitic lesion of the lung. As he appeared to derive distinct benefit from its exhibition, it was continued.

The following is an account of his condition noted on March 5th, 1907:—Tall pale man, weight 11 st. 2½ lbs. Chest somewhat poorly developed, expansion equal; at the level of the fifth costal cartilage the chest measured 37 ins. at the end of inspiration, 33½ ins. at the end of expiration. On percussion I noticed that the right infraclavicular area was more resonant than the left, and that there was some impairment of note on the right side, posteriorly extending from about the third spinous process to the level of the ninth rib, being most marked in its upper portion. The breath sounds were fairly normal throughout the chest, but tended to be somewhat deficient and altered in quality over the dull area. The vocal resonance was slightly increased over the same area. There were no adventitious sounds of any kind. Dr. Hunt had some time previously examined the larynx, and declared it normal. While examining the patient, one most interesting physical sign was noticed—a definite systolic bruit could be heard on listening at the open mouth, and also on auscultating over the trachea. The area of distribution in the chest of this murmur is shown on the chart. It was loudest in the second and third right spaces, near the sternal margin, and was audible over most of the right chest in front. In the back it was just audible along the vertebral border of the left scapula. The deep cardiac dulness extended two inches to the right and four inches to the left of the mid-sternal line. There was some heaving of the lower end of the sternum and epigastrium.

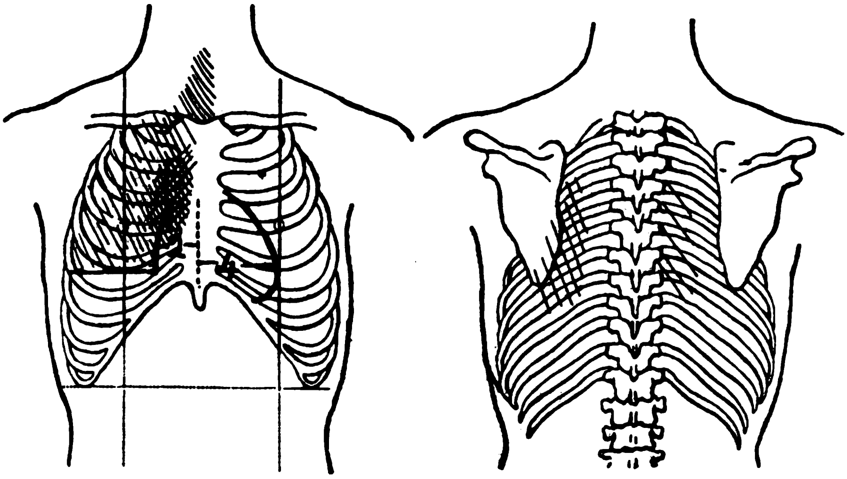
Fig. 3.—Chart showing the area over which the systolic murmur was audible.

The heart sounds were quite clear to the left, and over the aortic area the systolic bruit already mentioned did not seem to be associated with the first sound. This murmur persisted whether the patient stood up or lay down, and was more pronounced at the beginning of expiration. The pulse was frequent, over 100 per minute, soft and regular in time and force. The radial pulses were equal, and the pupils reacted normally and were of the same size.

Dr. Holland kindly examined the man's chest for me with the Röntgen rays. On the screen it was at once obvious that the excursion of the right side of the diaphragm was diminished, and that the right lower lobe did not appear to be so transparent as the left. The apices lit up fairly well. The heart and vessels were apparently normal. A photograph was taken, and the plate showed the presence of patches of thickening scattered through the central portions of the right lung, and also at the root of the left lung. There is nothing further to note except that there is no history available of night-sweats or of any abnormal temperature. The entire and continuous absence of expectoration has already been referred to.

On March 5th, the date of the examination of the patient, liquor hydrargyri perchloridi was ordered in combination with potassium iodide. Four weeks later I heard from the patient's medical attendant, Dr. Sykes, that the dyspnœa had become very much less distressing, and that the cough had almost disappeared. The cardio-pulmonary murmur remains unaltered. In this case the interest undoubtedly centres around the diagnosis, and the question arises—whether we are dealing with pulmonary tuberculosis which has undergone fibroid changes, or with a pneumonokoniosis, or, lastly, with pulmonary syphilis? I am inclined to look upon the case as belonging to the latter class. There can be no doubt that in this patient there is a scattered fibrosis at the roots of the lungs, extending chiefly into the right lower and middle lobes; the question is simply as to the nature and cause of the lesion.

It is very generally accepted by authorities on pulmonary syphilis that syphilis is much more prone to attack the root of the lung, the middle lobe, and the central portion of the lower lobe than the apices; in fact, Grandidier states that a dulness in the interscapular region, extending as far as the middle of the base of the right scapula, is almost pathognomonic of pulmonary syphilis. Fournier describes three degrees of pulmonary syphilis: the first, in which the disease is latent and unexpected; the second, in which there is dyspnœa but no constitutional disturbance, with the physical signs of induration or cavitation; and the third, which is severe in type and presents all the features of well-marked consumption. The marked and persistent dyspnœa, out of all proportion to the objective signs in the chest, is frequently referred to as very characteristic of syphilitic disease of the lung, and is certainly a prominent feature in this case. It is probably the result of sclero-gummatous changes in and around the bronchi at the root of the lung. Again, in favour of syphilis are the persistent absence of fever and the freedom of the apices from disease. If the lesion were tubercular, it is hardly likely that the apices would have escaped, and also that there should have been such a complete absence of cough during the year following the first hæmoptysis.

Again, if it were tubercular, one would have expected that at some period of the disease signs of constitutional disturbance, such as fever or night-sweats, would have shown themselves; these were, however, absent. The fact that the dyspnœa diminished, and that the patient gained weight under anti-syphilitic treatment, is strong presumptive evidence in favour of the syphilitic theory. Potassium iodide, as we know, when given to tubercular patients, tends to increase the number of the adventitious sounds, so much so that Turban advises its administration to patients for diagnostic purposes. In this man the exhibition of potassium iodide left the lungs persistently dry. Again, four years before any sign of chest trouble, the man without doubt suffered from syphilis, which appears to have been his only dissipation. There is another possibility—that he may have contracted pulmonary trouble when working among the marble and limestone. The short period of duration of this work (five years only), and the long period of complete immunity from any symptom of chest disease after ceasing to follow this occupation, render this assumption improbable.

We are therefore constrained—largely, I think, by a process of exclusion, to adhere to the diagnosis of pulmonary syphilis. The explanation of the peculiar murmur is not easy. I look upon it as cardio-pulmonary, but I must confess that when I first heard it, it suggested to me the possibility of a deep-seated aneurysm. But this view received no corroboration from the examination with the Röntgen rays, and it is not usual to find an aneurysm leaking into a bronchus over such a long period as five years. Long before that time had elapsed it would either have burst, or the diagnosis would have ceased to be a matter of doubt.

ACUTE PANCREATITIS AND MULTIPLE FAT NECROSIS.

By F. G. BUSHNELL, M.D.,

Pathologist to the Sussex County Hospital (Stephen Ralli Memorial) Brighton.

A. T. 3.—Æt. 40. The patient was admitted on January 14th, 1906, under the care of Mr. Ionides, F.R.C.S., Surgeon to the Sussex County Hospital. Twenty-four hours previously she was taken with sudden epigastric pain. There was no sickness. The abdomen moved well. The pulse-rate was 80, and the temperature was normal. The bowels were open 24 hours before onset of pain.

On January 15th pulse-rate was 120. There was tenderness in epigastrium and right iliac fossa. The abdomen worked well in upper part. Operation by Mr. Ionides.

Some smoky fluid was found on opening the abdomen. Numerous omental and subperitoneal fat necroses were seen, but the pancreas was not swollen. The appendix, tubes, and ovaries were natural. There was a small fibroid in posterior wall of uterus. The cavity was washed out and sewed up.

She sank gradually, and died on January 16th, 1906, at 12.30 p.m. The post-mortem was made on January 17th, by Dr. Reynolds, M.B. The abdominal walls were 8 ins. thick; fat was increased in omenta; there was turbid, sanious fluid in abdomen. The foramen of Winslow was patent. The parietal and visceral peritoneum were covered with areas of fat-necroses, from a pin's head to a pea in size, especially around the pancreas and in small sac. The stomach, duodenum, and intestines showed no signs of catarrh to the unaided eye. They were not thickened or thinned. About 3 centimetres from the entrance of common duct was a swelling, about 1.5 centimetres in size, oval, firm, and movable below mucosa. Cæcum and colon walls were thick, hyperæmic; liver enlarged and red, but ducts not dilated. The gall-bladder contained chocolate-coloured bile, but no calculi and no signs of catarrh. The pancreatic duct joined the common bile-duct about 3 centimetres from end, and was patent, narrow, and its walls thin, but contained no calculi. Pancreas measured 16 centimetres in length; its tissues were firm and doughy; section showed areas of hæmorrhage, recent and of longer duration. Its colour was pale yellow, beefy and dark red. It was œdematous. The radicles of splenic veins thrombosed, as also was the vein itself. The splenic, hepatic, coronary and superior mesenteric arteries contained a little fluid blood. The aorta showed atheroma about the entrance of the cœliac axis and superior mesenteric artery. The mesenteric and lumbar glands were somewhat enlarged and yellowish, soft; some showed blood extravasations. Spleen was slightly enlarged, its pulp soft and diffluent. Peripancreatic tissues were œdematous; fat-necroses were numerous. There were soft, semi-fluid areas of light chocolate colour, especially seen over right kidney. The kidneys were enlarged, of a dark red colour, firm, and the capsule stripped easily. The surface was mottled; cortex and medulla of about normal ratio. The pelvic fat was increased.

Microscopic Changes.—The pancreas showed hæmorrhages and areas of necrosis, with leucocytic zone at borders, evidently of ante-mortem origin. The nuclei showed karyolysis, karyorrhexis, and pyknosis in necrotic areas. The interlobular vessels were engorged. Areas of tissue resembling latticework were seen. Islands of Langerhans unaffected. No bacilli were seen. Epithelium of ducts was, in places, desquamated. Vessels contained leucocytes and shed endothelium; others were thrombosed; some were necrotic. There was no clear evidence in sections examined of arteriosclerosis. There were bundles of radiating crystals as of fatty areas and calcium.

Liver.—The periphery of lobules showed fatty degeneration, and the parenchyma cloudy swelling and congestion. No amyloid change.

Kidney.—Showed cloudy swelling of the tubules; the convoluted tubules, or intermediary part, escaping. Malpighian bodies showed slight increase of nuclei. No hæmorrhage present. No amyloid changes. There was decided congestion. Interstitial changes were not present.

Duodenum.—The duodenum showed necrotic condition of mucosa and a polyadenoma of Brünner's gland.

Spleen.—The spleen showed congestion.

A smear from pancreatic juice showed cocci (in pairs and threes), Gram + and — diplococci, bacilli capsulated, and short streptococcal chains.

The culture from gall-bladder showed colon-like bacilli and cocci in pairs and short chains, Gram +.

The bacillus isolated gives characteristics of the bacillus coli communis.

Gelatine.—Streak, moderate white growth. Stab, moderate white growth, no liquid.

Shake bubbles on third day.

Agar.—Luxuriant, moist, whitish growth, iridescent. Microscopic appearance: bacilli, straight, round or pointed ends, in pairs or singly, Gram —. From gall-bladder, also diplococci and short chains of cocci were obtained. From pancreas, a coli-like organism and some large bacilli with square ends, Gram +, grew in broth.

Several cases of this fatal and interesting affection have been recorded in the *Lancet* and in the *British Medical Journal.* It may be compared to a gastric erosion in respect of the ease and extent to which grave hæmorrhage follows on small local damages to tissues which have a powerful (digestive) secretory function. The origin of the local damage may vary, being circulatory, septic, or due to changes in the vessel wall in different cases.

The fat necroses are certainly secondary to the abnormal diffusion of the steapsin of the pancreatic juice and its subsequent action in the fat. A summary of the chief experimental work bearing on the subject is as follows:—

(1) Flexner produced acute hæmorrhagic pancreatitis by injecting gastric juice into the duct of Wirsung, and Opie by injecting bile in dogs.

(2) Opie, by ligating the pancreatic ducts of cats, produced necrosis of the abdominal wall fat, and of fat elsewhere.

(3) Endarteritis is described by Dürck in the pancreatic vessels, also embolism or thrombosis.

(4) The presence of bacteria in the pancreatic juice and duct is stated by Metchnikoff to be usual in the vertebrata.

(5) The fluid from these pancreatic cystic swellings may be sterile (*British Medical Journal*, February 27th).

(6) Flexner has demonstrated steapsin in fat necroses which are frequently sterile.

(7) Fat necrosis may be caused by the action of the pancreatic juice, but not by trypsin (Hildebrand and Dettner).

(8) H. A. Williams produced fat necroses by placing pieces of pancreas under the skin and into perirenal fat of dogs.

(9) Duodenal catarrh, biliary calculi, bacterial injection of pancreas, renal cirrhosis, and alcoholism are frequently associated with the disease (Mayo Robson).

P.S.—The specimens and microscopic preparations were exhibited at the Brighton and Sussex Medico-Chirurgical Society. The lantern-slides were by Dr. Spitta and Mr. Caush, L.D.S.

CLINICAL RECORDS

ROYAL INFIRMARY, GLASGOW.

OUT-PATIENT DEPARTMENT.

Emphysema,

By JOHN T. MACLACHLAN, M.D.

IT is astonishing to find how many patients suffer from emphysema of the lungs. Patients frequently come to the dispensary complaining of an annoying cough—it may be only of a few weeks' duration. When the chest is examined, the semi-tympanitic percussion note at once raises the suspicion that emphysema is present. Then we find the normal cardiac and liver dulness reduced by the overlying emphysematous lungs. The respiratory murmur is found to be unduly slow and protracted. Not infrequently the breast-bone projects, and the spine is unduly curved, giving a rounded appearance to the shoulders. The chest in typical cases is barrel-shaped. When we inquire into the past history of such cases, we find there has been a winter cough, subsiding or disappearing during the summer months of the year, but after a few years there is a morning cough all the year round. This morning cough is very harassing, as there is very little expectoration, and what there is is often described as "a small pea," which seems to tickle the throat, and the patient is not right until he gets it up. Going upstairs, or hard exertion, brings out the disabled condition of the lungs, as the patient becomes breathless. At times a certain amount of asthma is present, and their bed-fellows hear the cooing, wheezing, and whistling sounds produced during respiration from the spasm of the bronchial tubes. When the patient gets a fresh dose of cold, he seeks advice, but it is impossible to cure the organic changes present. We may get rid of any recent catarrh by expectorants and small, guarded doses of opium. Afterwards we may endeavour to arrest, if possible, the progressive emphysematous state.

We must find out what is keeping up the irritation. Certain trades, such as that of a potter, or that of a hewer of stones, are responsible for certain cases. Chronic whisky drinking is perhaps the most common cause in this country. The rheumatic and gouty states contribute their quota. Syphilis is likely to be a fertile source, although not easily demonstrated. Cardiac disease may be a predisposing cause, and will certainly aggravate the condition. Sometimes a persistent cough may be the chief sign of cardiac disease, and digitalis will then act like a charm. Change of temperature affects emphysematous patients greatly. Thus going to bed usually starts the cough, or rising from the warm bed in the morning. Then strong tobacco smoke and dust may excite much coughing. The following scheme of treatment may be found useful:—

(1) Remove vascular congestion by keeping patient in an even temperature; a milk diet, medicines such as antimony, ipecacuanha, sweet nitre, and diuretics, with occasional purgatives.

(2) Remove cause, if possible.

(3) Treat diathetic conditions, such as rheumatism, gout, etc., with alkalies, iodide, etc.

(4) Astringent sprays to harden mucous membrane.

(5) Harden the skin by brine baths, tepid or cold sponging.

(6) Finally, tonics, especially the compound syrup of the hypophosphites.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

OPERATION FOR COMPLICATIONS OF MASTOID DISEASE.—MR. PEYTON BEALE operated on a boy, æt. 14, who had been admitted in the summer with the following history:—Three weeks previously he had had suppurating otitis media; an abscess had pointed behind the ear, and had been opened and drained by a doctor in the country; a discharging sinus remained, and bare bone was felt at the bottom of it. Soon after admission a vertical incision was made through the sinus and a large portion of the temporal bone, including part of the petrous and mastoid portions was found quite loose and was removed. All discharge ceased in a few days; the wound was healed in a fortnight, and the boy was sent to a convalescent home with instructions that he should be watched very carefully for the onset of any cerebral symptoms. The boy was certainly wanting in intelligence, and was slow in speech and in movement, but how much of this was natural it was impossible to say. When he had been at the home about fourteen days he was suddenly seized with violent frontal headache and vomiting, obviously cerebral in origin;

he was drowsy, the temperature was subnormal, and the pulse slow. He was promptly sent back to the hospital, and on being watched for a few days it was quite obvious that he was suffering from cerebral compression; he was therefore trephined over the temporo-sphenoidal lobe of the same side as the ear disease. The brain was found to bulge considerably, and was explored in all directions through the trephine opening, first with a probe and then with the little finger. The white substance was unusually soft, and a good deal escaped in the process; the lateral ventricle was then tapped, and about four ounces of perfectly normal cerebro-spinal fluid, under considerable pressure, withdrawn. The symptoms of compression were at once relieved, and for three or four days the boy appeared to be going on well; then all the symptoms returned, and the lateral ventricle was again tapped with the same result. The boy again became worse in a few days, so it was decided to trephine over the opposite temporo-sphenoidal lobe with a view of tapping the other lateral ventricle. This was done with the same result, the boy again becoming better, and again relapsing in a few days. At this stage both discs were normal, the pupils were equal, there was no general paresis or sensary disturbance, but there was slight one-sided facial paralysis and slight aphasia. The boy was then thoroughly overhauled, and it was found that there was slight optic neuritis on the left side, some nystagmus, vertigo, and inco-ordination; an opinion was given that there was in all probability a right cerebellar abscess. The right cerebellum was therefore trephined, and explored in all directions; it bulged considerably into the wound and a good deal of the cerebellar substance escaped. The opposite cerebellar lobe was also explored, but nothing was found. A long tracar and cannula was then inserted, so as to again tap the posterior part of the right lateral ventricle, and three or four ounces of fluid, again perfectly normal, were thus removed. The symptoms were again relieved, but in about a week's time they recurred. Lumbar puncture was then performed, cerebro-spinal fluid thus removed was found to be normal. After this the boy appeared to be doing well, the pulse rate quickened, the temperature rose to normal, and then to about 100. The cerebellar wound at this time was quite normal, and had healed with the exception of one place, where a gauze drain was kept. The wounds made for the cerebral trephining were both soundly healed, but the original wound at the back of the ear was still discharging. It was now found that the patient had some foul discharge from the meatus on the opposite side; a mastoid operation was therefore done here, and the wound in due course healed. After this his temperature remained above normal, and in a few days some foul smelling pus was found coming from the cerebellar trephine wound, from which it was assumed that there had been an intra-cranial abscess deep in the cerebral or cerebellar tissue, probably the former, which had not been found at any of the previous operations, but which had lately increased in size and burst through the cerebellum.

Mr. Beale said that after all these complications extending for a period of over three months the boy was still in the hospital, and that his general condition was in no way worse than when he left the convalescent home, except that he was somewhat weaker, but that at the present time there were no marked cerebral symptoms.

We hope to report further upon this case in Operating Theatres.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, DECEMBER 13TH, 1907.

The President, E. H. TWEEDY, M.D., in the Chair.

The PRESIDENT showed, for Dr. DUKE, a self-retaining tenaculum for cervix, and an apparatus for the rapid removal of swabs from a Playfair's probe.

Dr. HENRY JELLETT exhibited (*a*) Uterus showing unusual thinning of the muscle of the fundus after pregnancy; (*b*) double carcinoma of the ovaries secondary to double mammary cancer. The first specimen, he said, was of interest, not on account of the condition for which it was removed, but for the condition found present after removal. The patient, who was thirty years old, was sent to him suffering from carcinoma of the vagina. There was a large patch on the posterior vaginal wall involving about the upper third of the vagina, and though it was separate from the cervix, it had a tendency to extend into the right fornix. The rectum was free. He considered the case was operable, provided he could operate by the abdominal route, and he decided to do so. The patient had had a baby four weeks before going into hospital. On the night before the operation her temperature rose to 104° F., and she got severe rigors. On the morning of the day of the operation her temperature was still 104°, and her pulse anything up to 140. Having to leave town, he was in a difficulty as to how to deal with the case; operation was contra-indicated, and so he thought it best to wash out the uterus and see if he could find the cause of the rise in temperature. Before doing so he passed a sound, and this passed into the abdominal cavity straight through the fundus, whose resistance was quite inappreciable. He did not like to leave a probably septic uterus with an opening into the peritoneum, and so he removed the uterus by the vagina and as much of the cancerous vaginal wall as he could. After the operation, he split the uterus to see why the sound had gone through it, and he found that there was a cone-shaped excavation extending through the fundus almost up to the peritoneum. The rest of the wall preserved its normal thickness. Microscopical examination of the fundus showed no evidence of malignant growth. The only explanation he could offer as to the cause of the perforation was that the placenta had exercised an eroding influence on the uterus at one spot. The patient got better for a time, but died about two months afterwards of general metastases, *plus* weakness. The second specimen was two carcinomatous ovaries removed from a patient on whom Dr. Haughton had performed a double-breast operation about six months before. There could be no doubt that the ovarian tumours were secondary to the breast tumours.

Dr. HORNE expressed great interest in the case, as he had had to perform a similar operation recently on two patients, both comparatively young, thirty-two and thirty-four. In one case, when he traced the broad ligament into the left ovary, he found a mass of cancer, of which he would have known nothing if he had attacked the case by the vaginal method. Three months later she had symptoms of return, and he found another mass of cancer high up in the abdomen.

The PRESIDENT exhibited a double pyosalpinx removed intact. He said the patient complained only of sterility. She had no pain, and she did not look ill. She was young, two or three years married, and had been sent to him to be curetted. He palpated the tumours, and diagnosed double ovarian cyst; the uterus was felt lying between them. He was very much surprised to find that they were really very large tubes. They were taken out, joined together, and without difficulty. The point of interest was that he hoped he had thus cured the patient's sterility. There was one ovarian cyst, which was removed. The other ovary was resected, and a good sound piece left behind together with healthy tube stumps.

DISCUSSION ON THE CHANGES WHICH HAVE BEEN SUGGESTED BY THE GENERAL MEDICAL COUNCIL IN THE METHOD OF TEACHING PRACTICAL OBSTETRICS.

Sir **William Smyly** opened the discussion with an address, which will be found in another column under the heading of "Original Papers." In the discussion that followed—

Dr. **Horne** said the subject was of particular interest to Dublin, which was practically the home of obstetrics. The Dublin School for a great number of years had rightly insisted that the course of study should be a comparatively long one, and the General Medical Council, in order to raise the standard of both England and Scotland, had offered to compromise with Dublin by suggesting that the period of study should be three months. The question of examinations was of great importance. There were great difficulties in the way of taking a number of students to a lying-in hospital to have them examined, but he believed with Sir William Smyly that the difficulty could be overcome. He did not see why men could not be brought for examination to a lying-in hospital just as they were brought to a clinical hospital for examination of the chest. A grave defect in the teaching at present was that the students had only to satisfy the registrars of the various licensing bodies that they had taken out their midwifery attendances. He would like to see men compelled to take out from forty to sixty clinical attendances during the three months. Midwives in Dublin were in a far better condition than students, as they were under the full control of the hospital; they were obliged to attend regularly day after day; they attended to the lectures, to the cliniques, and they saw cases from day to day. The students did not do so. He thought they were all agreed as to the first recommendation of the General Medical Council. As to the second, a great difficulty confronted them. Annually in Dublin something like two hundred students had to take out their course of midwifery. If they simply attended for three months, it would be utterly impossible to supply them with material for each man to take out his twenty conductions. The period was too short. How it would be accomplished in England he did not know, but he felt that if they in Ireland were unanimous and kept to their rules, they would be still far in advance of the recommendations of the General Medical Council, and would have nothing to fear from them. The Dublin school had up to the present been recognised as the principal obstetrical school in the United Kingdom, and he did not believe that the keeping up of their standard would cause a single pupil to leave the country.

Dr. **Kidd** said he had always impressed on students the fact that when they were taking out their practical midwifery they were for the first time face to face with a practical side of their profession, which involved the safety of two lives. He therefore agreed that every student should have the experience recommended by the General Medical Council. He deprecated the desire to attend practical work before theoretical lectures. There was no subject in which it was more necessary to have a thorough knowledge of the theory before the practical was attempted. He thought the higher mortality in Ireland in obstetrics was due to the fact that while they could—to use Sir William Smyly's figure—bring the horse to the water and make him drink, they could not make him keep on drinking. It was an established fact that the mortality in lying-in hospitals was lower than that of general practice in the country, notwithstanding that the dangers to a woman in a hospital were greater than those in private practice, and the cases were more morbid and serious. It was, therefore, forced upon them that the doctors and nurses did not carry out in general practice the same strict rules of asepsis as in the institutions where they were taught to do so. He thought that the practical aspect of examinations might be improved if it were made compulsory on students to have attended not only a number of cases in the house under the supervision of the medical officer, but also at the end of their period to give clinical notes of the whole course of the puerperium, for at least five cases. He thought that the education of the student should be such as to enable him to detect when any case was abnormal, or becoming abnormal, so that he might then know that he should seek the assistance of those placed in supervision over him. As regards the period of six months, he felt that a man who lived in the precincts of a hospital for one month would, in all probability, lay up a greater store of knowledge than one who attended a lying-in hospital two days in the week for three months. The midwives, under the present rules, had an opportunity of being trained in even a more practical way than the students.

Dr. **Purefoy** said they agreed that the clinical character in the examinations should be present in a greater degree than it had been, and an endeavour should be made now to bring it about. He suggested that some arrangement might be made with the masters of the hospitals, by which the obstetrical examiners of the colleges might make a monthly visit and have opportunity given to examine certain students. This would obviate the difficulty of carrying out the practical examination for a large number of students at one time. The additional advantages thus secured by the students was an important consideration. He thought an effort should be made to develop the plan of encouraging students to reside, even for one month, in some of the maternity hospitals. He did not think they should be in a hurry to adopt the General Medical Council's recommendation as to three months' attendance, except, perhaps, to the extent of allowing a certain number of students, who might particularly desire to do so, to take out their number of cases in that period. He also thought that some practical advance might be made if a committee of the masters and assistant masters were formed to carry out some of the suggestions which had been made.

Dr. **Henry Jellett** said the two points that appeared to him to stand out with special importance were the institution of practical examinations, and the regulations governing students' practical instruction in maternity hospitals. With regard to the first, he would only say that while he had no doubt as to its extreme advisability, he had doubt as to its practicability at present. They were all probably agreed that the recommendations of the General Medical Council were extremely good, with the exception of the alteration in the course of attendance at maternity hospitals from six to three months. In Ireland such an alteration would shorten the present course, whereas in England and Scotland it would raise it to a much higher standard than before. He was quite aware that the present state of affairs was open to the objection that all students did not attend the full course. This fact was due to the regulations of the licensing bodies, which regulations were capable of improvement, though they were very many degrees ahead of the regulations on the other side of the water and considerably ahead in their potential capacities of the recommendations of the Council. They all wanted to teach students properly, both to maintain the reputation of the school, and, still more, that students might be sent out with a proper training. Why, then, should they limit themselves to what was practicable on the other side of the water? A three months' course presented the great practical difficulty that students could not be given their twenty cases in so short a time. Students had a habit of going to maternity hospitals at certain months, which were free from examinations and lectures, and if limited to a three months' course, a student would frequently be unable to complete his necessary number of attendances or conductions, and the onus would then be thrown on the hospitals to provide cases and to provide extra time. He thought that an intimation from the hospitals to colleges as to the impracticability of providing twenty cases for every student in three months would show the difficulty of the matter to those who did not understand it. It was absurd to think that students would be driven out of the country by the present system, since the difference between the courses in Ireland and in Great Britain will be lessened instead of being increased. He thought the Section might suggest to the colleges, in a resolution, that some more definite regulations should be laid down to govern the attendance of students at maternity hospitals. In the recommendations of the General Medical Council, the student is required to attend regularly for three months, but there is no definition as to the meaning of the word "regularly." He thought that if the colleges adhered to their six months' course, and made some attempt to define regular attendance, they would not only maintain, but enhance the reputation of the Dublin School, and would make the obstetrical training of the greatest value to the student.

Dr. **ROWLETTE** said that the medical curriculum seemed at present to be over-weighted, and if any part of it was to be increased, other parts would have to be diminished, and the clinical teachers must impress on their brethren who taught the more purely scientific branches at the beginning of the course that that part must be cut somewhat short. The reason why the student took the minimum quantity of instruction in midwifery and gynæcology was that he was worn down by the earlier studies, which were made so great and difficult that his clinical work was often crowded into the last eighteen months. If teachers of anatomy and physiology were capable of doing their duty, botany and zoology were unnecessary. There were certain faults in the final examinations in midwifery and gynæcology, which, being taken away, the subjects would be more attractive to students: one was the excessive amount of surgery required by the gynæcological examiner; it was no part of the duty of an ordinary medical practitioner to be able to perform highly technical operations. If the student was going to be a specialist, he must make up his work after his qualifying examination, not before it. He was only referring to highly technical operations; operations of emergency must, of course, be within the knowledge of every medical man. As to the high mortality in private practice, he thought it might be explained by the fact that more cases of childbirth were left unattended by medical men in Ireland than in England. It was also quite impossible for a medical man to practise the same aseptic precautions in a country cottage as in a hospital.

Dr. **TREVOR SMITH** said that much of the fault for the existing state of things lay in the fact that many of the nurses turned out were of a very inferior class. Illiterate nurses who did not know the use of the thermometer were often left in charge of women without the assistance of a medical man. He was not referring to the handy woman, but to so-called nurses who held diplomas.

The **PRESIDENT** said it was pleasant to see with what unanimity the members of the Obstetrical Section opposed the suggested curtailment of the period at present deemed necessary for attendance at maternity hospitals. Outside this section he regretted to say that many teachers were of opinion that a six months' course of study of midwifery and gynæcology was quite unnecessary, and unless energetic action was taken he much feared that the Royal Colleges would cut down the course to three months. He was certain this step, were it adopted, would make it very difficult for the maternity hospitals to deal with the number of patients they at present attend. He agreed that the present regulations of the licensing bodies in respect to midwifery required alterations, but the change should not be a retrograde one. These bodies should determine in the first instance precisely what they mean by an attendance for six months. If they do this they may rely upon the hospitals to enforce their regulations. At present the six months' attendance was interpreted in a very loose manner by some students, and those who desire to evade the course could, to a large extent, do so. On the other hand, many men considered it a great privilege to be permitted so long a course, and it was to these men we look to sustain the future reputation of the Dublin School of Obstetrics.

It was then proposed by Sir **WILLIAM SMYLY**, seconded by Dr. **JELLETT**, and passed unanimously:—"That the Obstetrical Section of the Academy of Medicine regards the recommendations of the General Medical Council regarding Obstetrical teaching as, in many cases, a very great advance on the present conditions. The Section, however, considers that the suggested alteration of the period of attendance on a maternity hospital from six months would not be advisable or practicable. The Section considers that, instead of reducing the attendance, the licensing bodies should adopt such regulations as will ensure regular attendance of students at the clinical teaching of the hospitals. With regard to the adoption of a practical examination in midwifery and gynæcology, the Section considers that such a step is most desirable, and urges its members to aid it by all means in their power."

Dr. **PUREFOY** then proposed, Dr. **KIDD** seconded, and it was passed unanimously:—"That a committee consisting of the masters, assistants (past and present) of the Dublin Maternity Hospitals be appointed for the purpose of urging upon the licensing bodies the inadvisability of changing the course of practical obstetrics from six months to three months."

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, DECEMBER 19TH, 1907.

The President, Mr. **FRANK T. PAUL**, F.R.C.S., in the Chair.

PLASTIC OPERATION BY THE TAGLIACOTIAN METHOD.

MR. **G. P. NEWBOLT** showed lantern slides of a case operated upon by the above method. The patient's forearm had been severely injured in a railway accident, both bones being broken, the skin much lacerated, and the muscles and tendons partially torn away. A long flap of skin was raised from the abdomen below the left breast, and the arm passed under it, so that it lay as if in a sling. As a result of this operation, which was completed in two further stages, the arm had been saved, sensation was good, and there was some movement in the fingers. The patient was still under treatment.

TREATMENT OF UN-UNITED FRACTURE BY BONE GRAFTS.

Mr. **RUSHTON PARKER** related two cases of un-united fracture treated by cleaning out unossified tissue from between the fragments, and planting in the interval small pieces of bone clipped from the seat of fracture. One case was that of a carter, æt. 35, whose left humerus had been broken six months previously, and imperfectly united by incomplete callus, permitting movement and unfitting the limb for use. Union resulted in six weeks. The other case was that of a lady, æt. 48, with total non-union of the left ulna of eight months' standing. There was pain as well as weakness and flexibility at the seat of fracture. Union was still absent in six weeks, but after hammering the seat of fracture, resulted firmly a week later. The practice was based upon the principle laid down by Sir William Macewen in his celebrated case reported to the Royal Society in 1881, repeated and amplified in his lecture at the University of Liverpool in December, 1906, again related to the Royal Society in January, 1907, and published in the *Proceedings* of June, and in the *British Medical Journal* of June 22nd, 1907.

The **PRESIDENT** said he quite accepted the truth of Sir William Macewen's observations, on which Mr. Parker had based his treatment of these interesting cases; but he did not consider that these observations contained the whole truth in reference to the development of bone. If so, how were they to explain the formation of bone in various tissues such as arteries, where no bone cells had ever existed. The constant precursor in such cases was a calcareous degeneration. If this excited any inflammatory change, the young connective tissue formed bone. Calcified arteries, cysts, tumours, etc., in this way frequently originated bone in the neighbourhood of the calcareous deposit, and he would suggest that Mr. Parker tried the effect of the presence of phosphate of lime alone, as this could be introduced without a regular operation.

Mr. **T. C. LITTLER JONES** showed a patient, both of whose feet he had amputated on account of the condition known as tabetic or trophic foot. Lantern slides were shown of X-ray photographs of the feet at various stages of the disease, exhibiting very clearly the progressive melting away of the phalanges without primary inflammatory changes. The patient had none of the ordinary symptoms of tabes dorsalis, appeared to be in excellent health, and could walk remarkably well on his artificial feet.

PHYSIQUE AND HEALTH IN THE LIVERPOOL SCHOOLS.

Dr. A. S. **Arkle** read a paper on the above subject, based on his examination of children from schools of three classes under the control of the County Borough Education Committee and the boys of a public school. The statistics showed clearly that there was a close relation between status in life and feeding and the growth and development of the children. The influence of feeding was shown by comparing the children of industrial schools and those of the lower class of Council schools. In regard to health, attention was drawn particularly to heart lesions, abnormality of the eyes, ears, nose, throat and teeth.

Dr. T. R. **Glynn** said that some of the facts demonstrated by Dr. Arkle's figures might have been anticipated, but others—as the smaller number of congenitally syphilitic children—was contrary to what might have been looked for. The explanation was in some degree the early death of the infected children. He hoped Dr. Arkle would have an opportunity of extending his observations in other directions, such as the relative prevalence of hereditary degeneration.

Dr. E. V. **Hope** mentioned that the excellent work which had been done by Dr. Arkle during the last few years gave some indication of the magnitude of the task of the medical inspection of school children. It was absolutely necessary, as the excellent Memorandum of the Board of Education pointed out, to follow up the examination by an extension of the amelioration of the sanitary condition, which had already proved so powerful a factor in improving the health of children. The methods of carrying out the Act had not been decided upon, and Dr. Hope expressed the belief that the views of the medical profession, if focussed and brought to the notice of the Education Authority, would receive every consideration at the hands of that body. He regarded the medical inspection of school children as an extremely important accessory in public health administration.

Mr. J. **Bark** agreed with Dr. Hope that the Education Department's object was to prevent the occurrence in children of certain diseases, which were detrimental to their physical and intellectual future. In the case of adenoids, the earlier the removal was undertaken the better. The best results were obtained in children operated on between the ages of two and seven years. Ninety per cent. of young children with enlarged faucial tonsils had adenoids. If the new Act was carried out efficiently, the future generations would be freer from deafness and chest troubles than the present. Dental examination and treatment were most important. Oral sepsis was responsible for much of the physical deterioration of our race.

Dr. A. C. **Wilson**, Medical Officer to the Truant Schools at Hightown, said he agreed with Dr. Arkle that under-feeding was the great cause of bad physique in the poorer classes of children. He rarely met with congenital syphilis, and this he attributed to the infected children dying out or getting into special Institutions for the deaf and dumb, blind or imbecile, etc. The most pressing reform needed was the better care of the teeth. He was glad to say that the Liverpool Education Committee had recently appointed a dentist for all Liverpool schools. He believed that defective vision in children was to some extent due to the eye not being trained to distances.

Several other members having spoken, Dr. T. R. Glynn proposed, and Dr. G. Stopford Taylor seconded, the appointment of a sub-committee of the Institution to consider and report on the Memorandum of the Board of Education. This proposal was adopted, and a sub-committee elected.

Somerset County Council and Medical Officer of Schools.

A long discussion took place at a meeting of the Somerset County Council, held at Taunton, regarding the medical inspection of children attending elementary schools. The County Education Committee announced their intention of appointing a chief medical inspector, who should give his whole time to the duties, and receive a salary of £500 per annum.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 5th, 1905.

Pulmonary Consumption

Prof. Renon gave recently some very interesting clinical lectures on the modern practical methods of treating phthisis. These lectures were published in the *Journal des Praticiens*, and merit reproduction :—

I hesitated for a long time (says Prof. Rénon) to treat this subject, as I had no sensational discovery to announce, nor had I found a specific remedy for tuberculosis. But at the recent Medical Congress the papers read on the treatment of consumption were so contradictory in their conclusions that I was convinced of the necessity of taking up the study of this treatment, which presents so much difficulty to the general practitioner. Some advise purely hygienic treatment, air cure, and supplementary feeding. Above all, no drugs, which simply poison the patients. Others recommend just as strongly the treatment by serums and tuberculins—serums of Maragliano, Marmoreck, tuberculin of Koch, Denys, or of Beraneck. Still others proclaim the advantages of sea water serum in large doses.

In face of propositions so radically different, it is difficult for the practitioner, if he has not acquired sufficient personal experience, to know exactly what to do.

From time immemorial new treatments for consumption have been tried, and recourse has been had to most curious methods, according to the medical doctrines of the period, and frequently with some success.

For a long time, for instance, tuberculous patients were treated with red cabbage; they were given it to eat in various make-ups and also as syrup. This treatment gave certain results from the fact that red cabbage contains 18 per cent. of lime salts. Some thirty years ago patients were recommended to sleep in cowsheds, as the air of these sheds was esteemed particularly beneficial to phthisical persons. Prof. Jaccond, of Paris, obtained good results from this method.

Each year produced some new treatment for the malady. I will examine before you the most recent additions to the already interminable list of drugs, in passing over cacodylates, arrhenal and lecithine, inhalations of nitrate of thorium of Sharp-Gordon, injections of petroleum and ether of Vnoukov, paratoxine of Lemoine, all of which require confirmation. But I will insist on atoxyl, opotherapy, sea water serum, and the treatment of Ferrier.

Atoxyl was supposed to be a specific for tuberculosis, but if this agent is inoffensive when employed in small doses, it has no real action on the malady. However, M. Hallopeau seems to have obtained good effects from atoxyl in the treatment of renal tuberculosis, and concluded that it might be useful in the pneumonic form.

Lesions of the glands of internal secretion, being frequent in tuberculosis, many were led to consider the rôle of opotherapy in the disease. Leaving aside the thyroid gland, I will say a few words on the hypothesis. M. Torri (Italy) and M. Garnier (France) noted frequently lesions of this gland in tuberculous patients, and Marfau having discovered that the arterial tension was lowered in such persons, it was thought that the gland given internally might, by raising the tension, render service. But from experiments made both by myself and others, we were forced to the conclusion that if the arterial tension was raised in reality, and that the appetite improved and insomnia disappeared more or less, the administration of this organ had no influence on the progress of the malady one way or the other.

Two years ago MM. Quinton and Simon recommended for tuberculosis injections of marine serum rendered isotonic and sterilised. I treated several apyretic patients with this plasma in small doses (one or two ounces), repeated twice a week, and obtained an increase in weight and appetite, and a general bracing up of the constitution. But when I tried it on febrile patients, and, on the advice of M. Quinton, increased the dose to four and six ounces, I was positively frightened at the results. The fever rose 2 or 3 degrees, followed by depression, loss of strength, appetite and weight—in a word, all the symptoms were aggravated, and I was obliged to abandon the injections. I would not advise anyone to have recourse to injections of marine serum for any patient whose rectal temperature exceeded 100° F., and only in small doses (2 oz.) in apyretic patients once a week.

The method of M. Ferrier consists in recalcification of tuberculous patients. In 1905 M. Ferrier made known the results of this new treatment, which was based on logical facts. According to him, consumptive persons underwent a process of decalcification, and his method consisted in restoring to the organism the salts that were wanting. The idea struck me favourably, and I determined to try it both in hospital and private practice, and was convinced that it could give good results where other agents failed. The agent employed to this end was chloride of calcium in small doses. Chloride of calcium has been recommended in the treatment of pruritis, pneumonia, albuminuria, and it acts just as well in small as in large doses; consequently small doses of the salt are sufficient to obtain recalcification of the organism.

We will now speak on the specific treatment of tuberculosis by serums and tuberculins.

M. Maragliano discovered some ten years ago an active serum for tuberculosis, which he made known through various publications. At the Congress, held last year at Lyons, he presented several observations of cases treated more or less successfully by his serum. Some months ago I was called in consultation to a lady who showed signs of wasting, but without presenting any definite symptom of consumption. In order to clear up the case the diagnosis by tuberculin, according to the method of Moeller, was tried. The reaction was positive, and we concluded that the patient was tuberculous. The treatment by the serum of Maragliano was advised, and the patient gained 14 pounds in weight at the end of three months. At the end of two more months she was submitted again to the experiment of tuberculin, but this time no reaction took place. We concluded consequently that the serum had removed all trace of the malady. But in reality the lesion, if lesion there were, was insignificant and almost imperceptible to clinical examination. My colleague, M. Guinard, obtained also, in some patients, interesting results from the employ of the serum of Maragliano.

I have not, for my part, utilised the serum of Marmorek, but German, English, and French authors have borne favourable testimony to the method. M. Marmorek possessed the merit of sustaining alone his ideas, and had the rare courage to treat consumption in its advanced stages, and consequently to expose himself to failures. However, on account of accidents produced by his serum, he was obliged to modify his *modus operandi*, and to prefer rectal injections to subcutaneous injections.

According to statistics published it does not seem that this serum is superior to the preceding. But any of these serums are liable to cause accidents as soon as injected. It is thus that Dr. Guinard describes what frequently follows these injections: "In from 15 to 20 seconds after the injection of serum of the goat or of an immunised horse, and sometimes even during the injection if done very slowly, appear suddenly phenomena of general stimulation of the vaso-motor system and the involuntary muscles, with troubles of the respiration and the cardiac rhythm. The symptoms commence generally by a difficulty in breathing; the patient believes he is choking, while waves of heat pass over the face with symptoms of vertigo. The face, neck, thorax, etc., become scarlet, the eyes are injected, and the heart beats are rapid, but so weak as to be almost imperceptible; the peristaltic action of the intestines is stimulated and the contractions are painful, accompanied by a desire to go to stool. A few seconds after these first phenomena, and when the patient is beginning to feel better, symmetric white spots, due to vaso-constriction, appear on the face, the chest, under the eyes, at the corners of the nose, on the forehead, ears, etc. Gradually all these symptoms disappear and the coloration of the skin becomes normal, when perspiration sets in, sometimes accompanied with rigor and a sensation of cold, by which the series of accidents terminates.

During a few following hours the patients suffer from a slight headache, while the temperature rises suddenly in the evening to 102° or 104° F.

We will now proceed to pass in review the different tuberculins: The old tuberculin of Koch T.O., the new tuberculin T.R., that of M. Denys (Louvain), and of Beraneck (Neufchâtel).

The tuberculin T.R. was employed by many authors, and especially by the celebrated English *savant*, Wright, who introduced his method of opsonins by which the use of the tuberculin could be regulated according to the reactions produced by the organism after each injection. Wright obtained good results in local tuberculosis, but as my colleague, M. Jousset, justly said in his report to the Société d'Etudes Scientifiques sur la Tuberculose, Wright seems to have abandoned the attempt against pulmonary consumption by the tuberculin T.R. which, in his opinion, was too dangerous to handle.

We will continue this subject in our next lecture.

GERMANY.

Berlin, Jan. 5th, 1908.

At the Medical Society, Hr. Langenstein discussed the problem of the

Artificial Feeding of Infants.

The starting point of the problem was the chemical comparison of the physiological and aphysiological foods. A comparison of human and cow's milk showed the quantitive differences in albumen, sugar, and salts. As regarded the quality of the food, it was to be observed that the fat of human milk was richer in olein than that of cows, that there were fundamental differences in the albumen of the two kinds, and that cow's milk contained considerably more casein and less albumen, human milk on the other hand less casein and more albumen. Whilst the carbohydrates were essentially represented by the milk sugar, as regarded the salts, we were not acquainted with them with sufficient certainty to give the average value of each different kind of salt; at any rate, it seemed possible that human milk was subject to considerable oscillations as regarded its different salts.

The inquiry for a long time was mainly devoted to the difference in the albuminous constituents of the two kinds; clinically, only one point justified this direction, and that arose from morphological considerations. In the fæces of many children fed on cow's milk particles were seen that bore a certain resemblance to curd. The chemical analysis of these particles, their constituents of phosphorus and nitrogen confirmed the belief that they were undigested casein.

The arguments of Heubner and Czerny however were not sufficient to do away with the belief in injurious food remnants, and the hypotheses springing from a biological mode of thought that the bad effects of feeding with cow's milk was due to the albumen rather helped this notion than otherwise. Whilst albumen of its own kind was given to the infant at the breast, the one fed aphysiologically received albumen of a strange or foreign kind. These injurious effects of cow's milk were supposed not to occur when the intestinal glands of the infant were washed in the albumen of its own kind. Experimental and clinical experiences both spoke against the correctness of this theory. The most carefully carried out experiments taught us that there was no difference in the digestibility of the two kinds of albumen; so far as investigations on the using up of albumen made on the living infant were available no differences were recognizable in the different albuminous bodies of milk. Examinations of nitrogenous constituents of fæces in natural and artificial feeding gave no special results in the direction of difficult digestion of cow's milk. The power of resorption for albumen of both kinds of milk was the same in healthy children whatever kind of milk was given. In the intestines of the calf killed after the first meal of colostrum the same fragments of albuminous bodies were met with as in the intestines of the full-grown dog fed on horse-flesh. The new-born animal came into the world gifted with the same power of digestion as the adult, it brought with it pepsin and trypsin, and from the fifth month of foetal life, as the speaker had ascertained, the albuminous enzyme erepsin. Nothing remained over therefore as regarded an experimental basis for the supposed bad effects of feeding with albumen but the biologically different behaviour of different kinds of albumen. The disciples of the "injury" theory themselves confessed that the foreign principle was destroyed in the stomach.

Clinically it had been shown that in alimentary intoxications in children that were treated by fasting for 24 or 48 hours the giving of albumen at this period did no harm. It was remarkable also that even the strongest believers in the bad effects of albumen were also most energetic advocates of buttermilk feeding, a food that contained quite as much albumen as whole milk.

The prospects were more promising when attention was directed to the other two organic components of cow's milk. We might indeed say that our knowledge that the fat of cow's milk was a harmful factor in the artificial feeding of infants was a great step in advance, both from a scientific and a practical point of view. Here we had an injurious effect in the treatment of which by buttermilk signalised its triumph, but it was not by any means the panacea that it had been made out to be. The injurious effects of fat were most in evidence when we studied its action on the course of enterocatarrh.

When we turned our attention to the effects of the carbohydrates in infant feeding the problem seemed very difficult to clear up. As positive knowledge it had been shown that too much carbohydrates, whether starch or sugar, led to a form of injury that was very characteristic.

For the clearing up of the problem of artificial feeding the salts also appear to be of immense importance. L. F. Meyer's experiment, in which he gave human milk fat and human milk albumen in a vehicle of cow's milk whey, and, on the other hand, cow's milk fat and cow's milk albumen in a vehicle of human milk whey without any disturbance, disturbances being observed when the salts were given, indicated the great importance of both quantity and quality of the salts in artificial feeding, as the albumen contained in the whey and certain still unknown substances were certainly not responsible for the injurious effects observed.

It was certain that far-reaching changes were brought about in the milk by heating to a temperature of 100 C. From certain experiments made it was probable that when human milk was given in a cooked state the child would not thrive so well, but clinical experiences in hospitals for infants had not shown that more could be done in the matter of feeding with uncooked than with cooked milk.

There was no doubt that theoretical speculations and clinical experiences had led to an improvement in artificial feeding, and to more exact formularising for special indications. We had at least learned to dread foods containing fats; we must have learnt that coddling with excess of meal and sugar led to sickness and death. In the future we should not be content with these two experiences, but give due consideration to the "Katalysators" of nutrient material.

AUSTRIA.

Vienna, Jan. 5th, 1908.

Hepatic Rupture.

Foderl exhibited to the Gesellschaft a number of cases he had operated on. The first was a patient, æt. 30, who was operated on 19 hours after the accident, and confirmed the diagnosis of hepatic rupture made on his reception. On the day of operation sugar and acetone were both present in the urine, which could not be due to intra-abdominal hæmorrhage, but to the implication of the pancreas, which was also torn. The acetone disappeared after the operation, and the sugar later, when the diet was robbed of its carbohydrates. Later the dieting had no influence, and the patient remained sugar-free after taking any kind of food.

The next case was a revolver shot in the stomach. The peculiarity in this accident was the extraordinary amount of reflex contraction in the rectus muscle of the abdomen, which determined the operation twelve hours after the accident had occurred. On opening the abdomen a suffused clot of blood about the size of a five-shilling piece, with a gaping wound, was observed in the parietal peritoneum over the stomach, while the wall of the organ was quite free from any injury. In the median line, and directed towards the smaller curvature was a suffused tract penetrating the serous covering of the organ, and through which a long sound could be passed. The revolver used was a 7-metre weapon, making an imperceptible entrance over the region of the stomach, but no exit of the bullet could be discovered. The Röntgen rays were applied, and discovered the projectile lying embedded in the first lumbar vertebra. It seems that the bullet, after penetrating the abdominal wall, was deflected downwards along the rectus muscle till it reached the lumbar vertebra. This peculiar direction accounted for the abnormal contraction of that muscle.

Extirpation of the Saphena Vein.

Schnityler presented two patients on whom he had operated for acute phlebitis, both commencing in the gravid state. In the first case he removed the vein completely from Poupart's ligament to the malleolus, while in the second he only removed portions of the vein, particularly the varicose portions, thus avoiding a long wound along the leg, which gives equally good results and has a better appearance when complete. He thinks this intermittent operation in the saphena is advisable in both inflammatory and non-inflammatory varicose condition of the veins.

Haberer stated that he had a similar case which he had operated on in the same way, and obtained excellent results.

Injury to the Arteria Pulmonalis.

Sternberg demonstrated from an anatomical preparation which had died suddenly from a needle penetrating the pulmonary artery. The needle first had entered the anterior wall of the pericardium, and thence made its way to the posterior surface, where it penetrated the pulmonary artery. The absence of any healing of wounds in the pericardium or artery proved that the fatal injury occurred immediately before death.

Club Foot Therapy.

Semeleder treated the members to another rehearsal of his special treatment of club foot with a peculiar shoe which he has introduced for this purpose. At the very outset he condemned forced "Redressment," as it often produced another deformity in the form of flat foot, or a return in a short time to the equinus state. He next demonstrated his own method, which is a modification of tenotomy with the subsequent application of an apparatus or "shoe," as he calls it, whereby the weight of the body corrects the deformity.

By this means he contends that the paralysed groups of muscles are awakened, and the whole limb strengthened by the over-contractile muscles being relieved. Reiner could not agree with Semeleder in this "model" cure of the deformity, nor could he believe that the equinus could be so easily transformed to the valgus.

He thought the treatment with Semeleder's "shoe" was a failure, because it did not provide for adduction and inflexion.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Royal Infirmary.—The annual report of the Infirmary, which has just been issued, shows that during the year ending September 30th, 1907, 11,140 in-patients were treated, a decrease of 76 as against the previous year. The average daily number of patients was 832, and the average duration of treatment 27.3 days. The deaths within 48 hours of admission numbered 191; the percentage mortality, deducting these, was 5.69; including them, 7.31. The out-patients numbered 38,660. The total ordinary income was £35,707, being £2,012 more than last year. The managers' last report mentioned the appointment of an organising secretary, and they are glad to say that the results already attained through that official's efforts are most satisfactory. A regular system of periodical collecting in mines, factories, etc., has been successfully introduced, resulting in an increase of £284 on the Edinburgh collections, and of £1,016 on those in the country districts. The ordinary expenditure amounted to £33,479, an increase of £1,362, accounted for by the higher cost of articles of maintenance, coal, etc. The entire ordinary expenditure per occupied bed was £64 5s. 6½d., an increase of £2 3s. 2½d. on 1906. The increase was entirely on maintenance, medical expenditure having diminished by 6s. 7½d. The legacies and donations of £100 and upwards have reached £35,125; and the extraordinary expenditure on drainage, new surgical out-patient theatre, etc., has been £11,436. The managers then refer to the Royal visit, when T.R.H. the Prince and Princess of Wales were conducted through the hospital; to the retirement of Miss Spencer from the position of Lady Superintendent after 30 years' service, and to the appointment of Miss Gill as her successor. The average number of nurses and probationers was 245.4; the number of applications still far exceeds the number of vacancies, but has been somewhat reduced by the deterring but beneficial results of the preliminary examination. In addition to the drainage, the chief new works undertaken during the year have been the reconstruction of the surgical theatres attached to wards 16 and 17, and wards 10, 11 and 12. It is intended during the ensuing twelve months to reconstruct the medical out-patient department, which is not equal to modern requirements. During the year the managers took leave, with deep regret, of Mr. C. W. McGillivray, one of the acting surgeons, and of Dr. Alexander James, one of the acting physicians. As a testimony of their esteem for them, the managers have appointed Drs. McGillivray and James members of the consulting staff. The managers further record their regret at losing the services on the board of Dr. Affleck and Professor C. Hunter Stewart, whose term of office expires, and of Dr. Underhill and Mr. Carter, who do not desire re-election. Since the report was written the managers have to record, with deep regret, the loss by death within a day of each other of two members of the surgical staff, Professor Annandale and Sir Patrick Heron Watson. They allude in suitable terms to the eminent services rendered to the institution by these two distinguished men. Sir Patrick Watson's services were so notable and highly appreciated that on the expiry of his term of office the managers appointed him for a period of five years an extra-surgeon to the institution.

BELFAST.

Training of Nurses at the Union Infirmary and Hospital.—An interesting discussion took place at the Belfast Board of Guardians last week, when, by a large majority, the Board adopted a new scheme for the training of their nurses, as recommended by the Infirmary Committee. Under the new scheme the training will extend over four weeks, instead of three, as at present, and the period devoted to training in fever wards will be extended to six months. The actual cost of nursing last year was £6,128. there being 1,689 sick poor under the care of the Guardians in their various hospitals. It is estimated that the cost under the new scheme may be increased to about £7,150, with greater efficiency. The new arrangement seems, from all points, to be a good one, for the nurses from the Belfast Union go all over Ulster as charge nurses in the smaller Unions, and a thorough training is most desirable.

Public Health.—The High Death-Rate.—At the monthly meeting of the Corporation, held last week, Dr. Kink-Kerr, the Chairman of the Public Health Committee, attempted to explain the excessive death-rate which has characterised the returns from Belfast for many weeks now, giving it generally the unpleasant prominence of the most unhealthy large city in the United Kingdom. The explanation given was that the bad weather had caused an excessive amount of chest affections, and had also caused great mortality among the children suffering from measles, an epidemic of which now prevails. Another reason adduced is that the population of the city is really greater than the estimate of the Registrar-General, on which the rate is based. But all these circumstances are not sufficient to satisfy the citizens that all is right with the Public Health Department when we groan under a death-rate of 25.5 per 1,000, and the report of the late Commission upon the health of the city is eagerly awaited.

LETTERS TO THE EDITOR.

INHERITED SYPHILIS.

To the Editor of The Medical Press and Circular.

Sir,—Mr. R. Clement Lucas's address, printed in your issue of this week, forms a very valuable contribution to the discussion of this question. It is particularly interesting to me for the reason that clinical observation led me, long years ago, to protest against the common exaggeration of the danger of syphilitic fathers begetting tainted progeny. I find from my note-book that I made such a protest at least as far back as March 24th, 1897, when a letter from me was published in your paper of that date. Further experience, including observation of children in hospital practice, has confirmed my views. My experience would support Mr. Lucas's view, that "for transmission of syphilis it is necessary that the woman be first infected." It is almost impossible on any other grounds to explain the facts, or at least the facts which clinical experience has brought before me. My experience has been that a syphilitic father, whether he has been treated or not, seldom if ever begets tainted offspring after disappearance of secondary symptoms, say, two years after primary infection, and that after four years the danger is twice as remote. With properly carried out mercurial treatment during the first two years, the danger of producing infected children is very small, and after a further interval of two years with treatment, it can be barely said to exist. The number of children presenting unequivocal signs of syphilis among the progeny of undoubtedly infected parents is very small, and much smaller when the father alone carries the taint. Syphilis is responsible for so much unhappiness that it would be well if some portion could be reduced by a less pessimistic prognosis than is often given to young men contemplating matrimony. They can often be assured that after a sufficient lapse of time and steady perseverance throughout in treatment by mercury and potassium iodide, the danger of conveying disease to wife or child is so small as to be insignificant.

I am, Sir, yours truly,
An Average Practitioner.

January 2nd, 1908.

THE FEEDING OF SCHOOL CHILDREN.

To the Editor of The Medical Press and Circular.

Sir,—Although not written there, it is evident, from the impartial manner in which your correspondence columns are kept open for the expression of different opinions that the motto, "Audi alteram partem," really dominates them, and I am certain you will allow me very briefly to express my dissent from the reasoning in your leader under the above heading this week. The appearance of underfed children at school is merely one superficial symptom of grave social maladies; and these maladies are certainly not to be cured, and will be probably aggravated, by any measures save such as go straight to the true prime causes. And in the first place, I would remark that a great proportion of the children who are ill-nourished and look underfed are really suffering from damaged constitutions due to improper food and feeding in infancy—often from the mother's inability to suckle them. Many are underfed because the mothers are entirely ignorant of the art of cooking. They know nothing about food materials and the proper way of preparing them. The English poor throw away or neglect to use cheap foodstuffs which foreigners, French and Germans, to a great extent live upon; and very few English wives know how to prepare oatmeal porridge or any of the cereals which are almost enough alone for the nourishment of children. Not one in a thousand understands the making of soup from bones, and the thickening of it by potato, rice, or bread into an appetising and nourishing food. By taking away the incentive to learn housewifery, and by putting a premium on ignorance by the public feeding of the children, a vast amount of harm will be done. Those mothers who make a sacrifice and try to do their duty to their children will be made worse off than the thriftless and improvident. Then where do the rates come from to pay for the feeding? Out of the pockets of many citizens not more able to afford the impost than those upon whom it is expended. And, again, the thousands of pounds thus expended are taken from funds which would otherwise be used in employing labour, and for every few hundred children fed a certain number of workmen will have their employment curtailed or taken away. These are only a few of the facts which should be considered in problems like that in hand. If children are sent to school underfed, every case should be inquired into. If the parents are carelessly neglecting their duty, they ought to be prosecuted; if they are destitute the Poor-law or charity should deal with them. The crude Socialistic experiments based upon expediency, which ignore economic and scientific facts, and which are now the fashion, will, if carried far enough, lead to the moral and material ruin of the State.

I am, Sir, yours truly,

Medical Economist.

Christmas. 1907.

THE *STAR* AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—Unsigned letters in the lay Press from members of the profession have little weight, and there exist more than enough reasons why one cannot publish one's name in papers like the *Star*. Would you allow me to put the following query to the Editor of your contemporary, through your valuable journal, and at the same time vouch for my good faith and professional position? I wish to ask him how he accounts for the fact that, with the exception, perhaps, of the extremely rare instances in which a medical man is an anti-vaccinationist, the whole of the profession take care that their own children are vaccinated? Does he believe that a man, when he becomes a doctor, is converted into an anti-human monster capable of sacrificing his own children in a vile conspiracy for paltry, sordid gain? Does he not see that if the profession—not only in these islands, but throughout the civilised world—have the operation carried out on those they love, it must be because they, as an army of skilled witnesses, are satisfied that at least vaccination is a perfectly harmless process?

I am, Sir, yours truly,

A Surrey Doctor.

Near Reigate, January 3rd, 1908.

[We have received for publication a number of letters which have passed between Mr. G. W. F. Robbins, Secretary of the National Anti-Vivisection Hospital, and the Hon. Sydney Holland, on the subject of the equipment of the hospital in question. As the correspondence is far too long for insertion in our columns in their present crowded state, we refrain from commenting upon it. Probably some of the dailies will be able to give it space.—Ed. M. P. and C.]

A case of suspected cholera has occurred in a suburb of Constantinople. The victim, a Greek, died on Friday.

OBITUARY.

ROSS JORDAN, M.R.C.S., L.S.A.

We record with sorrow the death, which took place on January 2nd, of Mr. Ross Jordan, of Birmingham. For some time past Mr. Ross Jordan had not been in the best of health, and early in November he had an acute attack of pneumonia. From this he apparently recovered, but early in the year he was not so well, and he unexpectedly died in his sleep. At Queen's College Mr. Ross Jordan received his early medical education, but a suitable opportunity occurring for his entry into a merchant's office at Bradford, he spent three years in the service of a mercantile firm. At the end of three years family arrangements required his re-entry into the medical profession, and, returning to Birmingham, he rejoined Queen's College and resumed his studies there. He qualified for practice as M.R.C.S. and L.S.A., and commenced to practise in Birmingham. In 1868 and 1869 Mr. Ross Jordan and three friends—Drs. George Jones, James Neal, and Lumley Earle—became convinced of the necessity for a hospital to be entirely devoted to the alleviation of cases peculiar to women. The effort was at first unsuccessful, but at last Mr. Ross Jordan succeeded in enlisting the interest of Mr. Arthur Chamberlain, who undertook the duties of honorary secretary, and with the aid and support of a number of gentlemen—amongst others Mr. Joseph Chamberlain and the late Dr. Heslop, George Dawson, Arthur Ryland, Charles Vince, Dr. Samuel Berry, and Joseph Nettlefold—in 1871 the Birmingham and Midland Hospital for Women became an accomplished fact. The hospital was first opened in the Crescent, but the out-patients' department was transferred to the Upper Priory in October, and the in-patients' department to Sparkhill in the December of that year.

Of the hospital Mr. Ross Jordan was regarded somewhat in the light of the founder. His peculiar knowledge and ability in women's cases were employed in its interest during its early years, and until an unfortunate illness in 1880. After this he continued to render it valuable service as consulting surgeon. His connection with the hospital was maintained from its inception, and in many ways he was able to aid by his abilities the institution and its patients. He was regarded by the entire staff with the greatest esteem and respect, and with the kindliest of kindly feelings.

HENRY ALCOCK DIXON, M.R.C.S.

We regret to announce the death on December 24th of Dr. Henry Alcock Dixon, of Burnley. Dr. Dixon was a Burnley man, the son of Mr. John Alcock Dixon, solicitor. Dr. Dixon was educated at the Burnley Grammar School, afterwards at Rossall College and Stonyhurst College, and subsequently was apprenticed for seven years at the Royal Infirmary, Manchester, being the last senior apprentice that institution had. He then qualified as a member of the Royal College of Surgeons, and commenced practice in Burnley. Dr. Dixon, who had a large practice, was highly respected, and his reputation was greatly enhanced by his unflinching devotion to smallpox patients during the epidemic in the Kirkgate district. Some years ago Dr. Dixon had a severe illness, and this being followed by another, he lost the sight of his left eye.

SPECIAL ARTICLES.

THE TEACHING OF MIDWIFERY IN IRELAND.

We publish in our present issue a report of a most important discussion, which took place at the Obstetrical Section of the Royal Academy of Medicine in Ireland, on the recommendations suggested by the General Medical Council with regard to the teaching of midwifery. We also publish in full the address with which the discussion was opened by Sir William Smyly. The recommendations of the Medical Council may be briefly stated as follows:—Students before commencing the study of practical midwifery must have attended lectures on surgery and midwifery, and have held the post of surgical dresser and medical clinical clerk. They must then attend the indoor practice of a lying-in hospital for three months, and after having received instruction in the conduct of labour, must conduct twenty cases of labour. Further, the Medical Council suggests that clinical examinations in midwifery ought to be held by the licensing bodies. These recommendations constitute an enormous advance on the present state of affairs as it exists in Great Britain. As an instance of the extent of that advance, it may be mentioned that, at the present time, certain licensing bodies only require the student to attend six cases of labour, and after this he is considered to be qualified to attend all normal and abnormal labours. In Ireland, on the other hand, these proposals constitute in one important particular a retrogression, because, in Ireland, the licensing bodies have united to demand a six months' course of attendance at a recognised maternity hospital. If the recommendations of the Medical Council are adopted *in extenso*, this course will be reduced to three months, and, although certain benefits will result from the adoption of the other recommendations, they will by no means counterbalance the injury done by the shortening of the course of practical instruction. It is, therefore, not surprising to find that at a meeting at which were present almost all the leading Dublin obstetricians, a resolution was unanimously carried, which, while recognising the great advance the recommendations of the General Medical Council would effect over the existing state of things, condemned as undesirable and impracticable the substitution of a three months for a six months' course by the Irish licensing bodies. We understand that those who are in favour of the alteration in the length of the course of instruction, base their opinions on the facts that students, as a body, do not continue to attend the maternity hospital after they have taken out the necessary number of cases. This is a fact, and it is a fact which calls for the serious attention of the licensing bodies, because it is due to the failure of their regulations to lay down explicitly what is expected from the student. It is impossible for the hospital authorities to force on a student more than the licensing bodies require from him, but once the licensing bodies definitely specify their requirements, we are sure that the hospitals will be only too pleased to insist on compliance with them. For this reason we welcome the further paragraph in the resolution adopted by the Obstetrical Section of the Academy of Medicine, calling on the licensing bodies to insist on regular attendance at clinical instruction in the hospitals as well as on the conduction of 20 cases of labour. If the course recommended by the Dublin obstetricians is adopted by the licensing bodies in Ireland, the high position and reputation of the Irish obstetrical school will be maintained. If, on the other hand, the present effort to raise the standard of obstetrical training in Great Britain results in a lowering of the standard in Ireland, the result will be in the highest degree prejudicial to the reputation of the Irish school and to the obstetrical training of the future Irish medical student.

REVIEWS OF BOOKS.

BOOK OF PRESCRIPTIONS (a).

"BEASLEY'S PRESCRIPTIONS" is an old friend to many generations of practitioners, and in its new form, re-written by Mr. E. W. Lucas, it is bound to have many readers. The book, of course, is little more than a compilation, as have been the previous editions, and that, we fancy, is a great advantage, for when a pharmacist, however accomplished, seeks to indicate the uses of drugs, it is not long before he fails. For instance, even Mr. Lucas himself, when he is tempted to step from his last, tells us that sulphonal "is absorbed so slowly that it takes some hours to act," which is what we were all told ten years ago, and which patients have disproved for us over and over again. So, too, in the next paragraph, he says rather abruptly of trional, "No use when there is acute pain"—another far too sweeping an assertion. But in the general course of the book we find the author painstaking and trustworthy, and the prescriptions are not only, as far as we can see, quite accurate, but varied, well chosen, and useful. To the student who wishes to learn to prescribe, and to the practitioner who wishes to keep himself *au fait* with the art, we can recommend their perusal, for there is much that is suggestive and helpful, and it is a great thing nowadays to be able to give elegant mixtures to patients without resorting to some preparation manufactured by an enterprising firm who are unacquainted with the particular patient's needs. The doses are all given according to both the imperial and metric systems, and we think the author is wise in having adopted the approximate equivalents—viz., 30 cc. for an ounce, and .06 gramme for a grain—rather than plunge into pedantic morasses of exactitude. Altogether the new edition of this old favourite promises well to maintain the popularity of the work, and when we have the pleasure of reviewing the tenth edition, we trust that we shall not find in it the second prescription on p. 110—at any rate under the same description as at present.

ORGANIC CHEMISTRY. (a)

THE authors of text-books on organic chemistry are usually enthusiasts to whom the mass of formulæ and hard facts have a strong attraction, and their efforts in writing are generally of a harsh and uninviting nature that renders the subject repulsive to the medical student. As a striking contrast to such volumes we welcome the work under consideration, which, while being thoroughly in line with modern work, places the matter in as attractive a manner as possible, thus causing the student to acquire an interest in the subject. As the requirements of the English examining bodies are greater than those required by German ones, the translator has made the necessary additions to the text, which include an appendix on practical methods. The chapter on proteins is of peculiar value as the recent work of Emil Fischer is referred to, while the nomenclature of these bodies is that recommended by the Physiological and Chemical Societies. The book reflects considerable credit on both the author and translator.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

FELIX ALCAN (Paris).
- Le Ventre II. l'Estomac et l'Intestin. Par Dr. F. Cantru et Dr. M. Bourcart. Pp. 335.

BAILLIERE, TINDALL AND COX (London).
- Aids to Pathology. By Harry Campbell, M.D.Lond. Illustrated. Pp. 184. Price, cloth 3s. 6d. net, paper 3s. net.
- The Hair and its Diseases, including Ringworm, Greyness and Baldness: an Introductory Handbook. By David Walsh, M.D.Edin. Second Edition. Illustrated. Pp. 94. Price 2s. 6d. net.
- Medical Laboratory Methods and Tests. By Herbert French, M.A., M.D., F.R.C.P.Lond. Second Edition. Pp. 175. Price 5s. net.

CHAPMAN AND HALL, LTD. (London).
- A Text-Book of Organic Chemistry. By A. F. Holleman, Ph.D., F.R.A.Amst. Translated from the Third Dutch Edition by A. Jamieson Walker, Ph.D., B.A., and Owen E. Mott, Ph.D. Second English Edition, re-written. Pp. 589. Price 10s. 6d.

CHURCHILL J. AND A. (London).
- The Borderland of Epilepsy. By Sir William R. Gowers, M.D.Lond., F.R.S. Pp. 121. Price 4s. 6d. net.
- Year-Book of Pharmacy, 1906-7: with the Transactions of the British Pharmaceutical Conference at Manchester, July, 1907. Edited by J. O. Braithwaite, E. Saville Peck, M.A., and Edmund White, B.Sc., F.I.C. Pp. 549. Price 10s.

THE CLARENDON PRESS (Oxford).
- The Quarterly Journal of Medicine. Edited by Wm. Osler, J. R. Bradford, R. Hutchison, etc. Volume I., No. 2. January, 1908. Pp. 223. Price 8s. 6d. net.

(a) "The Book of Prescriptions." Rewritten by E. W. Lucas, F.I.C., F.C.S., Late Examiner of the Pharmaceutical Society of Great Britain. Introduction by Arthur Latham, M.A., M.D., F.R.C.P. Ninth Edition. London: J. and A. Churchill.

(a) "Text-Book of Organic Chemistry for Medical Students." By Dr. G. v. Bunge, Professor of Physiological Chemistry in the University of Basel. Translated with additions by R. H. Aders Plimmer, D.Sc.Lond., Assistant Professor of Physiological Chemistry, University College, London. Pp. 260 and ix. London: Longmans, Green and Co. 1907. Price 6s. net.

Archibald Constable and Co., Ltd. (London).
  The Essentials of Cytology. By Chas. E. Walker, with a Preface by Prof. C. S. Sherrington, F.R.S. Pp. 139. Price 7s. 6d. net.
Unione Co-Operativa Editrice (Rome).
  The Hygiology of Rome and Rome as a Health Resort. By John J. Eyre, M.R.C.S., L.R.C.S.P., D.P.H.Camb. Reprinted from "The Seven Hills Magazine," March, 1907. Pp. 23.
Wm. Green and Sons (Edinburgh).
  Arterial Hypertonus, Sclerosis and Blood-Pressure. By Wm. Russell, M.D., F.R.C.P.Edin. Illustrated. Pp. 194. Price 7s. 6d. net.
H. K. Lewis (London).
  Injuries to the Eyes of the Employed and the Workmen's Compensation Act: Problems in Prognosis. By W. M. Beaumont, Surgeon to the Bath Eye Infirmary. Pp. 160. Price 5s.
  The Opsonic Method of Treatment. By R. W. Allen, M.B., B.S. Pp. 138. Price 5s. net.
  A Guide to the Administration of Ethyl Chloride. By G. A. H. Barton, M.D. Second Edition. Pp. 54. Price 2s.
London Homœopathic Publishing Co. (London).
  Thomas Skinner, M.D. A Biographical Sketch. By John H. Clarke. Pp. 93.
Longmans, Green and Co. (London).
  The King's College Hospital Book of Cooking Recipes. Being a Collection of Recipes contributed by friends of the Hospital in aid of the Removal Fund. Pp. 272. Price 1s. net.
  Movable Kidney and Other Displacements and Malformations. By David Newman, M.D., F.F.P.S.G. Pp. 233. Price 5s. net.
  Transactions of the Clinical Society of London. Volume XIV. Pp. 295.
  Proceedings of the Royal Society of Medicine. Volume I., No. 1. Price 7s. 6d. net.
  Comparative Electro-Physiology. By Prof. J. C. Bose, M.A., D.Sc. Illustrated. Pp. 760. Price 15s. net.
Macmillan and Co., Ltd. (London)
  Primary Nursing Technique for First-Year Pupil Nurses. By Isabel McIsaac. Pp. 197. Price 3s. net.
Associated Newspapers, Ltd. (London).
  The "Daily Mail" Year Book for 1908. Edited by Percy L. Parker. Pp. 269. Price 6d. net.
Young J. Pentland (Edinburgh).
  The Edinburgh Medical Journal. Edited by Alexis Thomson, M.D., F.R.C.S.Edin., and Harvey Littlejohn, M.B., F.R.C.S. Edin. New Series. Volume XXII. Pp. 564.
Rebman, Ltd. (London).
  Hygiene of the Lung in Health and Disease. By Prof. Dr. L. von Schrotter. Translated by H. W. Armit, M.R.C.S., L.R.C.P. Illustrated. Pp. 135. Price 2s. net
  A Manual of Surgery. By Francis T. Stewart, M.D. Illustrated. Pp. 778. Price 15s. net.
  Lateral Curvature of the Spine and Round Shoulders. By R. W. Lovett, M.D. Illustrated. Pp. 188. Price 7s. 6d. net.
  Retinoscopy (or Shadow Test). By James Thorington, A.M., M.D. Fifth Edition, revised, enlarged and illustrated. Pp. 67. Price 4s. 6d. net.
Sands and Co. (London).
  The Nurse's Day and Night Report Book. Price 6s. net.
W. B. Saunders Co. (Philadelphia).
  The Pancreas: its Surgery and Pathology. By A. W. Mayo Robson, D.Sc., F.R.C.S., and P. J. Gammidge, M.B., D.P.H. Illustrated. Pp. 546. Price 21s. net.
  Diseases of the Genito-Urinary Organs and the Kidney. By R. H. Greene, A.M., M.D., and H. Brooks, M.D. Illustrated. Pp. 536. Price 21s. net.
Sherratt and Hughes (Manchester).
  A Plea for Establishing Municipal Maternity Homes for Cases of Abnormal Labour and Puerperal Fever. By Sir Wm. J. Sinclair, M.D. Pp. 97. Price 3d.
John Wright and Co. (Bristol).
  Precious Stones for Curative Wear: and other Remedial Uses: likewise the Nobler Metals. By W. T. Fernie, M.D. Pp. 486. Price 6s.
  An Index of Treatment by Various Writers. Edited by Robert Hutchison, M.D., F.R.C.P., and H. Stansfield Collier, F.R.C.S. Pp. 877. Price 21s. net.

LITERARY NOTES.

We have reason to believe that, before many months of the New Year have passed, the two medical journals, the *Edinburgh Medical Journal* and the *Scottish Medical Journal*, will be amalgamated. Rumour has it that the support accorded by the profession in Scotland has not been sufficient to maintain the two in healthy rivalry, and that one of these must necessarily "go to the wall."

⁂

One of the events of the year now closed was the retirement in December of Mr. Pentland, of Edinburgh, from the medical publishing business, and the disposal of his stock and copyrights to Mr. Froude and Messrs Hodder and Stoughton, hitherto publishers of religious works. It is matter for congratulation that, at least on the present occasion, "medicine has not gone to the dogs," but to the angels.

Another journalistic change to chronicle is the incorporation of *The Health Resort* with *The World of Travel* with the opening of the New Year. The former, which has changed hands more than once during its brief career, now ceases to exist as a distinct entity. The first number of the amalgamated journals is before us, and appears to be conducted on similar lines, the only notable feature being its altered title.

⁂

The first volume of the *Dublin University Calendar* for 1907-8 has recently appeared. It contains the usual information as to the ordinary and Honours courses in Arts and in the professional schools, together with the ordinary papers set in the year 1906-1907. The volume, therefore, is specially the book for information for students. Its contents are arranged in fairly accessible manner, and we have detected very few blunders.

⁂

This excellent publication ("Hazell's Annual") lies on our library table, with all the comely importance that can be assumed by a standard reference book in the twenty-third year of its issue. The familiar arrangement of sections is again adopted, and the usual multitudinous array of facts and figures is contained between its handsome red covers. Our readers cannot do better than buy a copy of this useful book for their library table. It is a veritable storehouse of facts garnered with untiring industry from many devious fields of human activity.

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Two excellent diaries and note-books have come to hand for 1908. One is "The Consultant's Appointment Book," issued by Messrs. Burroughs, Wellcome and Co., which, we believe, has been presented gratuitously to the majority of the profession, and which appears to have taken the place formerly held by "The Visiting List." The other is "The Doctor's Diary and Emergency Note-Book," a smaller publication, as its title indicates, and this has also, we understand, been very freely presented to members of the profession by Messrs. Scott and Bowne. Both are elegantly bound in leather, and will be found extremely useful pocket companions during the New Year on which we have now entered.

⁂

The course of lectures that Miss Kanthack delivered last year to the voluntary health visitors in St. Pancras on "The Preservation of Infant Life" have been published in book form by Messrs. H. K. Lewis (price 1s. net), and form an excellent guide to ladies undertaking such work. Properly organised and with suitable visitors, this work forms a desirable portion of the scheme for reducing infant mortality, and Miss Kanthack's experience of the matter allows her to speak with experience. We are glad to notice the constant emphasis laid on the necessity for invoking medical skill, and the reprehensibility of the visitor tendering medical advice.

⁂

Herbert Fry's Royal Guide to the London Charities makes its forty-fourth appearance this year, and is as welcome as ever. To medical men, especially those in the metropolis, it is invaluable, as at a glance they can refer this, that, or the other broken-down wayfarer to the proper channel for relief. To those not acquainted with Fry's Charities the number of eleemosynary societies and institutions existing in London will furnish a surprise. Nor are the objects for which many of them exist less astonishing, and the juxtaposition which alphabetical arrangement connives at produces some incongruous results. For instance, the "gentlewomen of high moral character, in reduced circumstances" benefiting from the "Annuitants Homes" find themself check by jowl with the Anti-gambling League, and the Clapham Maternity Hospital adorns the same page as "Becker's Bounty for Poor Pious Clergymen." We cannot help being struck with the immense number of charitable institutions served gratuitously by medical men, and the fact that only two societies exist for the benefit of them or their widows.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Cholecystitis with Gangrene of the Gall Bladder.—Ross (*Canadian Practitioner and Review*, Dec., 1907) reports five cases of gangrene of the gall bladder. In each case the patient was operated on, and the gall bladder opened and drained, with successful results. The author says: "I find that the symptoms of the disease are of a very marked type. The patient, perhaps in the midst of health, is seized with a sudden acute pain in the right hypochrondrium, which may be so severe as to cause collapse, faintness, and prostration. The most peculiar symptom I have observed is the condition of the pulse, the rate of which varies very quickly from 70 beats to the minute to 130 to 140 to the minute, when it becomes feeble and running, and is accompanied by lividity of the face, blueness of the hands and feet. There is always an elevation of temperature, and sometimes a rigor. When such a condition is present, and a mass is found in the right hypochondrium, beneath the edge of the liver, extremely sensitive to the touch, we are justified in diagnosing gangrenous cholecystitis, and immediate operation is indicated. By early operation and open drainage, I have been able to save 100 per cent. of my cases." S.

The String-cutting Method of Treatment for Impermeable Œsophageal Strictures.—Abbe (*Med. Record*, Nov. 30th, 1907) reports a case which he treated successfully fifteen years ago for the above condition, following the accidental swallowing of caustic. Since then the author has tested the œsophagus once a year, and there has never been the least recurrence of stricture. At the time of the operation only fluids could pass the stricture, and the amount of food that could be swallowed was growing daily less. The smallest filiformed bougie would not pass through the stricture from the mouth. The stomach was opened and stitched to the abdominal wall. Guided by the index finger, a long filiform whalebone bougie was passed from the stomach to the mouth, though impassable from above downwards. To the end of this a string was tied and pulled up through the œsophagus. To its lower end a Billroth dilating bougie was tied, and drawn up till it engaged the stricture. As it would not pass through, it was withdrawn temporarily, and an extra string drawn up, and again the bougie pulled tightly into the stricture. By pulling the second string backwards and forwards, while the wedge-like end of the bougie was tightly crowded into the stricture, it was felt that the bougie passed rapidly up. Larger ones were immediately substituted, and under their stretching the stricture quickly melted away before the string friction. With almost no bleeding the largest bougie passed entirely from stomach to mouth. The gastric fistula was closed after two weeks. The largest bougies were passed every few days at first, and later at longer intervals. In 1904, the author treated a child of three years in the same way for a similar condition. When the gastric fistula was closed dilatation was continued for some time. In the course of months, however, omission to continue this treatment faithfully led to partial closure, although swallowing of soft food continued. As it was not desirable to open the stomach again, the author devised a dilating metal guide which carried a string down to the face of the stricture and back again, so that, working entirely from the patient's mouth, the stricture could be worn through on the same principle. The *technique* is as follows:—An assistant holds the head back, and the instrument is pushed down the straight œsophagus until the probe-ending guide engages in the stricture, and the metal shoulder bears hard against it. While the operator forces the instrument onwards, a third assistant pulls the string backwards and forwards, and wears away the cicatrix where the string presses against it. It is thus impossible for the instrument to go astray from the canal, which widens as it advances, and harmful perforation, the author claims, cannot occur. In the above case, with more frequent dilatation during the ensuing year, no more trouble followed. The child is now able to eat everything, and is in robust health. In summarising, the author says—(1) Most obstructive cicatricial œsophageal strictures can be dilated from above, and should be so treated. (2) Those which are only permeable by a fine bougie offer great chance of serious perforation of the walls of the tube during dilatation where much force is required to push it through. (3) Those that admit a probe of some size can be safely cut from above by the string-cutting œsophagotome. (4) Very tight and impermeable ones can always be safely, quickly, and permanently cured by gastrotomy, followed by string-cutting. S.

Primary Sarcoma of the Vermiform Appendix.—Carwardine (*Brit. Med. Journ.*, Dec. 21st, 1907) reports a case in which this rare condition was found. There are only two other recorded cases. The patient was a lady, æt. 45, who had suffered from colicky pain for five months. Tenderness then appeared, and a deep-seated swelling was found, occupying the false pelvis. On operation the appendix was found to be 3½ inches long, as big as one's thumb, and very hard and very adherent. It was enucleated with considerable difficulty, and fractured like a carrot near the base. The cæcum and ileum were normal. The base of the appendix presented into the cæcum like an os uteri. Microscopic sections showed the appendix to be uniformly composed of round cells. The pathological changes involved the whole of the wall between the peritoneum and the musculares mucosæ. The growth was regarded to be a lympho-sarcoma having its primary origin in the submucous tissue. S.

Removal of a Lump of Wax from the Bladder by Benzin.—Lohnstein (*Berlin Klin. Woch.*, July) reports the case of a workman, æt. 23, admitted to hospital with cystitis and hæmaturia which had been going on for over three months without any apparent cause. The urine was turbid, and contained clumps of bacteria. Cystoscopy showed a yellowish white mass attached to the vertex of the bladder. At first this was believed to be a ligature encrusted with salts, but as no operation had been performed on the patient this was obviously incorrect. The introduction of any foreign body per urethram was denied. Repeated cystoscopic examinations showed that this white mass was not attached to the wall of the bladder, but only kept its place in the vertex of the bladder because it floated up to the top of the fluid in the bladder. The only possible substances that would do this were wood, cork, or wax. As it would have been impossible to introduce an object so large into the bladder per urethram if made of cork or wood, it seemed certain that the foreign body was a lump of wax. On being told that he had wax in his bladder, the man then admitted that six months previously, owing to severe itching in his urethra, he had broken off a piece of candle and moulded it so that it could pass into his urethra, and only a small portion of this escaped externally. As the surface of the wax had not become encrusted with salts, it seemed possible to dissolve it with benzin. After emptying the bladder, 15 c.c. of benzin were injected into the organ, and as no painful symptoms followed, the fluid was allowed to remain for 40 minutes, when it was withdrawn by a catheter. Another injection of 25 c.c. of benzin was given, but this almost at once caused pain, and the patient felt as if he had been drinking spirits, so the benzin was withdrawn at once. By evaporation rather more than 5 gm of solid stearin was obtained; the third time the bladder was washed out the benzin returned pure, without any trace of wax. Cystoscopic examination showed no foreign body, and the bladder walls only slightly hyperæmic. The urine soon became normal, and the patient was discharged cured. Bergmann and Rothschild have reported similar cases. G.

Palliative Operations for Cancer of the Bladder.—Cabot (*American Journ. of Urology*, Sept., 1907) reports several cases of cancer of the bladder in which palliative operations had been performed, and after considering the subject fully, comes to the following conclusions:—(1) That palliative operation is of value in cases of cancer of the bladder; (2) that in properly selected cases operation will prolong comfortable existence very materially; (3) that suprapubic drainage of the bladder will relieve the symptoms and promote the comfort of patients for whom nothing more radical can be done; (4) that hæmorrhage should not be allowed to continue unchecked unless efficient examination has shown that the cause cannot be removed by any form of operation. G.

Non-Operative Treatment of Stricture.—Begg (*Post-graduate*, Dec., 1907) gives a very full account of strictures of the urethra, and pleads for a more thorough trial of the non-operative means of treating such cases. He believes that no stricture should be cut until dilatation has been first attempted. Few strictures need to be cut, and urethrotomy should only be resorted to when the stricture is undilatable or where an emergency demands immediate bladder drainage. The writer does not believe that internal or external urethrotomy should never be performed; there are certain cases where it is obligatory. The type of stricture in which it is undesirable to attempt dilatation, and in which either internal or external urethrotomy are indicated are strictures at or within one inch of the meatus. In hard, fibrous strictures which are practically undilatable, again in resilient strictures which contract as soon as dilated, strictures behind which an extravasation of urine has occurred, should be dealt with at once by a cutting operation, strictures complicated by severe cystitis, so that drainage of the bladder becomes necessary, and, lastly, in cases of stricture complicated by renal or pelvic inflammation. G.

The Local and Internal Treatment of Gonorrhœa.—Prof. Neisser (*Medizinische Klinik*, No. 14, 1907) regards the local measures as of the most importance in cases of gonorrhœa. He prefers injections to irrigations, for the latter require too much time and special attention, and cannot be therefore used in all cases. If the patient be provided with a proper injection and a suitable syringe, and, further, be carefully instructed in their use, they are entirely harmless in all but most exceptional cases. Prof. Neisser admits that the injection treatment is neither ideal nor simple; he does not believe that the use of balsams alone is sufficient to cure gonorrhœa, but says that they are a valuable adjunct to local measures. They relieve the distressing symptoms due to the irritation of the mucous membrane, and so render more efficient local measures used during the early stages of the disease. The author believes that gonosan is the best form in which to administer the balsams. It is the most effective preparation in allaying the irritation and preventing painful erections. Even where vesical inflammation is present, gonosan acts as a sedative to the nerves of the bladder, and at once relieves the annoying dysuria. The opinion expressed by a large number of observers that gonosan, given internally, is sufficient to cure gonorrhœa, without the aid of local measures, is opposed by Neisser. He admits that in isolated instances this may occur. His contention is based on the assumption that none of the balsamics, including gonosan, is capable either of destroying the gonococcus or of affecting its growth. G.

MEDICAL NEWS IN BRIEF.

Birmingham Sanatorium for Consumptives.

THE Health Committee of the Birmingham City Council have prepared a scheme for the utilisation of the Salterley Grange Estate on the Cotswold Hills, near Cheltenham, which was purchased by the Corporation for £17,000 as a site for a sanatorium for consumptives. The Local Government Board having sanctioned the expenditure, the committee entrusted Mr. W. H. Ward with the preparation of the plans. Several of the leading sanatoria in the country have been visited by him and the Medical Officer of Health, with the object of obtaining the fullest possible information on their construction and general arrangement. Members of the committee have also visited some of these institutions, and they believe that the scheme which will be submitted to the City Council on January 7th embodies the best knowledge on the subject.

It is proposed to make provision for 40 patients in four blocks of châlets—two blocks being for 16 patients each and two smaller ones for four patients each—and that these buildings shall be erected in local brick, faced with rough-cast stucco. The question as to whether the buildings should be erected on the "single" or "grouped" system, and as to whether the material should be brick or wood, was carefully considered, and the committee early arrived at the decision that "grouped" châlets, as now proposed, will have many advantages over single wooden ones.

The question of the heating of the châlets was carefully discussed, and it was finally decided to provide a small stove in each room, which can be used when necessary. It is anticipated that fires will very rarely be necessary, but to guard against severe cases or exceptional weather conditions, it is felt that some provision should be made.

The question of the necessary furniture for the institution has been carefully considered by the Medical Officer of Health. He estimates that a sum of £1,200 will be sufficient to provide all that is necessary. This amount has been included in the estimates. The committee will ask the Council to apply to the Local Government Board for a loan of £8,500 to defray the cost of the works recommended in their report.

Mr. Chamberlain and the Mary Kingsley Medal.

THE Liverpool School of Tropical Medicine, of which Princess Christian is honorary president, decided to confer the Mary Kingsley memorial medal on Mr. Joseph Chamberlain in recognition of the work he inaugurated by the establishment of schools of tropical medicine. The following letter was sent with the medal to Mr. Chamberlain:—

"January 1st, 1908.

"Sir,—In the name of the Liverpool School of Tropical Medicine, we have the honour to transmit for your acceptance the Mary Kingsley memorial medal.

"In selecting you as a recipient of the medal, the school desires to recognise the fact that your services to the great cause of the advancement of our knowledge of tropical medicine have assisted that cause as effectually as the labours of the most devoted scientists. We trust that you will accept this medal in the spirit in which it is offered, and that it will serve to remind you of a not unimportant work achieved in a strenuous life. On behalf of the Liverpool School of Tropical Medicine, we remain,

"HELENA, Hon. President.
"ALFRED L. JONES, Chairman.
"RUBERT BOYCE, Dean.
"ALAN MILNE, Secretary."

Mr. Chamberlain has replied as follows:—

"Highbury, Moor Green, Birmingham,
January 3rd, 1908.

"Sir,—I beg to acknowledge with thanks the receipt of your letter of January 1st and the Mary Kingsley memorial medal. I highly appreciate the compliment which the Liverpool School of Tropical Medicine has been good enough to pay me. I feel, and have always felt, that the Liverpool School has largely contributed to the altered sanitary conditions of the tropics, and I regard with pleasure any efforts I may have been able to render to the cause, though I feel that they have been small compared with those of such institutions as your own. I recognise your appreciation and value very much your present testimony.

"I am, etc.,
"J. CHAMBERLAIN."

Belladonna Poisoning at Manchester.

AN inquest was held by the Manchester Coroner on January 3rd concerning the death of Albert Clegg, aged 57, a cloth agent, who died on Thursday last from the effects of belladonna poisoning.

The widow stated that on Wednesday evening her husband came home from the Albert Park Bowling Club at Didsbury. He was all right then, and after having a little toast went to bed. The next morning he was all right at half-past seven, but an hour later she heard a noise in his bedroom and found him sick. She gave him brandy, and when she saw him again ten minutes later he was in a semi-conscious condition. A doctor was called in later, but her husband died about ten o'clock. He had been troubled with sciatica, and used liniment for rubbing purposes. He kept the liniment in a bottle on the washstand in his bedroom, and near by was a bottle containing brandy.

In answer to the Coroner, the witness said she knew of no reason why her husband should take his life. He was quite cheerful, and had no trouble of any kind so far as she knew.

Mr. Harvey Simpson, solicitor, said he had known Mr. Clegg intimately for eight years. Last week he complained of sciatica, and with that exception he appeared to be in good health. Witness was with him on Wednesday evening at the Albert Park Bowling Club, and they played billiards together. Mr. Clegg was quite cheerful, and he promised to meet witness the following evening. During Wednesday evening Mr. Clegg had nothing to drink except a teetotal drink.

Dr. Darwin said death was due to belladonna poisoning. The liniment and brandy in the respective bottles would be the same colour. He knew Mr. Clegg personally, and he was perfectly rational.

The Coroner said it was quite possible that Mr. Clegg, having sciatica pains, got out of bed to take a little brandy, and for some reason or other made a mistake between the two bottles.

The jury returned a verdict of death by misadventure.

Illegal Operation at Sheffield.

SERIOUS allegations were made at an adjourned inquest held by the City Coroner, Mr. D. Wightman, on January 3rd, on an unmarried woman, aged 24, who died about a month ago in the Firvale Workhouse Hospital from peritonitis. Two doctors agreed that the use of instruments in performing an illegal operation had set up the disease. The woman made certain admissions as to the performance of an illegal operation, and the inquest was adjourned for the purpose of further inquiries.

The Coroner stated that every available means had been used for the purpose of elucidating the matter, but without success, and he did not think there was any use in further adjourning the inquiry.

Statements were made by Kate Stanton (18), Robertshaw Street, and Martha Procter, Woodside Lane, who had worked with deceased, as to allegations she had made to them in regard to a banksman at Nunnery Colliery, to whom she attributed her disgrace. Mr. Payne appeared for the man, but no evidence was given in any way connecting him with the criminal part of the affair. According to the statements made by deceased to her friends, it appears he denied having had anything to do with her misfortune.

A grave statement was made by Kate Stanton, according to whom the deceased confessed that she went to a herbalist on the Wednesday night that she left her work.

She refused to tell Stanton the man's name, and asked her not to split on him. She said he had told her not to speak about it, as if she did he would get a year's imprisonment.

The Coroner's officer stated that he had seen the man in question, who denied the affair altogether, and said he had no knowledge of anyone having been to him.

The Coroner said he did not think they could carry the matter any further in that Court.

A verdict was returned in accordance with the medical evidence that death resulted from peritonitis, brought on by an illegal operation.

Health of Edinburgh for 1907.

THE number of deaths registered during the past year was 4,978, giving a death-rate of 14.38 per thousand of the population. Of this total 903 were under one year, 529 between one and five, 609 between five and thirty, 1,318 between thirty and sixty, and 1,619 over sixty, of which 34 were above ninety years. Diseases of the chest accounted for 1,061, while 396 were due to phthisis, 221 other forms of tuberculosis, and 135 from cerebro-spinal meningitis. Old age and debility claimed 588 of the total deaths. The zymotic deaths numbered 326, of which 164 were due to whooping cough, 75 to measles, 32 to diphtheria, 24 to scarlet fever, 11 to typhoid, 10 to erysipelas, and 10 to puerperal fever.

The number of births registered during the year was 7,504, giving a birth-rate of 21.68 per thousand. The males numbered 3,856 and the females 3,648, while 583 were illegitimate.

During the year 2,819 cases of infectious disease were intimated in terms of "The Infectious Disease (Notification) Act, 1899," comprising 1,110 scarlet fever, 650 phthisis, 635 diphtheria, 300 erysipelas, 103 typhoid, 19 puerperal, 1 typhus, and 206 suspected cases of cerebro-spinal meningitis.

There were admitted to the City Hospital 3,560 cases, comprising 1,026 scarlet fever, 870 measles, 546 diphtheria, 410 whooping-cough, 152 erysipelas, 130 phthisis, 122 cerebro-spinal meningitis, 91 typhoid, 27 chicken-pox, 12 puerperal, and 1 typhus fever, and 173 were placed under observation. In the course of the year 304 patients enjoyed the amenities of the Convalescent Home at Musselburgh.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of this Society was held on December 20th, Dr. de Havilland-Hall in the chair. The records of the business in the later months of 1907 were stated to have been very satisfactory, as the moderate rate of sickness claims experienced during the autumn had more than balanced the somewhat heavy expenditure of the spring of the year. The number of new entrants was exceptionally large, and as the numbers of deaths and lapses were rather under the average, the net increase of membership is not greater than in any previous year of the Society's working.

The Lees and Raper Memorial Lecture, 1908.

THE Eighth Lees and Raper Memorial Lecture will be delivered in the Town Hall, Oxford, by Mr. William McAdam Eccles, M.S., F.R.C.S., on Tuesday, February 4th, at 8 p.m. The subject chosen is "The Relation of Alcohol to Physical Deterioration and National Efficiency." The chair will be taken by the Regius Professor of Medicine in the University of Oxford—Professor William Osler, F.R.S., M.D., LL.D., D.Sc. The subject is one to which Mr. Eccles has devoted much attention and will be illustrated by the lantern.

Ambulance Tramcars.

AT a meeting of the Metropolitan Asylums Board on Saturday, the Hospital Committee put forward a suggestion that four ambulance tramcars be obtained for use in connection with the small-pox hospitals, at an estimated cost of £850.

Objection to such an expenditure on "elaborate cars, beautifully fitted up," was taken on the ground that second-hand horse-cars suitable for the purpose could be obtained for a few pounds. The answer was that these cars had been tried and found totally unsuitable. It was agreed to purchase two cars only.

Royal College of Physicians of Ireland.

AT the meeting of the President and Fellows of the Royal College of Physicians of Ireland held on Friday, January 3rd, 1908, the membership of the College was conferred on W. J. Maguire, B.A., M.D., R.U.I., Queen's College, Belfast.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Antipodes.—Nowhere, we believe, is quackery more ripe than in Australia. In a recent report by the Government of Queensland, Dr. Ham, the Commissioner of Health in that Colony, says that: "Australia, like America, is the home of quackery." A large army of impostors, so-called "professors," "herrs," "nurses," "herbalists," and "specialists," with little or any professional training in medicine, are allowed to batten upon a credulous community.

Norfolk.—Such steps will probably be taken, for a recent conference of East Anglian education authorities has issued a report recommending the establishment of a school for blind and deaf children, at an estimated cost of £10,000, to be shared by the various authorities.

RESPIRATORY EMBARRASSMENT.

Doctor: Well, Buckins, how are you feeling this morning?

Buckins: Very much better, thank ye, doctor. The only thing that bothers me is my breathing.

Doctor: Um! yes. We must see if we can't get you something to stop that. —*The Sketch.*

G. W. F. R.—Please find note in reply under "Letters to Editor."

Dr. H. S.—We cannot refer you to any similar occurrence in this country, but M. Marcel Briand has described a case in which a lady and her two daughters, who were in a motor with closed windows for half an hour, became unconscious. They were eventually brought round, but suffered from ringing in the ears, vomiting, and loss of memory. It was found that the machinery of the motor had lately been repaired, and the planks of the floor had not been properly fastened together. The burned gases from the exhaust tube had escaped into the carriage, and the ladies were poisoned by the CO_2 contained in the discharge.

X. P.—We cannot recommend private firms, but must leave you to take your choice among those which are of good repute in the profession.

Meetings of the Societies, Lectures, &c.

Thursday, January 9th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20, Hanover Square, W.).—7.45 p.m.: Dr. J. P. Hedley, Dr. Harold Sington (introduced by Dr. Handfield-Jones), and Dr. A. H. N. Lewers: Specimens. Mr. J. Bland-Sutton: On Carcinoma of the Ovary from a Clinical Standpoint. Dr. Carver and Dr. Fairbairn: On Hæmorrhage into the Pons Varolii as a Cause of Eclampsia.

United Services Medical Society (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Major M. P. C. Holt, D.S.O.: The Advisability of Operation for Recurrence of Hernia in the Services.

North-East London Clinical Society (Prince of Wales's General Hospital, Tottenham, N.).—4.15 p.m.: Address:—Dr. Robert Hutchinson: Modern Theories of Diet in their Relation to Practice.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. Beresford Kingsford: Some Special Methods of Administering Chloroform and their Relative Advantages.

Mount Vernon Hospital (Central In-Patient Department) (7, Fitzroy Square, W.).—5 p.m.: Opening Lecture:—Sir Thomas C. Allbutt, K.C.B.: Angina Pectoris (Post-Graduate Course).

St John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Bullous and Vesicular Eruptions: I., Urticaria; II., Pemphigus; III., Pompholyx; IV., Varicella.

Friday, January 10th.

Royal Society of Medicine (Clinical Section) (20, Hanover Square, W.).—8.30 p.m.: Exhibition of Cases. Dr. Sidney Phillips: A Case of Fatal Illness in a Child with Post-mortem Appearances of the "Status Lymphaticus." The patients will be in attendance at 8 p.m.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. C. A. Parker: Clinique. (Throat.)

Hospital for Diseases of the Throat (Golden Square, W.) —5.30 p.m. First of a systematic course of Lectures on Diseases of the Ear.

Appointments.

Byrne, P. Kevin, M.D., M.R.C.P.Lond., Assistant Physician to the London Temperance Hospital.

Clark, Robert V., M.B.Edin., Medical Officer of Health of Leeds.

Dimock, Horace, M.B., B.C.Cantab., House Surgeon at Addenbrooke's Hospital, Cambridge.

Hailstone, J. E., M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at Addenbrooke's Hospital, Cambridge.

Higgs, F. W., M.B., B.S.Lond., M.R.C.P.Lond., Medical Registrar to St. George's Hospital.

Legge, J. H., M.B., B.Sc.Lond., Honorary Anæsthetist to the Dental Department of the Leeds Public Dispensary.

Maclure, W. J., M.B., B.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Conisborough District of the county of York.

Quick, Hamilton Ernest, B.Sc., M.B., B.S.Lond., L.R.C.P., M.R.C.S., House Surgeon at the Swansea Hospital.

Ward, J., M.R.C.S., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Leamington District of the county of Warwick.

Whalley, Frederick, M.B., Ch.B.Leeds, Honorary Anæsthetist to the Dental Department of the Leeds Public Dispensary.

Whitehead, Francis Henry, L.R.C.P.Lond., M.R.C.S., Medical Officer to the Post Office at Battersea, S.W.

Vacancies.

University of Sheffield.—Demonstrator in Anatomy. Salary, £150 per annum. Applications to W. M. Gibbons, Registrar.

Hartlepools Hospital.—House Surgeon. Salary, £100 per annum, with board, washing, and lodging in the institution. Applications to Robert Edger, Secretary, 15, Town Wall, Hartlepool.

Swansea, County Borough of.—Medical Officer of Health. Salary, £500 per annum. Applications to Jno. Thomas, Town Clerk, Guildhall, Swansea.

London Fever Hospital, Liverpool Road, N.—Resident Medical Officer. Salary, £250 per annum, with board and residence. Applications to the Secretary.

Chesterfield and North Derbyshire Hospital.—Senior House Surgeon. Salary, £120 per year, with board, apartments, and laundress. Applications to the Secretary.

Somerset County Council.—The County Education Committee.—Chief Medical Inspector of Schools. Salary, £500 per annum, with out-of-pocket expenses. Applications to the County Education Secretary, Weston-super-Mare.

Great Northern Central Hospital.—Pathologist and Curator. Salary £100 per annum. Applications to L. H. Glenton-Kerr, Secretary.

Fermanagh County Hospital.—House Surgeon. Salary £52 per annum. Applications to C. Wilson, Secretary.

Births.

Addinsell.—On Jan. 3rd, at 6, St. James's Road, Surbiton, the wife of John Howard Addinsell, L.R.C.P. (Lond.), M.R.C.S. (Engd.), of a son.

May.—On Jan. 2nd, at Woodleigh, Ware, Herts, the wife of George Ernest May, M.R.C.S. and L.R.C.P., of a son.

Thompson.—On Jan. 1st, at 4, St. Thomas' Street, London Bridge, the wife of Ralph Thompson, Ch.M., F.R.C.S., of a son.

Thorne-Thorne.—On Jan. 3, at "Grasmere," Mount Vernon Road, Woking, the wife of Berthold Thorne-Thorne, M.D., of a daughter.

Marriages.

Stock—Weston.—On Jan. 1st, at the Church of Emmanuel, Clifton, Bristol, William Stuart Vernon Stock, F.R.C.S.Eng., elder son of Granger Stock, Clifton, to Ella Christine, third daughter of John Weston, The Avenue, Clifton, Bristol.

Moorhead—Quinn.—On Dec. 19th, at Rathmichael Church, Shankill, by the Rev. H. Taylor, assisted by the Rev. J. Dillon, Rector of the Parish, and the Rev. H. Swanzy, Dr. T. Gillman Moorhead, Dublin, to Mary Beatrice, daughter of the late R. Erskine Quinn, Kingstown.

Deaths

Wiltshire.—On Jan. 3rd, at Winkleigh, Tunbridge Wells, Sarah Ann, widow of the late Thomas Wiltshire, L.R.C.P., in the 70th year of her age.

Birch.—On Jan. 1st, at his residence, St. Leonard's-on-Sea, Scholes B. Birch, M.D., L.S. and M.R.C.P.Lond. (retired), aged 82 years.

Granger.—On Jan. 4, at 6, Victoria Terrace, Weymouth, William Slocombe Granger, M.R.C.S., L.S.A., late of Wool, aged 70 years.

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BIBLIOGRAPHY.

AMYLACEOUS DYSPEPSIA. "In no case did I find Taka-Diastase fail in giving good results."—*Lancet*, August 7, 1897.

DYSPEPSIA. Excellent results in many obstinate cases.—*Liverpool Med. Chir. Jour.*, Jan. 1897.

GOUTY DYSPEPSIA. Most gratifying results after everything else had failed.—*Lancet*, October 10th, 1903, page 1052. Also see *The Practitioner*, Feb. 1907, page 168.

TUBERCULOSIS. A powerful aid to nutrition and increased strength.—*Medical Magazine*, June 1906.

CHRONIC CONSTIPATION. "Often brings about a cure in the most obstinate cases."—*Therapeutic Gazette*, October 15, 1906.

CONVALESCENCE. Invaluable after typhoid, etc., for enabling the enfeebled digestive powers to assimilate carbohydrate dietary.—*Therapeutic Gazette*, Oct. 15, 1906.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Soaring Healthwards.

A WELL-KNOWN medical sanitarian recently startled that section of the public to which sensation appeals, by pleading for a more or less universal adoption of skipping as a mode of progression. If we remember rightly, we highly commended the idea ourselves, for it is certain that, were the world to skip through the streets on light fantastic toe, half the worries and trouble of life would disappear, and, owing to collisions, there would certainly be plenty of additional work for doctors. That millennium has not yet been reached, but another gentleman, Dr. McKenzie, of New York, has just put forth an almost more original suggestion, namely, that the jaded should seek to throw off their woes by flying kites for an hour before breakfast each morning. "Flying a kite," he says, "is infinitely more sensible than swallowing time-honoured drugs, and the effect of a merry chat at sunrise in the open air on topics of outdoor interest is sure to be of a beneficial nature. In two weeks, I believe, almost any ordinary case of insomnia or other nervous affection can be cured." Again, we are prepared to endorse the suggestion, but we fear with as little likelihood of producing an impression. An ounce of example is worth a ton of theory, and if these gentlemen, instead of bodying forth their tantalising possibilities, would only turn them to shapes, we might get forward in the path of progress. Why should not some believer start a kite club in Hyde Park before breakfast, or a skipping race to the City? Followers would soon be forthcoming, and the barometer of national physique would rise like the mercury on a dry day. Our imagination kindles at the thought of changing the bed of the sluggard for the exhilaration of the kite on a sloppy January morning, and we only wait for the idealists to show the way before—urging others to follow.

Christian Science again.

AT an inquest held last week at Richmond on a lady who had died of bronchitis, in spite of the ministrations of a Christian Science "healer," the usual sort of tale was told at it. Dr. Michael Taylor, the Coroner, cross-examined the "healer" closely, and elicited the opinion that the lady must have died because she (the healer) had not put enough faith into her prayers for recovery. Followers of her cult, she explained, are graciously allowed to call doctors in when a patient is dying, "because it is the law;" which strikes us as a very convenient method for shelving the responsibility for patients' deaths on to the shoulders of medical men, although the *kudos* of a "cure" is not shared with them. Medical men must be very careful how they are made the dupes of these charlatan practitioners, who will annex their patients without scruple so long as anything is to be made of them, and as rapidly unload them again when there's trouble in the wind. The discredit for the failures should be brought home both to Christian Scientists and to the public by medical men refusing, so far as is consistent with humanity, to be drawn into any case with a Christian Scientist in the background, and certainly by refusing to give death-certificates. By holding an inquest on all patients who have been tampered with by the followers of Mrs. Eddy coroners can bring a strong educative influence to bear on the public, and do something to stop this tomfoolery which is as much blasphemy to the name of Christianity as it is disgraceful to the name of science; for many "healers" are simply impostors of the most noisome type. Honest Christian Scientists, of course, there are, just as there were till recently honest believers in the Druce myth, and honest believers in the godhead of Mr. Piggot of the Agapomone. But preying on these deluded creatures are a number of very offensive charlatans who get a wonderful amount of money by their bluster and pretensions, and these gentry cannot be submitted too frequently to the fierce light of publicity. In the case of adults who choose to be treated by Christian Science, we are inclined to agree with the view Dr. Michael Taylor evidently took in the case under notice, namely, that when they have deliberately placed themselves under a "healer," it is better not to prosecute the friends for neglect; but it should be possible, if inquests are held regularly, for fraudulent imposition to be detected, and followed up by due punishment. The religious question, and the risk of making "martyrs," complicates what would otherwise be a simple matter to deal with.

A Minor Haul.

THE will of Rae, the "miner surgeon," who died a few months ago, was recently sworn at £1,800 odd. As he was a working miner with a family, it is probable that before he embarked on his career as a bonesetter he had no capital, or, at most, a few pounds, and as he was only practising that trade during about three years, his profits, after paying all living and out-of-pocket expenses of every kind, were at the rate of at least £600 a year. To a man who during a longish life probably never had a ten-pound note, such an income must have seemed prodigious, and, with his example before their eyes, it is wonderful that any of his fellows can be found to work at their honourable occupation, when they have only to give the go-by to all ideas of truth and responsibility to achieve similar affluence. Rae was probably not of the exceedingly bad type of quack; he seems to have had hardly sufficient education to know how to go about advertising himself, and his reputation was made more for him by his credulous mates and interested reporters than by him. Still, this almost illiterate creature was able to make a very comfortable thing out of bonesetting, and he was happy in not living long enough to feel the force of the reaction which would pretty surely have followed. Whether the Cardigan brothers, of whom we have still heard but little of late, have now been swamped by such a reaction we do not know, but it is certainly a good plan for flamboyant charlatans to live plainly and make as much money as possible when the boom is on; it does not last long, and the financial ease is some recompence, perhaps, for a conscience that can lie none too easy o' nights.

M. Metchnikoff and Longevity.

It is almost ungrateful to say anything against a man who has rendered such distinguished service to science and medicine as M. Metchnikoff, but, for the sake of his great and well-deserved reputation, we would really be glad if he gave up, or at least contented himself with explaining among his indulgent friends, his theory of accomplishing man's immortality, or indefinite longevity. Although the prolongation of life is doubtless a desirable object, the indefinite prolongation can only lead eventually to a standstill, as death, within a reasonable time, is as important to the business of the planet as life is, and we hardly fancy the course of the earth is to be put out *sine die* because its inhabitants are trying to circumvent its inevitable law. But, from the point of view of those who are jealous about the reputation of science, it is galling to see the name of a man of M. Metchnikoff's service to medicine, made the butt of newspaper jokes and cheap sneers. In one particular M. Metchnikoff is lucky, and that is in possessing a name which does not catch on to the English ear or flow readily from the tongue, so that he is hardly a household word yet, and we should be very thankful ourselves if all the flippant talk and pseudo-scientific patchwork about old age that is being worked up were relegated to more obscurity.

Benevolent Bonesetters.

There is no false modesty about the characters of bonesetters, for by some obscure process, no sooner does one of these benevolent souls think of a kind act, than lo! it crops up in the broad sheets of the Press as though it were the announcement of a fashionable wedding. Without pretending to understand how it is that an anxious world harps on the generous promptings of the bonesetting heart, we can only accept the fact. We recently had occasion to criticise the book prepared by Sir William Treloar's agents to make known the need of his cripple's home, because it was made a medium for advertising certain of these people, and we trust that the advice was not thrown away on the benevolent baronet. Indeed, in view of recent incidents we have reason to think it was not. Mr. H. A. Barker, who now figures as "Dr." H. A. Barker (we do not know what sort of a doctorate is intended), wrote to Sir William Treloar the other day, offering to devote "some of his time" to the treatment of the crippled children of the Metropolis, and Sir William replied with cautious courtesy that he would submit the suggestion to his board of medical advisers, when constituted. Mr. Barker then wrote again, thanking Sir William for his promise, and saying that if his offer was accepted, he would advise part of the home being used as an orthopædic hospital for the treatment, wherever possible, of cases by the "non-cutting method." It is extraordinary how these perspicacious suggestions emanate from intelligent laymen; ideas so startling and original are apt not to occur to the routine medical mind! But Mr. Barker is prepared to back his suggestion, and offers £1,000 towards his scheme, if adopted. Could the loving kindness of the human heart assume a more practical form? We may remark, in passing, that another gentleman of the same fraterinty, Mr. Cliburn, is advertising his own willingness to undertake the treatment of these children. Which will be first, we wonder?

LEADING ARTICLES.

THE INFANT LIFE PROTECTION ACT.

Among the complex phases of the problem of infantile mortality that which deals with "baby-farming" is not the least important. In former times the evils arising from that particular calling became so grave that Parliament at length dealt with the matter in the Infant Life Protection Act; that most beneficial measure has now been in force long enough to justify a fairly accurate estimate to be formed as to its defects. Some of the latter seem so obvious as to need little more than a mere recital to ensure recognition. One of its chief anomalies, for instance, is the exemption from inspection of the child received by any person for a lump sum of over £20, whereas the child taken on a payment under that amount fell under the provisions of the Act. The absurdity of this arrangement has been recently insisted upon by Mr. George R. Sims, the well-known journalist, who has paid much attention to this subject. "The great blot upon this Act," he writes to the *Tribune*, "is the exemption of the 'one child' and the 'over £20' child. How serious this omission is is proved by the fact that within a comparatively short space of time 2,000 cases of cruel neglect have been brought home to the 'one child' receiver, and during the past eighteen months three women engaged in the 'one child' business have been hanged for child-murder." The case for revision of legislation in this direction, indeed, has for a long time been apparent, and it is not surprising, therefore, to hear from Mr. Herbert Samuel, the Parliamentary Under-Secretary of State for the Home Office, that he will shortly introduce, on behalf of the Government, an amending Bill to the present Infant Life Protection Act. It is somewhat surprising that at this precise juncture a deputation representing various powerful bodies should wait upon the Home Office to deprecate the proposed extension of compulsory registration and inspection of homes where two or more children are kept for weekly payment to homes where one child is thus kept. It is of some interest to note the compositon of the deputation, which was as follows:—Lieutenant-Colonel C. W. Long, M.P., the Rev. E. de M. Rudolf, secretary and founder of the Church of England Waifs' and Strays' Society; the Rev. P. S. G. Propert, chairman of the Fulham Board of Guardians; Mrs. Mylnes, vice-chairman of Paddington Guardians; Mr. W. J. Taylor, London Female Preventive and Reformatory Institute; Mrs. R. P. Wethered, Paddington and Marylebone Ladies' Association for the Rescue and Care of Friendless Girls; Mr. A. J. S. Maddison, secretary to the Refuge and Reformatory Union; and Mr. T. W. Hunter, representing the Roman Catholic Society of the Crusade of Rescue. Still more interesting is it to note the nature of the objections. Colonel Long said the deuputation's memorial represented the views of a large number of people. The London County Council had certainly put the present Act more zealously in force than any other body in the country, but if laws which dealt with human nature were made too drastic, although they might remedy some evils, they would increase others. His chief argument ran as follows :—"In the cases of illegitimate children, the desire of the mother to maintain her infant was the best hope of her own reformation, and, therefore, a consideration of the greatest importance from the point of view of national morality. But if, by official inspection, which always meant increased payment of the services inspected, the burden of maintenance was made so great that, in despair, the mother went to the workhouse, or, more probably, deserted her infant, so that it had to be taken to the workhouse; not only would there be an increase in the rates, but there would be the inference that infants could be provided for out of the rates without trouble or penalty to either parent, which must tend to be an incentive to immorality. Five shillings per child was the lowest rate at a baby farmer's, where more than one child was taken in; but official inspection of these homes had already led in some cases to an increase of the lowest rate to six shillings. On the other hand, a young mother could get her infant taken in by a poor friend or neighbour for two shillings up to five shillings a week. These one-child homes were also the best for the children, as well as the cheapest for the parent, as the nurse mothers took care of the children for humane motives, rather than as a matter of business. There was no doubt also that, if the provisions of registration and inspection were extended to those one-child homes, the philanthropic work of the various institutions represented by the deputation would be seriously hampered." The Rev. P. S. Propert said that in his experience, although there was a good deal of neglect in such homes, he had found no evidence of cruelty. A similar attitude was taken by Mrs. Mylnes, who remarked that her experience as a member of the Paddington Poor-law Board was that, while there were a great many cases of cruelty to children by married parents, cases of neglect by foster-mothers in one-child homes were extremely rare. In endeavouring to estimate the value of these two latter opinions the first question that suggests itself is, whether these speakers have had an opportunity of ascertaining the real facts of the case. As to Paddington, we venture to say that a more accurate estimate could be gained of the evils of baby-farming from the testimony of district nurses and visitors, and of out-patient physicians to voluntary hospitals, than from the routine of Poor-law administration. It is impossible not to sympathise with Mrs. Wethered, who said that in the rescue and care of friendless girls these foster-mothers were an immense help. They willingly took charge of the children of girls whom they knew, as an act of friendship; but they would not be so ready with their assistance if they were to be subjected to inspection by a Poor-law official. She feared that an increase of desertion, abortion, and even infanticide was likely to result from any addition to the difficulties and anxieties of fallen mothers. Somewhat more practical was the view of the Rev. E. Rudolf, who stated that the Waifs' and Strays' Society had always a large number of children boarded out in one-child homes—at present the number was 834—and not a single case of cruelty or neglect by a foster-mother had been discovered. In many cases these women took the children in for companionship. He was certain they would refuse to be inspected by a Poor-law officer as if they were mere baby-farmers. From the foregoing views it will be gathered that of the objections some are sentimental, and others spring from the fear that the work of various charitable organisations will be unduly hampered by an extension of the Act. Far more significant, in our opinion, than opposition by the London Diocesan Society, Dr. Barnardo's Homes, and the Charity Organisation Society, is the fact that the London County Council objects to the proposed extension. It is on that account reassuring to learn that the Government has decided to ask the House to appoint a Select Committee to investigate the single controversial question involved in the case of the one-child home. As regards the broader aspects of infantile mortality, Mr. Samuel has announced that the forthcoming Bill deals with many points outside those directly concerned with baby-farming.

CURRENT TOPICS.

Drunkenness and the Probation of Offenders Act.

A welcome instalment of the long-awaited scheme of criminal law reform has reached the British public in the shape of the Probation of Offenders Act. Although that beneficent measure has been in force only a short time, yet some of the decisions already arrived at plainly indicate that in future the magistracy of the kingdom will be armed with potential powers of no mean order as temperance reformers. It need hardly be remarked that under the new Act they have the power to release offenders on probation without proceeding to conviction. In this way a young woman, charged with drunkenness, was released on the undertaking that she would not enter a public-house or a music-hall for the next twelve months. A notice in writing setting forth the conditions to be observed was at the same time handed to the offender. In another case a young man secured release by giving his word to abstain from intoxicating liquors for a period of six months. This new departure in police-court methods should be hailed with acclamation by all advocates of temperance reform. From every point of view the new Act registers a notable advance towards a saner method of dealing with minor lapses, for the punishment of which the rigours of a formal criminal system seem no less harsh than ineffectual.

A Medical Writer "in Penitential Sheet."

The position of the medical author who writes for the public under his professional name and title may not be exactly defined, but it seems clear that if there be any offence it can exist only in the misty realms of an abstract ethical code. When such a man formally declares he does not practice medicine and does not claim to write for his professional brethren, his position appears to be still less amenable to any form of collective control. That appears to be more or less the attitude assumed by Dr. Saleeby, who has written to a medical contemporary stating he no longer acts as a medical man. The journal in question gently castigates him, and alludes to his appearance in penitential sheet. The mildness of this reproof seems to show beyond a doubt that there is no ground for questioning the right of Dr. Saleeby to address the public on medical topics in any capacity he pleases. Nay, more, our contemporary to some extent may be said to have stamped his particular book, "The Conquest of Cancer," with an air of authority and even with a certain modified kind of approval by inserting a bold notice of that volume in its advertisement columns. For our own part we should hesitate in interfering with the freedom of speech enjoyed by any of our countrymen, so long as the public welfare were not clearly assailed. There is another point, however, on which we have felt it a duty to challenge Dr. Saleeby, namely, his claim to the priority of Dr. Beard in the introduction of the trypsin treatment. This we have done as a simple act of fairness and quite independently of the merits of the method itself. The challenge has been formally advanced on evidence furnished by Dr. Shaw-Mackenzie, and we submit that no writer can be regarded as responsible who neglects at once to avail himself of the opportunity of justifying the claims which he has set forth emphatically in the above-mentioned book.

Milk Typhoid.

SOME three or four generations have elapsed since the first definite observations were made with regard to the origin of typhoid fever epidemics in the milk supply of an invaded district. Sanitary science has made many conquests since then, but the problem of milk-borne disease has not yet been brought fully under her control. Of the latter fact we were sharply reminded last week by the report of an outbreak of enteric fever in Glasgow, due to contaminated milk, whereby seventeen persons in the best part of the town were attacked with the malady. Enquiry revealed a not altogether unfamiliar tale. In the farmhouse from whence the incriminated milk was obtained the authorities found a young woman who was ailing, and had been lying in the kitchen the first week of December last. Her illness had been ascribed to influenza and pneumonia, but was in reality enteric fever. This occurrence, read in the light of modern sanitary achievement, points to a lamentable defect in our line of defence against preventable disease. Glasgow enjoys a deservedly high reputation for her administration of public health matters. Yet here we find her citizens attacked by a deadly malady from a source that has been recognised for half a century and more, and one that could be absolutely prevented by a concerted action between town and country sanitary authorities. What is true of Glasgow is true of the whole United Kingdom. How much longer will our practical countrymen be content to wait for some legislative scheme affording rigid control of our national milk supply?

Lead Poisoning from Water-pipes.

YORKSHIRE figures largely in the history of lead-poisoning from drinking water. The explanation is the marked softness of the water and the fact that, collected from the moors, it contains peaty products which are capable of dissolving lead, and, therefore, under certain conditions of storage and distribution, of becoming charged with soluble salts of that metal. Only last week the Ravensthorpe Coroner investigated a case of the kind. A commercial traveller, aged forty, was shown to have been affected with lead-poisoning, and it was stated in evidence that he had been in the habit of drinking a lot of water from the tap. The Coroner remarked that one lesson to be learnt was that people who had lead pipes to their taps should always, before using the water for drinking purposes, open the tap for a considerable time. That is all very well, so far as it goes, but much sounder advice would be to substitute iron for lead piping, and to abolish lead cisterns wherever those relics of a past age still survive. Indeed, it is difficult to understand how any sanitary authority alive to its duties and responsibilities could permit the use of lead pipes for a moorland water supply. For that matter, we are quite of opinion that the legislature would be justified in putting an end to that practice once and for all under such circumstances. Possibly the day may come when lead will be excluded from all contact with drinking water.

Protection of Skin against Rontgen Rays.

THE danger of dermatitis, especially in the case of susceptible persons, is ever a rock ahead in the mind of the radiographer. Any device that can be trusted to circumvent that particular risk without lessening either the therapeutic or the diagnostic use of the Röntgen rays would undoubtedly give a great impetus to the use of this modern method by the medical profession. Accordingly, it is with much interest that we hear it announced that Professor von Jaksch, the well-known Vienna professor, has introduced a simple plan which is said to prevent any possibility of skin burns. His plan is to cover the part of the body exposed to the focus-tube by a screen composed of an exceedingly thin sheet of silver coated with collodion. The metal is practically in the form of foil, as the thickness is stated to be not more than two one-hundredths of a millimetre. Amongst the crowd of ways and means that have been devised for preventing focus-tube dermatitis no single one can be regarded as altogether satisfactory. In the interests of medical work, therefore, it is sincerely to be hoped that our distinguished Vienna colleague will be found to have solved the difficulty.

The Responsibility of Anæsthetic Administration.

THE question recently raised by the City of London Coroner as to whether the responsibility for the proper administration of an anæsthetic rests with the surgeon or the anæsthetist is not likely to be settled off-hand. The lawyers appear to have no settled convictions upon the point, and seem to be quite content to leave its settlement to the advent of the "leading case" so beloved of the judicial mind. Some of our readers may remember that the question was suggested in the course of an inquest upon the body of a patient who died under chloroform at St. Bartholomew's Hospital. In that case the surgeon frankly and freely accepted all responsibility for the administration of the anæsthetic, which was performed by his house-surgeon, a recently-qualified young man. In another similar unfortunate accident the Coroner stated it was the thirty-ninth death under an anæsthetic which he had been called upon to investigate at Guy's Hospital within six and a half years. The aural surgeon who was the operator in that case disclaimed all responsibility for the anæsthetic, on the common-sense ground that he could not look after two things at once in a satisfactory manner. When the Coroner, as a lawyer, informed him that the operator was legally liable, he readily agreed with the suggestion that the sooner the law was altered on that particular point the better. Obviously the public are not likely to be satisfied with the present division of responsibility. Neither are they likely to retain their confidence in the management of Guy's Hospital unless steps are at once taken to place the system of anæsthetic administration adopted in that institution on an absolutely sound footing. We understand that a committee of the medical staff is considering the jury's recommendation on a former occasion: "That in all serious operation cases anæsthetics should be administered either by a staff anæsthetist or by a resident under his immediate supervision," and that a report thereon may be expected shortly. The City of London Coroner may be congratulated for the courageous way in which he has faced a difficult and delicate situation, and it is to be hoped that coroners generally throughout the kingdom will insist on a full enquiry into all deaths under anæsthetics.

The Matronship of Meath Hospital, Dublin.

A rather unnecessary attack was made some short time ago by the Dublin County Council on the Joint Committee of Management of the Meath Hospital. The Meath Joint Hospital Committee had occasion to elect a new matron for the hospital, and after advertisement and due inspection of the different candidates three names were sent up to the Joint Committee with the result that Miss Bradbourne, who had been connected with the hospital for seventeen years, was elected. The representatives of the County Council on the Joint Committee thereupon reported to the County Council that an improper choice had been made, and in proof thereof stated that it had been necessary to vote a sum of fifteen pounds to send the lady to an English hospital to learn her work. The County Council thereupon passed a resolution condemning the action of the Joint Committee. In reply to this resolution the Joint Committee stated " that Miss Bradbourne has proved herself during seventeen years spent in the service of the hospital an excellent nurse, who deserved the confidence of the Joint Committee. The Committee wish it to be understood that in voting the sum of fifteen pounds to be spent in sending Miss Bradburne to inspect some English hospitals, they desired she might be in a position to recommend such improvements as her visit of inspection might suggest." Actions like these on the part of local bodies make medical men and others interested in hospital efficiency dread the control of hospitals by such bodies.

Impurities in Lighting Gas.

In view of the chance of leakage of lighting gas through defective fittings, it is important to all consumers of gas that its noxious properties should be kept at a minimum. Coal gas is, of course, always poisonous, but some coal gas is more poisonous than others. In particular is the gas dangerous in proportion as it contains carbon monoxide. This body is well known to be present in considerable quantities in so-called "water gas," and consequently water gas fittings require greater care than those of gas prepared in the ordinary way. In Dublin the addition of a considerable quantity of water gas to the city gas supply a few years ago was followed by a considerable number of fatalities, due to the escape of gas. It is impossible to say that these accidents would not have occurred if the nature of the gas-supply had not been changed, but the coincidence in time was remarkable. Of late the public in Dublin has had to put up with another impurity. It appears that for some time past there has been a considerable quantity of sulphuretted hydrogen present in the gas as supplied to the public, and we need hardly say that this impurity is highly unpleasant and injurious to health. We understand that the Dublin Corporation has considerable powers over the gas-supply of the city, but we cannot find that they have ever exercised these powers to protect the health of the citizens.

PERSONAL.

The King has appointed to the Consulting Staff of the Officers' Convalescent Home at Osborne, Sir Thomas Clifford Allbutt, F.R.S.; Sir William Bennett, K.C.V.O.; Lieut.-Col. Havelock Charles; Mr. Watson Cheyne, C.B., F.R.S.; Dr. David Ferrier, F.R.S.; Dr. James Goodhart; and Mr. Pearce Gould, M.S.

The governing body of Rugby School have transferred Dr. Clement Dukes to the new post, created for him, of Consulting Physician to the school, with a salary, in consideration of the long series of years that he has acted as Medical Officer.

Dr. William Hunter, M.D., F.R.C.P., has been promoted to be full Physician at Charing Cross Hospital.

The eighth Lees and Raper Memorial Lecture will be delivered in the Town Hall, Oxford, by Mr. William McAdam Eccles, M.S., F.R.C.S., on Tuesday, February 4th, at 8 p.m. The subject chosen is "The Relation of Alcohol to Physical Deterioration and National Efficiency."

Dr. Hernforth Wood has resigned the post of Medical Superintendent of the Liverpool Sanatorium for Consumptives at Kingswood.

Dr. John S. Gayner has been elected to the post of Honorary Administrator of Anæsthetics, and Dr. Hinton Bateman to that of Honorary Officer in charge of the X-ray department at the York County Hospital.

Dr. J. D. Small, Senior Medical Officer of Southern Nigeria, has retired from the service.

Dr. A. D. Brunwin has been appointed Resident Medical Officer of the Colonial Hospital, Medical Officer to the Gaol, and Medical Officer, Suva, Fiji.

In accordance with the provisions of an Order-in-Council, Fleet-Surgeon G. D. Twigg, F.R.C.S.I., has been placed on the Retired List, at his own request, with permission to assume the rank of Deputy-Inspector-General of Hospitals and Fleets.

The Right Hon. the Earl of Plymouth, P.C., C.B., D.L., J.P., Lord-Lieutenant of Glamorganshire, has consented to act as President of the Twenty-fourth Annual Congress and Exhibition of the Royal Sanitary Institute, to be held at Cardiff from July 13th to 22nd, 1908.

A CLINICAL LECTURE
ON
TUBERCULAR LARYNGITIS. (a)

By **ANDREW WYLIE, M.D., C.M.,**

Assistant Surgeon, Central London Throat, Nose and Ear Hospital.

TUBERCULAR disease attacking the larynx, secondarily or associated with tubercle in the lungs or other organs, is a common disease, but as a primary affection it is so rare that at one time its existence was denied. In most cases of pulmonary phthisis the larynx is affected by the tubercle, and in a large proportion it can be diagnosed by the laryngoscope supplemented by clinical examination. It is therefore of great importance for laryngologists to thoroughly examine the chest in any case where there is the least sign of tubercular disease in the larynx, and conversely for physicians to examine the larynx in every case where the least sign of phthisis is detected in the lungs. It is, in fact, a necessary complement to every clinical report, because although the chief source of infection is from the lungs, yet it is held that primary tuberculosis of the larynx does occur without any sign of pulmonary deposit; although this has been clinically proved: pathologically in most cases other organs are found to be coincidently affected. The disease may also extend to the larynx from the tongue, fauces, or even ear, either by direct continuity or by the conveyance of bacilli.

ETIOLOGY.

Predisposing Causes.—It is much more common in males in proportion of about three males to two females, and is generally found between the ages of twenty and thirty years in either sex. Infants and early childhood are almost free from it, but it is by no means rare soon after puberty.

It is most common in those who abuse their voice, but rarely in professional singers. We cannot ignore heredity, especially when attended by habitual mouth breathing, nasal obstruction, &c.

It is the injudicious abuse of the voice, especially in those leading a sedentary, indoor and unhealthy occupation rather than the constant use of the voice, which is one of the most potent causes.

PATHOLOGY.

There are several stages or degrees of this affection. The first is one which we can appropriately describe as *Catarrhal*, since the changes are chiefly those of general transient hyperæmia, gland activity, and superficial desquamative changes. It is, in fact, a stage of irritation. These attacks of acute congestion often alternate with periods of pronounced anæmia. This may pass into a state of *Epithelial Thickening*, which is most marked in the posterior commissure, but also occurs as symmetrical patches on the vocal processes or cords proper. Another phase consists of *actual localised or diffuse infiltration of the subepithelial connective tissue* in the neighbourhood of the glands by lymphocytes, true circumscribed tubercles being the result. These may either subside, caseate, or ulcerate. The ulceration may involve the surface or extend deeply into the cartillages, producing perichondritis and necrosis, although some authorities hold that fully-developed tubercles do not undergo fibrosis. Coincidentally, wherever there is much loose connective tissue œdema is well marked. This is a most striking feature of laryngeal tuberculosis, especially when it involves the epiglottic and ary-epiglottic folds. The actual seat of definite tubercle is most commonly the ventricular bands, the walls of the ventricles and saccules, since these structures normally contain lymphoid tissue (like tonsils)—a favourite site for tubercular deposit. Although tubercular bacilli cause the process, yet they are not pus-producing organisms, and many of the changes and phenomena which take place are really due to the co-operation of other bacteria, such as diplococci, micro-tetrageni, &c., so often responsible for acute catarrh, and, later, other pyogenic bacteria such as streptococci, staphylococci, &c.

The probable cause of infection is by penetration of the surface epithelium by the tubercle bacilli which find their way into the lymph radicles, and eventually reach the deep lymphoid channels where, by endothelial activity, the tubercular foci are soon formed.

The tubercular process may assume another form—viz., the hyperplastic, marked by the development of granulomatous masses, which may present the appearance of new growths. They vary from a mere thickening, or sort of "cocks' comb" projection in the posterior commissure, to large smooth or ragged structures in any region of the larynx. They are true tuberculomata and consist of fused tuberculous elements with an abundance of lymphocytic infiltration, often covered with stratified epithelium or forming a rough ulcerated surface.

SYMPTOMS.

1. *Dysphonia.*—This may vary in degree from a slight huskiness and loss of quality to complete disappearance or aphonia. It is a most important symptom, and may be the only one present for a long time. Gradual but certain increasing feebleness and change in character, with occasional intervals of improvement, is a most significant feature.

2. *Cough.*—In the early stages it is usually irritable and dry. Irritable, since the larynx and pharnyx are exceptionally hyperæsthetic and dry, since there is no pus-producing area. It is only in acute catarrhal attacks there is much secretion. Later on, however, the local tenderness increases and cough paroxsyms are most pronounced, with abundant and "streaky" expectoration.

3. *Expectoration.*—In the early course of the disease it is scanty, mucous and "streaky," with few bacteria, tubercle bacilli being absent or very scarce. Later on, with the onset of ulceration, tubercle bacilli are plentiful, together with lymphocytes and leucocytes. It is now not only profuse, but is sometimes coloured. If the lungs are only slightly affected a great deal of this sputum is due to excessive salivation, which, owing to pain and discomfort in swallowing, accumulates in large quantities.

4. *Dyspnœa* is present in all stages and in varying degrees. It must be functional, due to general or cardiac weakness, or it may be obstructive, due to purely local causes generally, in the latter periods of ulceration and œdema.

5. *Deglutition.*—Disturbance of this function is one of the most prominent symptoms of laryngeal

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(a) Delivered at the Central London Throat and Ear Hospital on September 20th, 1907.

tuberculosis. It may vary from a slight discomfort in swallowing to one of intense pain (odynphagia), when deglutition is almost impossible. Difficulty of swallowing (dysphagia) is chiefly due to structural changes in the laryngo-pharnyx. Odynphagia is chiefly caused by perichondritis (arytenoid and epiglottis), which gives rise to excruciating pain during the contraction of the lower constrictors of the pharynx and the sphincters of the larynx. This also gives rise to considerable accumulation of mucus, and even food, which add to the patient's troubles, and starvation follows if means are not taken at once to alleviate this serious and important complication.

These are the chief special symptoms to which we may add the more general symptoms as :—Evening rise of temperature, sweating, emaciation, asthenia.

Clinical Signs.

Before dealing in detail with the special clinical features characteristic of laryngeal tuberculosis, it will be expedient to say a few words on the so-called *Pre-Tubercular Stage*, to which so much importance has been attached. This stage is practically an exaggerated catarrhal phase marked by recurrent attacks of mild laryngeal catarrh, dysphonia and local anæmia. Briefly the pronounced features are :—(1) Intense pallor of the laryngeal mucosa with intervals of "patchy" hyperæmia, not evenly diffused as in ordinary laryngitis. (2) A greyish macerated appearance of the posterior commissure and inter-arytenoid fold. (3) Patchy thickening of the cords themselves, especially in the region of the vocal processes. (4) Occasional impaired adductor movements of the cords.

It is extremely difficult to arbitrarily arrange the order in which different regions of the larynx are attacked, as so much depends upon the intensity of the process. One is tempted to classify tubercular disease into acute and chronic forms, but this classification would also be undesirable. It will, therefore, be more practical to consider the most striking features seen by the laryngoscope in different degrees and stages of the disease as seen in this country.

Every case presents one or more of the following changes :—(1) Colour ; (2) texture ; (3) form or contour ; (4) movement.

With regard to colour in the pre-ulceration period, the larynx is markedly pallid, except after a severe paroxsym of coughing or during an acute-catarrhal attack. The pallor now involves those regions which are normally tinted, such as ventricular bands, inter-arytenoid folds, &c., independently of general anæmia. Any deviation in colour, texture, form, and movement of the cords will be recognised at once by any one familiar with the structure of the normal larynx. In all cases, ulceration œdema, textural asymmetry, and restriction in the movements of the cords, should be carefully looked for. Limited mobility of the cords may be due to many causes. It may be arthritic, caused by implication of the crico-arytenoid joint or infiltration of the structures generally.

Differential Diagnosis.—In the early stages it is most important, and also very difficult, to differentiate early tubercular laryngitis from hysterical or functional aphonia. Hysterical aphonia is rarely a simple hoarseness or dysphonia, but it is a complete inability to phonate, which comes on suddenly without any change in the quality of the voice or cough and associated with other hysterical phenomena. In *Tuberculosis* complete aphonia is rare ; it is either a dysphonia, preceded or attended by hoarseness and getting gradually worse. It is in these cases where this symptom is only present for a short time and when there is no positive laryngoscopic evidence that much hesitation in diagnosis need be felt. In both cases anæmia is marked, both local and general, although in tuberculosis it may be only local. In tubercle there is generally also marked hypersensibility of the larynx, pharnyx, and fauces, while it is exactly the reverse in hysteria.

In both cases a marked catarrhal condition may be present which at once marks the diagnosis ; in a simple transient laryngitis the mere application of cocaine may relieve the congestion, but when infiltration of the tissues has been at work the application of cocaine does not change the colour and texture to any great degree. Cough may be present or absent in either, but it is more rare in hysteria, in which a "choking sensation" is common. In the event of tubercle, infiltration of the cords is generally unilateral and partial at first ; often only the posterior third is involved. Upon ulceration developing it will be seen to have a decided superficial and "nibbled" character, with a "beaded" base. The ulcers may be multiple and extend by fusion.

Sometimes long before ulceration happens the posterior commissure becomes corrugated and thickened, preventing proper adduction. This is a variety of *Pachydermia*. The inter-arytenoid fold becomes also thickened, presenting a convexity upwards which may soon break down and exhibit an irregular granulation surface. At this time perichondritis of the arytenoids is shown by a characteristic pear-shaped translucent swelling of the mucous membrane covering them. This is a feature rarely seen in any disease but tubercle. As soon as ulceration becomes marked a carefully-taken "smear" will at once reveal the bacilli. This is a much more certain method than examining the sputum, which is frequently unobtainable. In earlier stages bacilli are more difficult to find.

The appended table will help to differentiate it from syphilis and malignant disease at this stage of its progress.

Tubercular Laryngitis.	Syphilitic Laryngitis.	Malignant Disease.
Pallor of larynx		
Catarrh of one cord usually posterior third	One or both cords and generally anterior ends	Always one cord
Ulcers are small, grow slowly, edges ill-defined, base nodular, spread superficially, and when healed no deep scarring left	Ulcers large, grow quickly, edges punched out and undermined and tend to grow deeply and leave deep scars	Slight want of movement, a sort of dragging due to the growth
Irritability on laryngeal examination	Tolerance on laryngeal examination	
Intense odynphagia	Dysphagia often slight	Odynphagia and dysphagia variable and late
Granulations are diffuse, irregular, œdematous, and greyish white	Gummata are usually unilateral, and dull red colour	Cauliflower looking growth, one cord
Epiglottis attacked late in the disease on the laryngeal side	Epiglottis attacked soon, and in its anterior aspect	
Physical signs in chest	Scars on fauces	
Tubercular bacilli in sputum or swabs from larynx		
Evening rise of temperature	History of rash, &c	Age of patient
Night sweats	Peculiar harsh voice	
Character of voice		

Prognosis of Tubercular Laryngitis is grave in every case, but under careful hygienic surroundings the ulcers may heal, but they are unfortunately often only quiescent for a time, and re-awaken into activity on the slightest provocation.

The prognosis depends : (1) On the amount of dysphagia and odynphagia present ; (2) on the extent of the lung and general infection ; (3) upon the stage of the disease.

Treatment.

Absolute rest to the larynx is a most essential part of the treatment. Hilton's principle of rest to all diseased parts must be applied here most particularly. Patients should be kept like prisoners, and allowed only paper and pencil to communicate their desires, and on no account allowed to whisper. Irritable condiments, highly seasoned foods, smoking, &c., should be prohibited. Any cough, however slight, should be soothed as quickly as possible.

The Fresh Air Treatment is essential, unless the larynx is in an acute or far advanced state of the disease.

Nourishing, Wholesome Diet, as milk, eggs, soups, &c.; no rich foods, oils, or drugs should be given if they tend to injure the digestion or hurt the appetite.

Opsonic Treatment.—This should never be undertaken unless the patient can be kept at perfect rest, mentally as well as bodily, and in co-operation only with the strictest sanatorial attention. It is useless to make any opsonic observations while the patient is taking active exercise, otherwise the results will prove not only misleading, but probably harmful. Should the necessary favourable conditions be available, there can be no doubt that the tuberculin vaccination, although in its infancy, affords a valuable method of treatment.

Dysphagia is a grave symptom, and must be relieved as soon as possible. Patients swallow semi-solids more easily than fluids or solids, especially when lying in the prone or semi-prone position, with their head over the couch and taking the food through a tube held below the mouth. Raw unbroken eggs are easily taken in this position.

Local Treatment for Dysphagia.—(1) Orthoform and resorcin in powder, equal parts; by auto-insufflation through Leduc's tube, causes great relief. (2) Anæsthetics, as cocaine or menthol and paroline, injected into the larynx are useful. (3) Excision of a piece of the swollen arytenoid or epiglottic region by punch forceps eases for a considerable time this painful symptom.

Cough, when only slight, is relieved by demulcents, such as Iceland moss jujubes or jelly, but when the patient's rest and sleep is disturbed by it, Heroin, which does not affect the appetite, will be found superior to Morphine. Local remedies for tubercular laryngitis are useful when the pulmonary condition is not far advanced and when the strength of the patient is good.

Laryngeal applications injected into the larynx by means of a laryngeal syringe, guided with the larnygeal mirror, are most beneficial. They should be injected daily in order to have a permanent effect, especially when pulmonary complications are active and the sputum is highly charged with mixed bacteria. The following solution: Creasote or guaiacol, 5 per cent.; menthol, 1 per cent.; oil amygdal dul., 94 per cent.; relieves the cough and pain in a marked degree.

Local Reagents or lactic acid, in strengths from 10 per cent. to 60 per cent., also carbolic acid, formalin, and others applied by means of a swab, are efficacious.

Surgical Methods are resorted to when the dysphagia is very severe and when tubercular granulations are too profuse. These can be removed from the inter-arytenoid space, base of the epiglottis or cords by means of Heryngs' curettes (a few drops of a 5 per cent. solution of cocaine is first applied).

The galvano-cautery has been used with considerable success in reducing tubercular nodules or tuberculomata.

It is absolutely essential for tubercular patients to have a free nasal and naso-pharyngeal passage, so as to allow deep and normal breathing. Tuberculosis is liable to infect any adenoid vestige or unhealthy mucous membrane, therefore any such must be promptly and thoroughly dealt with.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Paul Claisse, M.D., Physician to the Pitie Hospital, Paris. Subject: "Embolism consequent upon Lesions of the Left Heart."*

ORIGINAL PAPERS.

SOME IMPORTANT ASPECTS OF SUPPURATION OF THE MIDDLE EAR. (a)

By J. DUNDAS GRANT, M.A., M.D.Ed. F.R.C.S. Eng.

Surgeon to the Central London Throat and Ear Hospital, and the Brompton Hospital for Diseases of the Chest, &c.

THE lecturer referred to the extreme seriousness of the various complications of suppuration in the middle ear, suggesting that the aurist probably saw more than his fair share and the general practitioner of medicine less, but whoever had experience of them realised the extreme danger and anxiety connected with them. He narrated a large number of cases from his experience of which the results had been fatal; he pointed out as far as possible the reasons for their having gone wrong, and how such results might, if possible, be prevented in the future. In some of the acute cases, however, incision of the tympanic membrane had been postponed or the opening of the mastoid cells had been relegated until infection of the blood or of the cranial contents had taken place. He discussed the reasons which had led to the delay, but in view of his later experience considered that these reasons were in many instances quite insufficient.

By way of contrast he referred to some illustrative cases in which early intervention appeared to have been the means of averting dangerous complications. He expressed the opinion that with antiseptic precautions even those who did not profess to be operative experts might put their patients in safety by making an opening in the mastoid cells when more skilled aid was not available. He advocated early and quick operation in diabetics in view of the rapidity with which the mastoid bony tissue breaks down in these subjects, though no doubt a positive result of the aceto-acetic test would be a contra-indication.

Among interesting errors in diagnosis he quoted a case of lateral sinus phlebitis, which had been previously diagnosed as enteric fever and one of enteric fever which he himself had diagnosed as otitic septicæmia. In another case he had found lobar pneumonia to be the cause of constitutional disturbances which had by others been attributed to purulent otitis. In another exceptional case certain cerebral disturbances were in view of a history of former otorrhœa attributed by the physician in charge to a probable intracranial complication of middle-ear disease, but in reality the lecturer had attended the patient for condylomata of the meatus, and the cerebral disturbances disappeared rapidly under treatment by means of mercury and iodide of potassium.

The difficulties in the diagnosis of malignant disease and tuberculosis when affecting the external and middle ear were described and illustrated by cases occurring in the lecturers' experience.

He considered the recognition of cholesteatoma

(a) Abstract of Second Hunterian Lecture, delivered before the Hunterian Society, January 9th, 1908.

of the middle ear as of vital importance in chronic suppuration of the middle ear and pointed out the dangers attending the use of watery solutions for instillation or syringing when this condition was present. Alcoholic solutions were, on the other hand, of the greatest value.

Dr. Grant referred to the indebtedness of students of otology over the whole world to Dr. Newton Pitt, the honored Fellow of the Hunterian Society, for the invaluable statistical and pathological study of the fatal sequelæ of suppurative middle-ear disease forming his Goulstonian Lecture.

CONTRIBUTION TO THE STERILISATION OF AIR.

By Dr. S. BERNHEIM,

Paris.

[Specially Reported for this Journal.]

The importance of the composition of air for animal life need not be proved since Pasteur's, Strauss', Laveran's, and Miguel's researches on the microbes contained in the atmosphere. In one day 10,000 litres of air pass through an ordinary man's lungs, that is to say, more than 400 litres per hour.

Modifications in the composition of atmospheric air are the cause of great disturbances in organism, and sometimes lead to death. These modifications differ, whether one examines air in the country or in large towns. While country air hardly contains from 200 to 300 germs per cubic metre of air, the city atmosphere, especially that of thickly populated centres, may contain as many as 45,000. My opinion is, that all these figurative elements, these living corpuscles, constitute the principal pathogenical agent of transmissible microbian diseases.

The first prophylactic consideration might have urged us before now to seek for means of sterilising the air we breathe. But, other imperious reasons exist both in medicine and surgery. In hospital wards, in attending surgery or accouchement cases, the air, saturated with micro-organisms, is a constant danger for the patients, for those who have undergone an operation or given birth to a child. Very often the most competent practitioners have observed, in spite of rigorous precautions, cases of infection of exterior origin. After a perfect asepsy, one may reasonably suppose that the contagion is due to an aerial origin.

However this may be, we thought it would be interesting to attempt to sterilise air charged to the utmost with bacteria, even if fully contaminated with a fine flora of microbes. To attain our end we used the simplest aparatus possible. It consists of :

1. A rectangular box containing a vat made of metal having good conducting properties, which is submitted to the action of a source of heat (gas or coal chimney). The said vat contains filtering matter (amianthus or filings).

2. A saturator is placed at the top of the vat, only containing plain or medicinal water, this saturator prevents the unpleasant dryness of the atmosphere. The inner sides of the box and vat are bored at their lower part by an opening on each side (exhausters), and at the top, at the level of the saturator, by two other openings by which the air escapes after having passed through the filter at a temperature of 180°. This high temperature is controlled bv a thermometer placed immediately above the filter of filings. In order to avoid the scum which inevitably arises from the dust, a movable basket is placed underneath the filter, into which all the sterilised dust falls. The dimensions of the apparatus vary according to the importance of the room. If the room is small, an alcohol lamp is sufficient to start the apparatus working and to bring it up to the temperature which the sterilisation of air requires. When a larger room is to be sterilised, and when one wants to arrive at a more complete sterilisation, the apparatus requires a more active and lasting fire. The exhausting action of the apparatus is very powerful, for the maximum of dust and germs may be ascertained half an hour after the operation begins.

For the last two years we have been trying a large number of experiments, and we are now only relating those which have been carried out with all the care that such researches deserve. Very often, indeed, unskilful assistants, after having entered the room fixed on during an experiment, have introduced a new atmosphere more or less charged with microbes. In order that the demonstration may be of value we must previously test the air of the room which is being experimented on at different points and heights, without giving any means of escape. By reason of natural orifices, a house is never and absolutely permeable, and that is the reason why it is very difficult, and nearly impossible to completely sterilise the air in a room. However, we have twice obtained this ideal result. Moreover, here is the report of the experiments just as they worked out :—

We gathered the dust in the air and scattered it according to Miguel's process. In most of the experiments an assistant stayed in the room in order to fan the air and cast the dust into a vacuum. It is true that that experimental measure is really useless, because in the natural circulus of the air dusts are generally gathered and kept up in the atmosphere, the movement being helped by heat.

In one experiment we started with 10,000 bacteria to a cubic metre, and two hours and a half after we began the experiment the air only contained 1,660 bacteria.

In another experiment, where the air was polluted, we started with 95,000 germs, and after an hour we found only 15,000 germs.

In another experiment we started with 47,500 germs, and after one hour and a quarter they were reduced to 2,500.

Here is another experiment, the air of which had been polluted. When we began the air contained 275,000 germs, and after one hour only 32,000.

In another experiment, in which the air contained at the beginning 82,500 germs, after two hours we found only 22,500.

Here is another experiment : We started with 45,000 germs, and finished with zero. No settlement was developed on the gelatine. But, as a matter of fact, this result can only be obtained and hoped for in very exceptional cases. In addition to this, we could relate a great many other experiments which resemble the preceding ones, that is to say, we have always obtained a considerable decrease of bacteria and mouldiness.

Considerations.—It is indeed very easy to renew and check our experiments. For our apparatus is so plain that anybody is able to construct one exactly similar and attach it to any chimney which draws well. An examination will show a heavy deposit of dust on the gridiron and on the filter of filings. As this matter rises to a high temperature the germs that travel over it die without fail. And, indeed, in all those experiments we obtained an exact result. After two hours of combustion we have considerably reduced the number of bacteria, to sixteen or seventeen times less numerous after the experiment is terminated. With a fire which lasts longer we shall be able to reduce the number of germs to a strict minimum, and possibly nearly to zero.

The importance of these results will be understood by all hygienists, surgeons, and accoucheurs. We know that air is not at all, or very little, harmful in regard to its chemical alteration, but only according to the germs it contains. If we can hope to sterilise with a simple apparatus the air of a dwelling-house, accidentally or continually overcrowded, this is an important hygienic progress for preserving health. We sterilise milk, we pay attention to a quantity of alimental commodities, especially meat, we boil water to avoid typhoid fever; why shouldn't we purify the air of apartments and habitations?

The "ærosterilisator" is especially designed for hospital wards, schools. colleges, barracks, where the air is so harmful. It will be of great use for all windpipe diseases, where pure air, the important food of the lungs plays so important a part. Give good food to a consumptive patient, with absolute rest in a vitiated atmosphere, and disease will continue its grave course; put this same consumptive person in an atmosphere free from bacteria, with the same rest and nourishment, and you will bring him to a state of health and to a cure. It is the same thing for those suffering from pneumonia, bronchitis, and emphysema.

Here is, therefore, a first list of directions for the "ærosterilisator." But what is one to say of the operating of accouchement rooms, where the chief operators take such precautions to avoid all infection from outside?

We are convinced that all these operators would be glad to strengthen their chances of success by sterilising beforehand, and during the operation, the air in their rooms. This new aseptic *guarantee* is so important that we need not further insist on it.

THE DIAGNOSIS AND TREATMENT OF

SIMPLER FORMS OF CONJUNCTIVITIS. (a)

BY LESLIE PATON, M.B., F.R.C.S.

GENTLEMEN,—Some explanation would seem to be demanded for choosing this somewhat hackneyed subject for a paper to your Society. It is not that I have anything new to say on either diagnosis or treatment. Very few of the great number of writers on this subject do seem to have anything new to say about it. Two factors influenced me in the choice: the first, a realisation that the commonplaces of a specialty were not of necessity commonplaces to men working on other lines; the second being that just at the time your Secretary asked me for a paper, a series of cases had come under my notice in which the non-recognition of any differentiation between the simpler forms of conjunctivitis had led to mistakes in the methods of treatment, or, on the other hand, a method of treatment had been adopted which had resulted in the perpetuation of the condition which it had been intended to relieve.

In using the term, "the simpler forms of conjunctivitis," I am excluding trachoma and follicular conjunctivitis, and also, except in an incidental fashion, phlyctenular conjunctivitis. Clinically, then, my subject includes catarrhal, purulent, and membranous or pseudo-membranous conjunctivitis. If I were driven to giving a simpler classification, I would say that I wish to talk about—(*a*) the inflammations for which the general practitioner prescribes boric acid lotion, and (*b*) those which he paints with silver nitrate. And, personally, I have found that to include the greater bulk of cases of conjunctival inflammation. Boric acid lotion is an excellent remedy. Unfortunately, it is of very little service in the type of case which forms the majority of all cases of simple conjunctivitis. Against the habit of prescribing it with an admixture of cocaine to relieve the pain and congestion I must most vehemently protest. I have seen many prescriptions for such lotions, but I am more and more convinced that the regular prescription of cocaine in any lotion or ointment for home use is a most vicious practice, and has in many cases had the result of perpetuating, or at least prolonging, the course of the malady to which it seems to give temporary relief. As to silver nitrate, in many cases it is the most valuable substance we can use, but in some cases it is of positive dis-service, whilst in others its use has to be guarded by precautions which are not always observed.

I have inferred that there is some basis for a more accurate differentiation of types of conjunctivitis than that given by the terms catarrhal, purulent, and pseudo-membranous. Of course, the best diagnosis will always depend on the identification of the exciting cause—in the majority of cases a bacterium. It is too much to expect a busy doctor to be in a position to prepare even smear preparations, far less to make cultures from every case of conjunctivitis, and it is the function of the specialist, as far as possible, to correlate the clinical aspects of any type of disease with its exciting cause, so as to enable any careful clinician to diagnose with some degree of probability whether the case before him is one caused by the diplobacillus of Morax, by the Koch-Weeks bacillus, by the pneumococcus, or by any of the other bacilli and cocci which may be the exciting cause of conjunctivitis. The organisms to which some pathogenic effect has been or is ascribed in connection with the conjunctiva, may be divided roughly into three classes:—(*a*) Those which are directly pathogenic, bringing about an inflammation without any other contingent cause when introduced into an otherwise healthy conjunctiva. In this class would be included the bacillus of Koch-Weeks, the diplobacillus of Morax, and the gonococcus, bacteria against which no normal immunity exists. (*b*) Bacteria which may be present, and frequently are present, in a normal, healthy conjunctival sac, but which under certain conditions may set up inflammation. Pneumococcus and certain streptococci are in this class—bacteria against which there is a normal immunity sufficient to protect, unless when for some reason there is a diminished tissue resistance or an increased germ virulence. (*c*) Organisms which only attack a tissue already weakened by some other infection. Such organisms are the staphylococci and most of the streptococci. In which class we should include Lœffler's diphtheria bacillus must depend on the answer we can give as to its relationship to the xerosis bacillus. The latter, and staphylococcus pyogenes albus, are practically normal inhabitants of the human conjunctival sac. If, then, we regard the xerosis bacillus as only an avirulent type of Lœffler's bacillus, the latter must be put in class (*b*); otherwise it would normally go into class (*a*). Until bacteriologists decide this question, the hapless bacillus of diphtheria remains suspended like Mahomed's coffin.

We find, then, three classes of organisms: (*a*) those which always cause conjunctivitis; (*b*) those which sometimes cause conjuctivitis; (*c*) those which attack a conjunctiva only when weakened by the attacks of *a* and *b*.

Classes *a* and *b* will include the majority of cases of simple conjunctivitis. Arenfeld, in his book on the "Bacteriology of the Eye," gives statistics of the eye clinique at Freiburg. Of 12,000 patients, 900 had some form of acute or chronic conjunctivitis; 519 of these were caused by the diplobacillus of Morax; 41 by the Koch-Weeks bacillus; 34 by the pneumococcus; 12 by gonococcus; 6 by diphtheria; 5 by streptococcus; 2 by the bacillus of Friedländer; 3 by the influenza bacillus. Of the remaining 278 cases, many showed the usual conjunctival inhabitants, staph. alb. and xerosis, the micrococcus catarrhalis was found 9 times, but the nature of the actual causative germ remained obscure. I think that table gives a just view of the relative frequency of the various agents. And you will note the great preponderance of the diplobacillus of Morax. Some years ago I made a series of observations on cases attending St. Mary's Hospital during a period of six months with acute and chronic conjunctivitis, with the result that I found about 50 per cent. of the cases were caused by this diplobacillus. Gonin's statistics give 185 cases out of 365 caused by it, and generally it is safe to say that diplobacillary conjunctivitis is the most frequent form of simple inflammation. Now it is the one form for

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(*a*) Read before the Harveian Society of London, Dec. 12th, 1907.

which boric acid is of little use, and silver nitrate is positively harmful. Luckily, the clinical picture it presents is a fairly straightforward and consistent one. It mostly occurs in adult life, and when it attacks children it is very apt to cause severe marginal blepharitis. In adults the features are so characteristic that one can usually pick out in an out-patient clinique such as Moorfields a series of a dozen cases, and predict with certainty that the diplobacillus will be found in each one. The patient comes with the complaint that the lids are gummed together in the morning, or very heavy, and that they have to be bathed with warm water to get them to open at all. This process is sometimes painful, but shortly the pain passes off, and during the day the eyes feel fairly comfortable. Towards evening the eyes begin to prick, especially in the corners. This may commence so sharply that a man will assert that he has got a bit of grit into his eye, and will tell you exactly where he was when the grit went in. The whole upper lid feels as if a dustbin had been emptied into it, and the ball of the eye feels hot and fiery. The discomfort during the evening may be very considerable, even giving rise to headache, and nearly always accompanied by a desire to scratch the inner angles of the eye violently. Usually a period of three or four days elapses between the infection of the two eyes, the incubation period of the organism being from three to five days. Objectively the most obvious sign is the reddening and inflammation of the angles of the eye and the lid margins. The caruncle is usually bright red. Along the roots of the lashes there is a fine greyish deposit, and at the inner angle a little mass of greyish yellow fibrinous matter, in which usually great numbers of the organism can be found. The palpebral conjunctiva is usually slightly inflamed and somewhat roughened, but the ocular conjunctiva, apart from the angles, is seldom much affected. The most characteristic feature, apart from the angular redness, is the erythematous condition of the skin of the lids. Usually the skin at both angles has a slightly eroded appearance, and the rest of the skin along the margins has a dry, crackly, semi-glazed appearance as if it had been badly starched. The disease usually commences in a sub-acute fashion, becomes chronic, and persists if untreated for many months. As the symptoms are often mild, it may be many months before treatment is sought. This form, then, is clinically chronic, angular conjunctivitis; etiologically it is diplobacillary conjunctivitis. Smears prepared from the small fibrinous deposit at the inner angle usually show the organism in great numbers. It is a squat, dumpy, squarish bacillus, always occurring in pairs, which sometimes form chains of several pairs. It does not grow well on ordinary media, but on blood or inspissated serum, or serum agar, it can be cultivated. If the medium does not suit it, it very soon develops involution forms of the most varied description.

If I have been successful in my clinical description, I think you will recognise that this individual with the bleary, red-rimmed eyes is of fairly frequent occurrence. Now the treatment to be adopted is not boric acid and silver nitrate, but zinc sulphate and again zinc sulphate. A lotion containing one or two grains to the ounce, made up with a little cherry laurel water, will do more good in three or four days than boric acid will do in a month. This smarts—in some cases it smarts very badly—and you have to warn people of it. I usually tell them to retire to a private place, where they can express their feelings strongly before using the lotion; but, whatever you do, don't prescribe a little cocaine with it just to take away the pain. If you do, the relief is immediate, but in a short time the congestion recurs, and, like dram-drinking, the effect is shorter with each dose, and in a week or ten days you get a sodden condition of congestion much more difficult to treat than the original inflammation. Again, silver nitrate is of no service, because the organisms are surface livers, and you do not want to produce exfoliation of diseased conjunctiva to carry away deep-seated organisms. Argyrol is in some cases of service, but the mainstay is zinc sulphate. For the comfort of the patient it is advisable to prescribe a simple ointment, to be used at night, to prevent the gumming of the lids. Vaseline is often sufficient, or a 1 per cent. iodoform ointment, or where the pricking is very marked I frequently order zinc oxide made up with lanoline, olive oil, and liquor calcis to a creamy consistency.

The ordinary cases of acute purulent or muco-purulent conjunctivitis may be caused by the Koch-Weeks bacillus, the pneumococcus, or the gonococcus. If we except cases of ophthalmia neonatorum from our purview, the majority of which, though by no means all, are caused by gonococcus, we find that only a very few are due to this last organism—12 out of 900 in Arenfeld's list. This is fortunate, because undoubtedly the most virulent forms of conjunctivitis are caused by the gonococcus. Within 24 hours the conjunctival œdema may be so intense that the lids cannot be separated, and the swollen conjunctiva projecting through the lids may seem in danger of sloughing from strangulation. And when ultimately, by slitting the canthus and free incision, one does obtain a view of the cornea, one often finds it already opaque and ready to slough.

It is to the Koch-Weeks bacillus and the pneumococcus that the majority of these cases of acute conjunctivitis are due. The Koch-Weeks bacillus possesses a higher degree of contagiousness than any other that can attack the eye. Out of 21 experimental introductions made by various authors on the human eye, 20 resulted in conjunctivitis; 15 cases where a pure culture was used were all attacked; in 6 cases a mixture was introduced into the conjunctival sac, and 5 of these were affected.

The clinical picture is simple. The eye first affected commences to burn and smart, and becomes slightly photophobic. The margins of the lids become slightly red and puffy. This puffiness seems usually more marked in the lower margin of the upper lid. The palpebral conjunctiva becomes greatly congested, very red and swollen, but usually retains a smooth surface. Only very rarely does one see any follicular enlargement in the fornices. The bulbar conjunctiva becomes of a uniform red colour. (In the picturesque language of the rank the disease is called "pink eye"). Later on, especially in adults, this becomes flecked with tiny little ecchymotic patches disturbing the uniformity of the pink. The bulbar conjunctiva usually shows only slight swelling or chemosis. Sometimes tiny swellings resembling phlyctenulæ develop at the corneal margin. In tuberculous children true phlyctenulæ may develop. Dr. Nias and I have shown that in these cases there is always a low opsonic index for tubercle, and some other evidence of tubercular infection. In the height of the inflammation there is usually a good deal of purulent secretion along the lid margins and in the angles of the eyes, and little flakes of pus float in the conjunctival sacs. The incubation period is from 24 to 48 hours, and consequently the two eyes are usually affected within three days. The organism is a thin bacillus about two-thirds of the length of the tubercle bacillus, and about the same breadth. It lies in clusters both extra-cellularly and intra-cellularly. It sometimes is found in the multilobular leucocytes in great numbers, and I have seen a desquamated epithelial cell with vacuolated, decrepit-looking nucleus crammed with the bacilli. These stain easily, and gram well.

The inflammation runs its course in from two to four weeks. Sometimes if untreated it tends to leave a chronic inflammation, in which there is follicular enlargement. If an attack confers any immunity at all it must be of a very temporary nature, as I have seen cases of children where a second attack came on within a very few months.

I do not pretend to distinguish between this form of acute conjunctivitis, and that due to pneumococcus. I believe that in the great majority of cases they are indistinguishable. The clinical picture I have given you of the one will serve for the other with some slight variations. The pneumococcal conjunctivitis is self limited, especially when it occurs in epidemic form. It is not so infectious. In epidemics it is mostly children that are infected. In severe forms it sometimes gives rise to membrane formation, but the membrane is never a true necrotic membrane. There is probably a greater tendency to the formation of phlyctene-like swellings at the limbus of the cornea, and in my experience a greater tendency to tiny ecchymoses. None of these points alone enable us to differentiate pneumococcal conjunctivitis from the Koch-Weeks form. The essential difference is in the course of the disease, which is self limited, reaching its climax in five or six days, and then resolving rapidly. This extremely interesting point has been made by Arenfeld, and has been confirmed by other observers, and you can see how it brings a pneumococcal inflammation in the conjunctiva into line with the inflammations set up by the same organism in other parts of the body. A second essential difference between the two organisms, though it does not affect the clinical manifestations, is that the Koch-Weeks bacillus is always pathogenic, while the pneumococcus is only a facultative pathogenic agent.

Fortunately, when we come to the question of treatment there is no need to differentiate between the two forms. The two essentials are efficient and regular cleansing with some simple aseptic lotion, and the destruction of the organisms and their removal along with the affected tissues and the replacing of the affected tissue by healthy tissue. In the use of a lotion the most important effect is the mechanical cleansing and irrigation. For this purpose the lotion should produce as little irritation as possible, should be used as warm as it can be with comfort, and should be used in no niggardly fashion. A weak boric acid lotion in most cases fulfils these requisites, but where it produces irritation as it sometimes does it is best to substitute normal saline. The comfort produced by the free use of lotions is probably almost entirely due to the freeing of the conjunctival sac from portions of desquamated epithelium and flakes of pus which act as irritants like any other foreign body. In mild cases this cleansing of the eye and the prescription of a simple ointment to prevent gumming of the lids is really all the treatment required. In more acute cases nothing can replace the salts of silver in efficacy, and for certainty and efficiency silver nitrate is still the best, and properly used is likely to retain its position.

We are dealing now with organisms whose action is deeper seated than the diplobacillus of Morax. They are not only surface livers. They get into the cells, and generally speaking their whole sphere of action is deeper. To rid the eye of them we have to employ some agent which will be able to attack them where they are most active. When we brush the eyelids with silver nitrate in a 1 per cent. or 2 per cent. solution what we first notice is, that a faint bluish white pellicle forms on the conjunctiva. This is due to the coagulation of the proteids of the cells by their conversion into albuminates of silver. This conversion means, of course, the setting free of a certain amount of free nitric acid, with the consequent great irritation which invariably follows painting with silver nitrate. In other words, then silver nitrate produces a coagulation necrosis in the surface cells. The conjunctiva immediately sets itself to get rid of this surface slough, and for the next two or three hours there is an increase in the amount of secretion from the eyes, and the eyes seem to feel even more gritty than before. The contained organisms are acted on at the same time as the cells, and are thrown off with the cells, and though some undoubtedly escape, the number has at least temporarily been greatly diminished, and the supply of toxins is diminished proportionately, with the result that the irritation caused by the toxins is very greatly relieved, and you get the frequent history that, within an hour or two of the painting, the eyes feel cooler and more comfortable than since the inflammation commenced.

In using silver nitrate then we must be fully cognisant of the results we wish to produce. As it is only the most superficial layers which are affected, it would be unwise to employ the silver nitrate in such strength as to affect the deeper lying tissues where there are no organisms, and it would be equally unwise to employ it before the lapse of a long enough interval to allow of a complete regeneration of new epithelium to replace that thrown off. The most serious danger in using it too strong or too frequently is that, by doing so, deep sloughs may be formed, which, when thrown off, may leave raw surfaces in opposition, and so give rise to adhesions which may become permanent. Such a result is not uncommon from over anxiety on the part of those in charge of a serious or important case. As a general rule I should recommend that an interval of at least 24 hours be allowed to elapse between any two successive applications of silver nitrate even in severe cases, and that any excess should be always removed or neutralised by salt solution at the time of application.

The great irritation caused by the use of silver nitrate has led to numerous attempts being made to replace the violently irritant inorganic acid by some non-irritant organic acid. Many of these preparations must be familiar to you all, such as protargol, collargol, and argyrol. My personal preference is distinctly in favour of argyrol, used in strengths varying from 10 per cent. to 25 per cent., and it is in this form that I always prescribe silver salts when I wish to give them to patients for home use. Argyrol is itself a silver albuminate, being a compound of silver with vitellin, the only pure crystallisable proteid, the crystalloid body found in the aleurone grains of wheat. Our friends the bacteriologists, arguing from their experiments made in little glass tubes, have asserted that argyrol has no germicidal effect, or at most very little. Clinically, and from personal experience of its efficacy I can assure them that in the human conjunctival sac it has a very beneficial effect. The probable explanation of the seeming discrepancy is that in the eye, especially the inflamed eye, we have metabolic processes going on, which *inter alia* allow the silver in the argyrol to be set free and to convert other proteids present into silver albuminates. The organic acids derived from the vitellin being of a non-irritating nature, argyrol is practically painless in its use. Unhappily, though they are useful allies, none of these preparations are substitutes for silver nitrate.

The remaining forms of conjunctivitis hardly come within the scope of my title, nor within the limits of your patience. Diphtheritic conjunctivitis is not a common affection. It only occurred six times in Arenfeld's list. It is almost invariably secondary to nasal diphtheria. There is always grave constitutional disturbance. The temperature is always raised, usually 101° or 102°. On everting the upper lid the palpebral surface is found to be covered by a membrane which requires some force for its removal, and which leaves behind it a raw bleeding surface. Obviously the treatment of such a case must be on the lines of the treatment of diphtheria elsewhere. It is said that such cases are only very rarely followed by palsies. Whether such is the case or not I am not in a position to give an opinion.

Streptococcal conjunctivitis also is fortunately not a common form. Like streptococcal infections elsewhere it may run a very grave course with serious constitutional disturbance. Its tendency to give rise to corneal complications is probably as great as in the case of gonococcus. The most hopeful line of treatment will probably be by means of vaccines. Treatment by anti-streptococcic serums has not been very efficacious. But vaccines prepared from the actual organisms may give more assistance in our future dealings with such cases.

In the cases in which investigation does not show the presence of any bacterium or only of those found in the normal conjunctiva, we must first regard the obvious physical causes, or chemical causes. When these have been excluded there remain certain possibilities. (*a*) The irritation may be due to the presence of some organism, which the means of investigation at our disposal have not enabled us to identify. This seems certainly to be the case in trachoma, and in some cases of infectious follicular conjunctivitis, possibly also in spring catarrh. (*b*) The possibility of an endogenous conjunctivitis: This seems undoubtely to have taken place occasionally in a generalised infection with the gonococcus, and we have to remember, in this connection, the fact that an early and an even severe conjunctivitis occurs in some of the acute exanthemata.

CONGENITAL TALIPES. (a)

By W. FEDDE FEDDEN, M.S., F.R.C.S.,

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My remarks concerning congenital talipes deal mainly with the treatment of the commonest variety—viz., equino-varus, and the methods which I have found most useful in attempting to cure this condition. It is a condition which is obstinate, and only yields with prolonged treatment, and which very frequently tends to relapse.

Other forms of congenital talipes must be treated on precisely similar lines, but I do not think time will permit of any special description.

The cause of equino-varus, I may say at once, is unknown. If you read through a treatise on orthopædic surgery, you will be surprised to see the number of theories that the mind of man has been capable of devising to account for this deformity, but no one of them alone fits in with every detail of the condition, and many of them are entirely hypothetical. I do not think we need waste time discussing them to-night, suffice it to say that the posterior and internal structures in relation to the ankle-joint and the structures on the inner side of the foot are ill-developed and shorter than they should be in proportion to the other parts.

Now I wish particularly to point out—simple as it may seem—that in equino-varus you have two distinct conditions to deal with—viz., the equinus and the varus; and a realisation of this fact is, I think, the essential point in the treatment of the condition, for I believe it to be absolutely essential for the successful treatment of the deformity that the varus should be cured before any attempt whatever is made to treat the equinus by division of the Tendo Achillis. My reason for this statement is that if the latter tendon is divided, free mobility at the ankle-joint is at once established, and any attempt to correct the varus is then expended almost entirely as a strain on the internal lateral ligaments of the ankle-joint instead of upon all the joints, tendons, and ligaments of the tarsus.

The varus deformity, it is worthy of note, occurs not only at the ankle-joint but also at the medio-tarsal joint, and, more than this, it affects every structure at the inner side of the ankle and tarsus, tendons, ligaments, and lastly the *skin*, and this last is quite an important element to consider in all cases of talipes, for it is only by prolonged treatment that the skin can become stretched, and it does not do to divide it or forcibly lacerate it, as the subsequent scar tissue would only increase the deformity.

The successful treatment of congenital talipes must therefore be conducted—(1) slowly, and in stages, and (2) by working on the most distal parts to commence with. In the case of equino-varus the first thing to do is to correct the varus at the medio-tarsal joint, then that at the ankle-joint, and, lastly, only when the foot is square with the leg is it then time to bring down the heel by division of the T. Achillis.

And now as to the carrying of these points into actual practice. First, at what age should the treatment be commenced? The answer is, undoubtedly—the younger the child the better. In fact, if equino-varus is present, the practitioner should commence the treatment as soon as the mother is satisfactorily through the third stage of labour.

In the first instance, in all cases the treatment should always be manipulative, unless the deformity is extremely marked. It is surprising what an amount of correction can be obtained in quite young babies by simple rubbing of the tense structures with olive oil night and morning, combined with manual attempts in the direction of correction, or, if possible, over-correction. In the course of time nature aids one's efforts in this direction owing to the straightening out of the neck of the astragalus, which in the young babe is set somewhat obliquely inwards; in fact, a slight degree of varus is normal in the new-born, and disappears as the child grows. Cases in which this is present to a degree somewhat more marked than that which can be considered normal may often be cured by manipulative methods alone, but if the condition is at all evident tenotomies in some form or another are most generally required. However, I think it is best to commence with manipulative treatment to see what amount of "give" is obtained, and after a while one or two more or less taut structures—fascial bands, tendons, ligaments, or what not—will be felt beneath the skin just below and in front of the internal malleolus.

Now is the time for a so-called tenotomy. In this particular small operation I confess that I never know quite what I am going to divide, or what I do divide in a small baby; but I enter a very small tenotome on the inner side of the foot and pass it deep to the tight bands, whatever they may be. These I divide freely from within outwards, until there is only skin left between the tenotome and my finger, which is making counter pressure on the outside.

Sometimes the tibialis anticus tendon, sometimes the tibialis posticus, sometimes both, are divided, together with bands of plantar fascia, and in some cases free arterial hæmorrhage follows; but I have never seen any trouble result from this, and never do more than apply a pad of dry gauze and a bandage.

The foot is then corrected as far as possible by forcible manipulation, and several unpleasant cracks may be heard, and the limb is fixed firmly to an outside splint, to which the foot is drawn by bandages and strapping.

Subsequently, in a day or so, when the puncture is healed, the mother or nurse must be instructed to continue the manipulation as before, rubbing the parts night and morning and everting the foot with the right hand, whilst firmly grasping the malleoli with the left. Again, after a time, other tense bands will make their appearance in the same neighbourhood, and will require division in a like manner—in fact, two or three of these so-called tenotomies may be required in a severe case of deformity before the varus can be fully corrected, and it is far better to do many small operations than to attempt too much at any one time, and also it is necessary to give time to permit the skin to stretch.

In the majority of cases, with suitable manipulative treatment in the intervals by the person who tends the child, combined with the division of any structure that becomes tense and appears to prevent the further unfolding of the foot, the varus can be fully corrected, and then—and then only—should the Tendo Achillis be divided and the heel brought down so as to correct the equinus position of the foot. If done at an earlier date, as I have said, the leverage action over the tarsal deformity is at once lost, and, as far as I have seen, you will then never cure the varus.

In bad cases I have generally found it necessary to divide the anterior portion of the internal lateral ligament of the ankle-joint. The anterior part of this, the deltoid ligament, I might remind you, passes forwards to blend with the spring ligament around the head of the astragalus, and also becomes attached to the tuberosity of the scaphoid. For this purpose I enter the tenotome deeply straight into the astragalo-scaphoid joint, and cut outwards, at the same time dividing the tense structures at the inner side of that joint.

The tension of the fore part of the deltoid ligament is, I believe, one of the most important, if not the most important, element which firmly resists correction of a bad varus deformity in a young child, and after such division forcible eversion of the foot is required, and may be accompanied by a loud crack.

As a rule, I do not employ any retentive apparatus at first, such as plaster of Paris or Scarpa's shoe, as I think such apparatus is apt to cause pressure sores if it is used to *maintain* a foot in a position which it will not itself easily fall into. Proper subsequent manipulation I believe to be far more efficacious, together with the application of an outside splint in the intervals.

In extreme cases where the above-mentioned measures do not permit of correction of the varus, it is almost certain there is fixed bony deformity, and these are the cases in which we can scarcely hope for a perfect cure. If the child be still young I believe that scraping out the centre of ossification of the astragalus to be the best measure calculated to give a useful foot. This is done in order that the resulting cartilaginous portion of the bone may assume a fresh shape by compression. I have not yet seen sufficient of this method to judge of its value, but it is quite certain that cases which can not be made to assume a normal position by division of soft parts alone will do so after cancellous bone has been scraped out of the centre of the astragalus.

(a) Read before the Harveian Society of London, Dec. 12th, 1907.

In extreme cases excision of the astragalus is an operation which has recently been largely practised, and I cannot say that I have ever seen what might be called a truly satisfactory result from it. True, the operating surgeon may speak highly of his results, and the foot may tend to assume a somewhat more sightly position, but the structures at the inner side of the foot remain exactly in the condition that they were previously, and a varus of the anterior portion of the foot invariably remains. Except in very extreme cases of deformity, and after honest attempts at treatment by other methods I am not in favour of removal of the astragalus, as I believe much improvement may be obtained by repeated division of tense bands, provided the case is seen sufficiently early in the child's career, and when it is ultimately decided that astragalectomy is necessary, the previous tenotomies will to a great extent have freed the inward turn of the parts in front of the medio-tarsal joint.

The older operation of division of all structures down to the bone on the inner side of the tarsus, allowing the incision to become a large open granulating wound, is now obsolete, and deservedly so. Anything that requires division can be divided subcutaneously, and the skin will stretch somewhat in the course of time.

The operation of removing a wedge-shaped piece of bone from the outer side of the tarsus, irrespective of the joints, still has a few advocates, and from what I have seen appears to be useless; the deformity usually remaining just as it was before. Moreover, such removal of bone converts the foot into more or less of a stump, instead of a pliable structure. This also applies to a very large extent to those cases in which the astragalus has been excised. In fact if astragalectomy has been performed and has failed, I think it is preferable to leave such cases alone, and not subject them to any further excisions about the tarsus. They must either continue with their deformity or part with the foot.

Finally, the way to be successful with any congenital talipes is without doubt to get the case at the earliest possible moment, and to give personal supervision over a lengthy period, coupled with the services of an intelligent nurse, who will properly carry out the instructions *re* manipulation, etc. It must also be remembered that cases show a marked tendency for the deformity to recur if they are not being carefully watched, and once the proper correction has been obtained it is necessary to see that any tendency to recurrence is not again permitted.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

TUBERCULOUS DISEASE OF THE WRIST. — MR. WILLMOTT EVANS operated on a man, æt. 55, who had been admitted suffering from tuberculosis of the wrist for more than 18 months. He had a swelling of the wrist, with pain and inability to use it. When seen he had a swelling most marked on the dorsum, extending for a short distance above and below the wrist; it was soft, and gave a sensation resembling fluctuation. There was a further swelling which existed just above the knuckle of the forefinger, evidently containing liquid, and which was almost translucent. A diagnosis of tuberculosis of the wrist was made. The patient also had, though he was not aware of it, a swelling in the right iliac fossa, rounded and firm. No definite fluctuation could be obtained in it. A diagnosis of chronic abscess in connection with disease of the ilium or sacro-iliac joint was made. It was decided to operate on the wrist first. The lower semi-translucent swelling was incised and found to be a tuberculous ganglion in connection with the extensor tendon. It was emptied, and as much of the sac wall as possible removed. The swelling of the wrist was incised in two places, on the inner side from the head of the ulna to the base of the fifth metacarpal bone, and on the outer side directly from the middle of the lower end of the radius to the interval between the second and third metacarpal bones. The tuberculous material was evacuated, and the bones of the carpus were removed, together with a portion of the diseased adjoining bones. No attempt was made at a set excision, but, so far as possible, all the diseased tissue was removed. The cavity was scraped with a sharp spoon, and then it was filled with the following powder: Sulphur, 1 part; boric acid, 7 parts. Drainage tubes were then inserted, and the wound was dressed, the hand and forearm being placed in a splint. The iliac abscess was opened a fortnight after the other operation, an incision being made parallel to and just above Poupart's ligament. By careful dissection it was found possible to open the abscess without injuring or even seeing the peritoneum. A large amount of pus was evacuated, and then a probe having been introduced, it passed backwards and inwards to the right sacro-iliac joint. The wound was drained and dressed. Mr. Evans remarked that the treatment of tuberculous wrist was often unsatisfactory, whatever form of operation was adopted; but he had found the best results from opening the joint where the swelling was greatest and removing all the damaged tissues as far as possible without attempting to follow the lines laid down in books on operative surgery. The extent of disease was not alike in two cases, and the amount of tissue removed must depend on the amount of disease present. It was never advisable, he thought, to leave any of the carpal bones, but the amount to be removed from the radius and ulna and the bases of the metacarpus varied greatly. He also attached great importance to filling of the wound with a sulphur powder. Sulphur thus diluted was an exceedingly good antiseptic, especially for tuberculous conditions, and yet it was not liable to give rise to any sloughing of the tissues such as may be produced if undiluted sulphur be employed. It tended to produce a healthy condition of the walls of the cavity, and favoured rapid healing. With regard to the iliac abscess, it was obviously necessary to drain it, but from the source of the suppuration—namely, tuberculous disease of the sacro-iliac joint—it was clear that the prognosis was bad. For the first few days there was much discharge, but the amount of this rapidly diminished, and in about three weeks from the time of operation the wrist wounds were healed. It was then found that the hand had slipped a little forwards, so a splint was ordered to hold the hand in its right position. A very successful result followed, and the movements of the fingers greatly improved. At the time of the patient leaving the hospital there was still some discharge from the iliac wound, but the man's general health had greatly improved.

OUR Edinburgh correspondent refers in another column to the retirement of that eminent alienist, Dr. Clouston, as Physician-Superintendent to the Royal Asylum. His whole medical career for nearly half a century has been devoted to work among the insane, and he will be greatly missed in the direction of affairs at that model institution. We are glad, however, to learn that, although retiring from the active duties of the post, his advice and assistance will still be at the disposal of Edinburgh's citizens.

TRANSACTIONS OF SOCIETIES.

HARVEIAN SOCIETY OF LONDON.

Ordinary Meeting, held December 12th, 1907.

The President, Dr. Sidney Phillips, in the Chair.

Mr. Leslie Paton, F.R.C.S., read a paper on

THE DIAGNOSIS AND TREATMENT OF SOME COMMON FORMS OF CONJUNCTIVITIS.

(This paper will be found in full on page 66 of our present issue.)

Before reading the paper, Mr. Paton showed several micro-photographs of organisms found in the commoner forms of conjunctivitis.

The paper was discussed by the President, Sir John Broadbent, Mr. Crisp English, and Dr. Fowler.

Mr. W. Fedde Fedden, F.R.C.S., read a paper on

CONGENITAL TALIPES,

which will be found on page 69 of our present issue.

Mr. Jackson Clarke discussed the paper, and also showed a case of talipes equino-varus.

Mr. Laming Evans agreed with Mr. Fedden that the varus deformity should be corrected before the equinus in all cases; he advocated that the supination of the posterior tarsal bones should be corrected at the same time as the adduction of the anterior tarsal bones. He showed casts, before and after treatment, of a severe case of congenital equino-varus in a child of 4, with marked bony deformities, which he had treated by tenotomy, manipulation, and a modified Scarpa's shoe. Although such treatment entailed much time, the result was a more elastic and supple foot than if treated by excisions. He showed also casts, before and after treatment, of a severe relapsed congenital equino-varus in a man of 18; he had treated this case by preliminary tenotomy, fasciotomy, manipulations, and retentive apparatus, until the greater part of the adduction and supination was corrected, and by subsequent excision of cuboid and partial excisions of os calcis, head and neck of astragalus and scaphoid. The result was a more shapely foot than after astragalectomy, with the varus deformity completely corrected, and a more supple and elastic foot than after a cuneiform resection without preliminary correction of the varus. In some cases he had found a partial enucleation of the astragalus useful, and showed a photograph of a boy of 12, in whom he had corrected some residual equinus by dealing with Nélaton's præ-peroneal tubercle in this way.

WEST LONDON MEDICO - CHIRURGICAL SOCIETY.

Clinical Evening, January 3rd, 1908.

The President, Mr. Richard Lake, F.R.C.S., in the Chair.

The following cases were shown:—

Dr. Seymour Taylor.—A man, æt. 59, with dysphagia, caused by an aneurysm of the third part of the aortic arch. None of the cardinal signs of aneurysm were present, but a bougie was obstructed 12 ins. from the incisor teeth, and a skiagram showed the tumour. There was also extensive calcareous degeneration of the arteries.

Mr. Percy Paton.—A man, æt. 47, with epithelioma of the floor of the mouth, attached to the jaw, also involving the tongue and lymphatic glands.

Dr. Phineas Abraham.—(1) An unusual form of tinea circinata on the wrist of a girl associated with impetigo contagiosa. (2) A large hairy nævus involving the greater part of the left side of a male infant, æt. 18 months. (3) A case for diagnosis. An excavated ulcer at the left outer canthus of a boy, æt. 5, with greatly enlarged and indurated glands of the same side of the face and neck; six weeks' duration. (4) Four bald-headed children; the condition caused by X-rays applied three months ago for the cure of ringworm.

Mr. Sampson Handley.—(1) A woman upon whom he had performed gastrostomy and excision of the larynx and part of the pharynx for epithelioma. (2) A woman whose breast has been excised for extensive carcinoma.

Mr. Aslett Baldwin.—A man, æt. 30, after removal of breast for carcinoma. The patient was shown at the last clinical evening two months ago. There was then a deeply ulcerated growth in the situation of the right breast, with secondary growths in the skin and enlarged axillary glands. The breast, sternal part of the pectoralis major, the deep fascia from close to the clavicle, in front of the sternum, 2 to 3 in. below the xiphoid cartilage to posterior boundary of the axilla, together with the axillary lymphatic glands, had been removed. The patient is now doing his full work as a butcher, and can raise his hand and arm vertically above his head without difficulty. (2) A girl, æt. 1 year 8 months, with what is probably a sarcoma starting in the left maxillary antrum. There is great prominence of the left eye, and depression of the palate on the same side; also a large swelling in the right temporal region. Mercury has caused no alteration in the growths, which are steadily increasing in size. They were first noticed on December 17th. (3) A man, æt. 71, with an epitheliomatous ulcer on the left side of the tongue and tonsillar region.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday, January 9th.

The President, Dr. John McCaw, in the Chair.

HOSPITAL ABUSE.

Mr. Fullerton called attention to the question of hospital abuse in Belfast, specially with regard to the Royal Victoria Hospital, and moved that a special meeting of the Society be called to consider the subject. After some discussion, it was agreed that a joint meeting of the Ulster Medical Society and the Ulster Branch of the British Medical Association should be held, and that all medical practitioners in the district should be invited to attend.

Dr. Cecil Shaw gave a short account of Paterson's method of removing papillomata from the larynx in children, and showed the tube spatula and long forceps used. He pointed out the objections to laryngotomy, and referred to two cases in which he had done this operation, and which he had exhibited at the Society. After using the instruments shown on two occasions lately in a case of papilloma in a girl of 13, he had no hesitation in recommending this procedure in preference to laryngotomy.

Mr. Robert Campbell read notes on three cases simulating perforating gastric ulcer, and showed a malignant pyloric tumour removed by operation. The cases simulating gastric ulcer, in all of which the abdomen had been opened, had turned out to be appendicitis in one, adhesions between the liver and pylorus in the second, and acute hæmorrhagic pancreatitis in the third. In speaking on the paper, Mr. Fullerton said that he had had one case similar to Mr. Campbell's third, in which also he had operated, expecting to find a perforated gastric ulcer.

Mr. R. J. Johnstone read a short paper on "Renal Decapsulation for Puerperal Eclampsia." The patient on whom Mr. Johnstone operated was having a fit every 20 minutes by the watch. He gave a third of a grain of morphia, and large amounts of saline by the bowel, and decapsulated one kidney. The urine, which had been about 2 oz. in 24 hours, rose to about 20 oz. Full details of this most interesting case will be published later, as this is the first time that decapsulation has been done for the relief of puerperal eclampsia.

Dr. A. G. Robb read a short paper on the use of Flexner and Jobling's serum in the treatment of cerebro-spinal fever. The Belfast epidemic, running into several hundreds of cases, began early last year, or rather at the end of 1906, and during nine months the mortality in hospital was 70.4, and outside hospital 74.7, figures which correspond closely with those of other epidemics elsewhere. Several different serums were tried during this period, but none had any perceptible effect. From September to December, all cases treated in hospital, 32 in number, were injected with

Flexner and Jobling's serum, and the mortality in this group of cases was 26.6. During the same period about an equal number of cases were treated outside hospital, and, according to the figures supplied by the Medical Officer of Health to Dr. Robb, the mortality among these was 87.5, showing that the type of disease had not altered. The serum was obtained from the Rockefeller Institute of Preventive Medicine in New York. Dr. Robb said that it was too early to draw definite conclusions, but the results so far were encouraging.

Dr. THOS. HOUSTON said that, tested in the Pathological Laboratory at Queen's College, this was the only one of the various serums which Dr. Robb had tried which produced any agglutinating effect. He attributed its apparently greater power partly to the fact that it was not injected subcutaneously, as the others were, but directly into the spinal cord.

GLASGOW NORTHERN MEDICAL SOCIETY.

MEETING HELD TUESDAY, JANUARY 7TH, 1908.

Dr. CAMPBELL MARSHALL in the Chair.

Dr. T. K. MONRO introduced a discussion on the TREATMENT OF CHRONIC RHEUMATOID CONDITIONS.

Dr. MONRO said that rheumatoid arthritis, chronic rheumatic arthritis, rheumatic gout, arthritis deformans, arthritis nodosa, nodosity of the joints, and osteo-arthritis are some of the names that have been applied to a group of joint affections, but for purposes of discussion it would be necessary to distinguish half a dozen types, the first three of which would come under the designation of rheumatoid arthritis and the last three under that of osteo-arthritis.

The first two types involve the smaller joints, such as those of the hand, occasionally the larger joints. The first of these two types is acute, and difficult to distinguish from ordinary acute rheumatism. The second is chronic, and is associated with striking wasting of the inter-osseous muscles of the hand and distortion of the digits. The disease in both types affects the synovial membranes and soft tissues about the joints. The third type affects children before the second dentition, and is associated with enlargement of the lymphatic glands and spleen. It runs a chronic course. The fourth type is the localised osteo-arthritis often confined to a single joint, *e.g.*, the hip, when it may be accompanied by obstinate sciatica. Here the cartilages, bones, and synovial membranes suffer alike. The fifth type consists of Heberden's nodes. The sixth type is constituted by some cases of spondylitis deformans, or rigidity of the spinal column, when this is due to osteo-arthritis. Chronic polyneural rheumatoid arthritis is occasionally due to infection from a septic focus such as an ulcerating pile or pyorrhœa alveolaris. The treatment of such conditions is essential in treatment of the joint affections. Diet in those cases should be generous, both in quantity and quality; further, carbohydrates and fats (cream, butter, and cod liver oil) are useful. Rest is necessary as long as there is pain, and patients often improve very much after long periods in bed. Of drugs guaiacol carbonate, arsenic, and iron are useful. For pain salicylate of soda in small doses, aspirin, and occasionally opiates are good. Locally much relief comes from the application of methyl salicylate under gutta-percha tissue. Tallerman's hot air bath inducing active hyperæmia, and Bier's passively induced hyperæmia may be useful. After the acute symptoms pass off passive movements prevent the formation of adhesions. The waters and baths of Bath, Buxton, Harrogate, etc., are useful in convalescence. The treatment of osteo-arthritis is much the same as that of rheumatoid arthritis, but great care is necessary in the use of passive movements. In chronic articular rheumatism guaiacum and sulphur with iodide of potassium, iron, and arsenic should be used in conjunction with a generous diet. Though the microbic theory of the origin of rheumatoid arthritis is still improved, there are joint affections undoubtedly due to a microbe, notably gonorrhœal rheumatism. Here the important point is to cure the original lesion, and then proceed to neutralise the tendency to fibrous adhesions by the use of iodide of potassium, guaiacum, etc.

A discussion of a general nature followed, taken part in by the President, Dr. John Donald, and Dr. John T. Maclachlan.

Dr. DONALD thought the X-rays might be taken advantage of in the shape of mild local applications round the affected joint.

Dr. MACLACHLAN considered it was not an easy matter to differentiate the various morbid affections, embraced by the term chronic rheumatoid conditions. In his experience he had found the persistent use of iodide of potash with a proteid dietary, in which starchy and saccharine materials were reduced to a minimum, give in some cases satisfactory results.

LIVERPOOL MEDICAL INSTITUTION.

AT the annual meeting, held on January 9th, the following list of officers and members of Council was adopted:—President: *T. H. Bickerton; Vice-Presidents: F. Charles Larkin, R. W. Murray, *Hugh E. Jones, *C. Thurstan Holland; Treasurer: Robert A. Bickersteth; General Secretary: J. E. McDougall; Secretary of Ordinary Meetings: *R. J. M. Buchanan; Secretary of Pathological Meetings: *D. Douglas-Crawford; Librarian: W. B. Warrington; Editor of the "Journal": John Hay; Council: W. N. Clemmey, William Crooke, Charles A. Hill, W. B. Paterson, Thomas Stevenson, Joseph D. Wright, *Frank T. Paul, *John Ambrose Cooke, *Henry Halton, *W. Blair Bell, *Joseph F. Blood, *Hubert Armstrong; Auditors: *G. P. Newbolt and *J. Lloyd Roberts. (Those marked * did not hold the same office last year.)

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 12th, 1908.

THE MODERN TREATMENT OF CONSUMPTION.

THE tuberculin of Koch, T.O., says Prof. Rénon, had been abandoned in France for a long time. It has continued to be used, however, abroad, especially in sanatoriums, where each author has his methods, injecting doses which, in Prof. Rénon's opinion, are too large.

In this country a few attempts have been made to take it up again. M. Guinard notably, has utilised it in the sanatorium at Bligny, but in exceeding small doses. He begins by injecting 1-250 of a milligramme, gradually increased to 1-20 milligramme.

He operates very slowly and at intervals so as to avoid any reaction, rise of temperature, loss of strength, or a sensation of fatigue. M. Guinard thinks that, administered with the above precautions, tuberculin can give good results in apyretic forms and in torpid consumption. I am of the same opinion, and the question has been submitted to the Special Committee on Tuberculosis, but it will take four years at least before we can have a precise idea of the therapeutic value of tuberculin.

Among the other tuberculins that of Denys, of Louvain, has been employed in the sanatoria of Switzerland, Belgium, and the North of France with variable results. At the last Medical Congress M. Stella made a communication in favour of this tuberculin, and showed himself very enthusiastic over this method. But he was opposed by Dr. Béco, of Liège, who asserted that he had studied the tuberculin of Denys for six years in the hospital on over 100 patients without obtaining any satisfactory result that could be attributed to the tuberculin.

Dr. Berauck, of Neufchâtel. has invented a tuberculin, which is much used in Switzerland. M. Bauer reported at the Medical Congress 150 cases of patients treated by this method with good results, and Prof.

Sahli, of Berne, who is a partisan of this tuberculin, said that it should be used in very small progressive doses. The treatment is difficult and long, requiring a large sum of patience and trouble, both on the part of the patient and the physician.

It is only applicable to a limited number of cases, and frequently has to be abandoned.

Such is the so-called specific treatment of tuberculosis by serums and tuberculins, but in reality no specific treatment has yet been found. However, it can be affirmed that every new method, provided it is inoffensive, is sure to give satisfactory results. The old saying, "take the medicine while it cures," expresses an absolute truth. If we were to compare one with the other the results obtained by the different anti-tuberculous treatments, we would find that they all obtained the same percentage of improvement, of cures, of stationary conditions. Any treatment imposed by a medical man who has faith in his therapeutic method develops in his patient the same faith. The patient allows himself to be influenced by the optimism of his doctor, and for a time a real improvement does take place. It is well known that any phthisical patient who changes his treatment or his doctor feels much better for two or three weeks.

Do we possess action on the parasite of tuberculosis? No, not at present, at any rate.

Can we obtain an anti-tuberculous vaccine? No, since our only hope is in the tuberculin of Koch employed according to a new posology not yet established.

Do we possess action on the organism in general? Yes, by making the patient live in air as pure as possible, by repairing the waste of tissue, by recommending substantial food, by stimulating the appetite, and by prescribing an active medical treatment.

The diagnosis of phthisis should be made as early as possible, and for that account should be taken of every sign, hæmoptysis, wasting, loss of strength, etc., that would suggest the existence of tuberculosis in its initial stage.

We found great hopes, at this present time, on ophthalmo-reaction. I tried it on 28 patients in my hospital service; 15 cases gave positive results. Three of these reactions were particularly intense. In one case the conjunctivitis persisted six weeks, a second patient presented a slight keratitis, and a third an interstitial keratitis with iritis, which lasted three weeks. The tuberculin solution I had employed was 1 — 100. Perhaps if I had used a weaker solution such accidents would not have occurred.

In any case, every eye on which the reaction is tried should be treated by an occlusive aseptic dressing, and in case of intense reaction taking place, a drop, three or four times a day, of the following solution should be placed between the eyelids:—

Argyrol, 3 gr.
Water, 2 dr.

The treatment of consumption should not be systematic; it should be adapted to each case on its special merits.

As to the prognosis of phthisis, a great reserve should be observed. Medical men believe too easily in the cure of consumption, which facts do not justify. Tuberculous patients might be divided into three classes: those who are but slightly predisposed to the disease, and who either get well naturally or with a little care. In the second class might be included those who have a more marked predisposition, presenting indisputable clinical lesions, and even fever. These can be cured if they are treated in time with intelligence, devotion and tenacity. But for many of them the cure is not permanent. With a great deal of care an "armistice" of a certain length of time may be obtained, but the enemy is not disarmed, and prepares for a new attack. These patients may seem to be cured, but they drag on an existence different to all others; their life is very fragile. In the third class might be placed those patients who are very much predisposed to the malady, and who present bacilli of a very virulent type in their expectoration. These will not get well, no matter what is done for them. Daremberg says that a third of tuberculous patients begin their malady by the last stage; they are irrevocably condemned.

When, consequently, one is called to express an opinion on the prognosis of the disease, one should not conceal from the family of the patient the extent of the sacrifices to be made in order to obtain a result, for even in the most favourable cases tuberculosis requires two or three years of intelligent, assiduous and devoted treatment.

Coxalgia.

At the last meeting of the Académie de Médecine, Prof. Lannelongue laid down the rules that should be followed in the treatment of coxalgia: Rest in the horizontal position, with continued extension of the limb; apparatus made of plaster or silicate should be proscribed, as they do not correct, in general, vicious attitudes, and compromise the future movements of the limb. At the same time as the continued extension, intra and extra articular injections should be made with substances, such as iodoform, ether, and creosote incorporated with oil:—

Olive oil, 3 oz.
Ether, 1½ oz.
Iodoform, 2 dr.
Creosote, ½ dr.

The ether spreads the iodoform over the whole internal surface of the joint—fungosities, cartilaginous ulcerations, etc. The iodoform arrests the noxious effects of the bacilli, and favours the healing of the tuberculous lesions already produced, while the creosote possesses a sclerosive action. Treated by this method at the outset of the malady, the patients have every chance of being cured.

GERMANY.

Berlin, Jan. 12th, 1908.

At the Hufelandische Gesellschaft Hr. v. Hansemann spoke on

Carcinoma of the Prostate.

It showed many peculiarities. The first preparation shown was from a young man, æt. 21. (?) What was remarkable was that the tumour had reached such a size and set up such manifold disturbances that a diagnosis could be reached from the clinical symptoms alone. The most frequent form was that of very small tumours, in which the prostate did not appear to be enlarged, and was not the seat of any symptoms, nor was it nodular and hard. On the contrary other symptoms made their appearance, which were of a diffuse nature, so that one had no suspicion that the case was one of cancer. Cancers of the prostate were more frequent than had been supposed. In the Virchow Hospital there had been four cases in 400 autopsies. Since that time careful microscopical examination had been made of the prostate with the surprising discovery that the percentage of carcinoma was much higher than had been thought. The speaker believed that 21 per cent. of carcinoma cases had hitherto escaped detection in previous examinations.

The clinical symptoms were dependent on the presence of metastases. Carcinoma of the prostate was often associated with bony metastases, as was first pointed out by Recklinghausen. It was an osteoplastic carcinoma in which bone masses were deposited, in which the spongy bones, and especially the bodies of the vertebræ were eburnated. These bodies of the vertebræ became enlarged, and pressed on the spinal cord so as to set up the symptoms of a myelitis.

It was different in a case of osteosarcoma in which the bone was destroyed, where in the skeleton loculi were found as if they had been punched out with an iron. In the case shown the osteosarcoma was more of a fibrous nature; it started from the bony tissue itself. It was different from a true myeloma. The skeleton of the trunk reminded one of osteomalacia; the softening had been caused, however, by innumerable tumours that had eaten into the bones.

Hr. Stauss had observed a patient whose sufferings had presented the appearance of spinal caries. The autopsy showed, however, that the vertebral column was filled with a number of small carcinomata of sizes from that of a bean to a cherry, which had had a destructive tendency. At the uppermost point of pain, where the speaker had heard a crackling when the patient sat up, there was a dislocation of the vertebra. Along the whole course of the large bronchi a fine yellowish grey mucus was present, which proved to be cancerous.

Hr. v. Hansemann thought the case related was both interesting and typical. He had himself observed several cases of the kind. They almost always went under the name of tuberculosis. Post-mortem examination showed the true nature of the disease. As they were sometimes associated with tuberculosis the diagnosis was difficult. But if tuberculosis broke out in a man over 60 years of age there was mostly a cancer at the back of it.

Sometimes we saw cases of putrid bronchitis, and there it might be that the real cause was carcinoma of the œsophagus. Cancers of the stomach also occasionally gave rise to no symptoms.

Hr. Ewald confirmed the occurrence of such latent carcinomata of the stomach and gullet.

At the Laryngological Society Hr. Alexander showed a female, æt. 20, who had suffered from hoarseness from her earliest childhood. On examination of the larynx both vocal cords were seen to be split in their ligamentous parts into apparently an upper and a lower lip. The deep base of the split showed a gray white. Whether there had been some ulceration at one time followed by epidermisation of the base, instead of cicatricial contraction, it was hard to say. After failure of all kinds of treatment methodical vocal exercises were going to be tried.

Hr. Schoetz said he had shown a somewhat similar case to the society in which, however, there was certainly no ulcerative process, but a paralysis of muscle. It looked like a case of necrosis of epithelium such as was seen after influenza.

Hr. Grabower suggested that aberrant cartilage cells had prevented cicatrisation. Hr. Ed. Meyer thought the condition was a congenital one.

AUSTRIA.

Vienna, Jan. 12th, 1908.

VAGRANT PLEURITIC EXUDATION.

SCHROTTER and Weinberg presented a peculiar case of pleuritic exudation. Three years ago the patient had right-sided pleuritic effusion, which had been aspirated several times with the object of curing the patient, but apparently without effect.

At the present time the fluid is, when the patient is sitting in bed, as high as the angle of the shoulder-blade, the fifth rib in the axilla; but when in the lying posture the fluid in the latter is in the fifth intercostal space. The exudation seems perfectly fluid and mobile. With the Röntgen rays this mobility of the fluid is easily traced, and more clearly when the patient is turned on the left side, when the whole fluid falls towards the mediastinum, leaving the costal surface free. The lung and diaphragm appear healthy, the former expanding on the descent of the diaphragm. Schwarz asked if the fluid had been carefully examined. Weinberg replied that it had a straw colour, although slightly cloudy, with a sp. gravity of 1018; with nitric acid a heavy flocculent deposit was thrown down, and the presumption was formed that tubercle was the basis of the pleuritic effusion.

Pius related a case of pericarditis which he had under his care for some time that acted in a similar manner, pressing on the lower lobe of the lung, and producing similar infiltration in the pleura which closely simulated pleuritis.

ARSENIC AND AUTOLYSIS.

Hess and Saxl gave an elaborate description of their investigations and experiments with arsenic and organic matter. When arsenious acid was added to organic matter and placed in the incubator it remained longer sterile and better preserved than with any other antiseptic, such as tolu oil water. This observation and the knowledge of preserving bodies inspired the idea that the autolysis was checked by the arsenious acid by some specific action.

To prove this it was necessary to take a portion of the liver of a newly-killed guinea-pig and weigh it into several equal parts, each placed in test tubes, with equal quantities of sodium chloride solution. The liver was broken up into very fine divisions, and to one of these test tubes was added 5 ctms. of arsenious acid solution containing 1.5 in 1,000. The other test tubes had 2 ctms. of tolu oil added. The test tubes were all closed, well shaken, and placed in an incubator, and after one, two, five and eight days carefully examined to see that sterility was produced. The post-mortem exhaustion of the albumen or autolysis was accomplished according to Schliesinger's method, which was entirely checked by the presence of arsenious matter, but the other test tubes autolysed as in the normal organ. It was found later, however, that the arsenious test tube autolysed also, which proves that the arsenious acid is only temporary and not permanent, thus neither destroying the cells nor injuring the albumen, but only the ferment, as the proteolysis ultimately proceeded unhindered to a normal finish. Further experiments of this autolytic ferment were made on trypsin, pepsin, and erepsin with large quantities of arsenious acid, but the results were negative; hence they concluded that autoxyl and cacodyl checked the hepatic autolysis. There is only another substance which has the same specific action on this autolytic ferment—viz., hydrochlorate of quinine, both of them may be termed anti-protozoic, or economisers of albumen. This may form a rational explanation for the use of arsenic in the case of tumours or excrescent growths in opposition to phosphorus, which encourages or favours autolysis. There is still another anomaly to be accounted for in the final product of arsenic and phosphorus, both of which produce a fatty condition of the cell and require further elucidation. Reicher thought these results were in opposition to Ascoli's, but Saxl said that Ascoli used arseno-tri-sulphide, which favoured the autolysis. Schrötter thought the use of arsenic in the growth of malignant neoplasms was very limited. Téleky recommended subcutaneous injections of arsenic, as it was more readily absorbed by the swollen lymphatic glands and more effectual in its action.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

EDINBURGH.

RETIREMENT OF DR. CLOUSTON.—Dr. T. S. Clouston has resigned his position as Physician-Superintendent of the Royal Asylum, Edinburgh. His retirement is an event of great importance, not only to the institution he has done so much to develop, but to the interests and reputation of all matters connected with lunacy in Scotland. Dr. Clouston's whole medical career of nearly half a century has been devoted to work among the insane. He acted as assistant physician at Morningside Asylum under Dr. Skae from 1860 to 1863, when he was appointed Superintendent of the Cumberland and Westmoreland Asylum, Carlisle, and continued in that office for 10 years, until in 1873 he succeeded Dr. Skae as head of Morningside Asylum. He at once proceeded to throw himself into the task of reconstructing the asylum, and as he himself phrases it, the building "has seldom been out of the mortar pot" since. However, the process of rebuilding culminated some 15 years ago in the opening of Craig House, which provides accommodation for the higher paying class of private patients, and in respect of situation and construction, is probably unrivalled by any similar institution. During the past 35 years £180,000 has been expended on building. At the date of Dr. Clouston's appointment the annual income from the better class of private patients was £8,600; at the present time it is £35,000 a year. The great prosperity of the asylum has depended not only on Dr. Clouston's reputation as an administrator, but on his remarkable personality, and there is no doubt that his really immense success in the treatment of the mentally sick, as well as his very extensive consulting practice, were due to a large degree to the faculty he has of throwing himself heart and soul into the business of the moment, and the confidence he inspires both in patients and friends. As the University Lecturer on Psychiatry the same impressive personality had full scope, and his lectures were invariably popular, well attended, and full of practical hints. His lectures were mostly clinical, and he utilised the material in the asylum to the best advantage. Dr. Clouston's retirement from active work at Morningside does not, we understand, involve his withdrawal from this post. His activities have been multifarious, and his opinions on medical and other matters of public interest have always commanded the respectful attention of his fellow citizens. He has a remarkable faculty of educating and leading public opinion, and is a lucid exponent of the views which he wishes to promulgate. Greatly therefore as his loss will be felt at the Morningside Asylum, his fellow citizens have the satisfaction of learning that he is still resident in their midst, and that his public spirited assistance and advice will still be at their disposal.

Edinburgh Royal Infirmary.—At the annual meeting of the court of contributors, held on January 6th, for the purpose of considering the annual report of the institution, the Chairman referred to the question of providing wards for the treatment of mental disease. The managers, he said, had a scheme prepared, which they were ready to go on with as soon as funds permitted. The addition of such a department meant a cost of between £60 and £70 per patient, and an increased cost of £1,500 per annum. Mr. Mackenzie suggested that the managers ought to look into the matter of the use of the institution by persons who were not sick poor. He suggested that a charge might be made to people who were able to pay it in return for the advice they received.

Dr. G. E. Cartwright-Wood, a son of ex-Provost Wood, Portobello, has been appointed bacteriologist to the Metropolitan Asylums Board, Belmont. He graduated M.B., C.M.M. 1875, and B.Sc. in natural science in 1887. He studied experimental pathology in Edinburgh and Germany, and chemistry at Wiesbaden. Later he worked under Hueppe, of Prague, and has made investigations in various branches of bacteriology. He recently held the appointment of bacteriologist to the laboratories of the Royal Colleges of Physicians and Surgeons in London.

GLASGOW.

Complimentary Dinner to Sir George Beatson, K.C.B., M.D.—A large turn-out of members of the medical profession assembled in the Grosvenor Restaurant, Glasgow, on January 10th last, to do honour to Sir George Beatson, in recognition of the high distinction conferred on him by His Majesty the King. Sir George recently had conferred upon him the K.C.B., in recognition of his eminence as a Surgeon to the Western Infirmary, the Cancer Hospital, and his pre-eminent services to St. Andrew's Ambulance Association, of which he was one of the founders. This Association has now granted certificates of proficiency to 47,000 pupils. Sir George, as Chairman of the Council, was chiefly instrumental in the equipment and despatch of the Scottish National Red Cross Hospital to the South African War. In 1888 Sir George originated the Volunteer Medical Staff Corps in Glasgow, and now commands five companies in the Glasgow Division of the Royal Army Medical Reserve Corps. Sir George is at present engaged in the equipment of the Queen's Victoria Hospital for the Sons of Sailors and Soldiers. His services have likewise been requisitioned in connection with the new Territorial force. His Grace the Duke of Montrose was in the chair, and proposed Sir George's health, recalling his public services in graceful terms. Sir John Ure Primrose proposed the toast of "The Medical Profession," responded to by Professor Sir Thomas McAllen Anderson and Professor Chiene, Edinburgh. Among those present were Sir Hector Cameron, Professor A. R. Simpson, Professor Glaister, Dr. Byrom Bramwell, Dr. Allan Jamieson, Dr. D. J. Macintosh, M.V.O., Dr. J. Mantone Thom, the respective Medical Superintendents of the Western and Royal Infirmaries, Professor Cunningham, Dr. Underhill, and many other well-known medical men and citizens of the west. Dr. Robert T. Halliday had charge of the arrangements.

Infectious Disease in Glasgow.—Owing to the prevalence of measles, the Glasgow and Govan School Boards have extended the Christmas holiday from the usual period of ten days to three weeks. A considerable outbreak of typhoid fever in the fashionable residential quarters of the city has also caused some disquiet. The first cases were notified in Christmas week, and since then others have occurred in rapid succession. The epidemic has been traced to an infected milk supply from a farm on the outskirts of the city. A young woman was found to be lying ill there with what was at first suspected to be pneumonia, but afterwards was found to be enteric fever. The Medical Officer of the City has taken every precaution, but it is feared that other cases may occur, as the incubation period of the disease has not yet been passed.

BELFAST.

Public Health.—The death-rate in Belfast continues abnormally and disgracefully high, having been 28 last week. That there is no great amount of infectious disease is shown by the fact that there are only 45 patients in Purdysburn Fever Hospital, including 9 typhus and 8 cerebro-spinal fever. The question of opening dispensaries for tuberculosis having been raised in the Corporation, the Lord Mayor (the Earl of Shaftesbury) has suggested that it might be more desirable to enter into a supplemental arrangement with the authorities of the Forster Green Hospital for Consumption for working their dispensary, and so effecting a considerable saving to the Corporation. The arrangement already made between the Corporation and the hospital is for the enlargement of the hospital and the treatment in it of a certain number of patients sent by the Corporation. The Lord Mayor and the Chairman of the Public Health Committee for the time being are to represent the Corporation on the Board of the Forster Green Hospital. Lord Shaftesbury's suggestion will no doubt receive favourable consideration, for any proposal to open new dispensaries would meet with considerable opposition. The poor general practitioner has already to contend with sufficiently numerous institutions supplying free treatment without the Corporation adding to their number. On the other hand, the public has been so stirred up by the recent Tuberculosis Exhibition that it is anxious at any cost to do something, and in a mood to do something foolish rather than nothing at all.

LETTERS TO THE EDITOR.

THE *STAR* AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—As your correspondent, "A Surrey Doctor," feels a difficulty about writing to the *Star*, perhaps you will extend to him the courtesy of allowing him to read in your columns the replies to the questions he puts to me.

He asks:—(1) How does the Editor of the *Star* account for the fact that, with the exception of the medical anti-vaccinationists, the whole of the profession take care that their own children are vaccinated? The answer is the familiar one of Dr. Johnson—"Ignorance, sir; sheer ignorance." The exceptions—the medical anti-vaccinationists—are not so "extremely rare" as "A Surrey Doctor" supposes; but they have looked into the question, and have learned so much that they cannot treat their children in the way the rest of the profession treats theirs.

(2) Does the Editor of the *Star* believe that a man, on becoming a doctor, is converted into an anti-human monster, capable of sacrificing his own children in a vile conspiracy for paltry, sordid gain? The answer is "No." Their ignorance sufficiently explains the vaccination of their own children, but will not explain the vaccination of other people's children (by certain

public vaccinators) at ages of from one day to a week in the last quarter before the reduced fees came into operation. Is "A Surrey Doctor" familiar with Emeritus-Professor Crookshank's confessions in his "History and Pathology of Vaccination"? In the preface to this work Mr. Crookshank said his personal investigations had been forced upon him because he "gradually became so deeply impressed with the small amount of knowledge possessed by practitioners concerning cow-pox and other sources of vaccine lymph, and with the conflicting teachings and opinions of leading authorities in both the medical and veterinary professions." At the end of the book stands this perpetual challenge to the profession :—"Unfortunately, a belief in the efficacy of vaccination has been so enforced in the education of the medical practitioner that it is hardly probable that the futility of the practice will be generally acknowledged in our generation, although nothing would redound more to the credit of the profession and give evidence of the advance made in pathology and sanitary science."

(3) Does the Editor of the *Star* not see that if the profession have "those they love" vaccinated, it must be because they, as an army of skilled witnesses, are satisfied that at least vaccination is a perfectly harmless operation? The answer is "No." The "skilled witnesses" appear to be on the other side. What means the doctors may have for ensuring the harmlessness of the operation on their own children he does not know; but the evidence that vaccination is not perfectly harmless to all children is overwhelming; and, as recently as last October, your contemporary the *Hospital* said :—"It is of the very essence of vaccination that it is 'prejudicial to the health of the child.' Everyone knows that it is the intentional transmission of a disease," etc. What wise man will assert that the intentional transmission of a disease can be guaranteed in all cases to be "perfectly harmless"?

But all these questions are irrelevant to the contention of the *Star*. Doctors may hold any opinion they choose about vaccination. The *Star* did not complain of their vaccinating their own children, or the children of consenting parents. It objected to their being empowered to thrust it upon those who deny its efficacy, and to their having a pecuniary interest in this compulsion.

I am, Sir, yours truly,
THE EDITOR OF THE "STAR."

INHERITED SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Many phases of the subject handled so nonchalantly in Mr. Clement Lucas's address deserve careful attention. The point raised by your correspondent last week above the signature of "An Average Practitioner," is specially worthy of illumination from many sides. It seems a pity that your correspondent, who is evidently a shrewd observer speaking on the basis of such clinical experience, should not add the authority of his real name. Your correspondent states his experience shows that "a syphilitic father, whether he has been treated or not, seldom, if ever, begets tainted offspring after disappearance of secondary symptoms, say, two years after primary infection, and that after four years the danger is twice as remote." As *treated* cases are dealt with later, we may assume that "Average Practitioner" is speaking of untreated syphilis in the father. His statement, therefore, that such fathers are unlikely to beget unhealthy children is somewhat startling. If this be the case, why is it not recognised by the authorities upon syphilis, who have studied the subject on a basis of accumulated and exact data? So far I can recall no such writer who has laid down any general proposition such as that of your correspondent. That untreated syphilis tends to cure itself is well recognised, but that is a very different thing. It seems to me probable that nowadays very few cases of syphilis escape treatment of some kind, and in many cases the chief aim of the sufferer is to avoid any attention being drawn either to the malady or to its cure. That very fact constitutes a serious fallacy at the outset of any attempt to investigate the proportion of hereditary syphilis found in the offspring of an untreated syphilitic father. The settlement of this point is of importance, and many of your readers must have valuable experiences to relate, could they be induced to come forward. Should "Average Practitioner's" theory be accepted as it stands, it would obviously tend to excuse slackness in the treatment of an essentially curable condition both on the part of the patient and of the practitioner.

I am, Sir, yours truly,
DAVID WALSH.

London, W., January 13th, 1908.

OBITUARY.

JOHN ROBERTS, J.P., M.D.ABER., L.S.A.

CHESTER has suffered a great loss by the death of Dr. John Roberts, J.P., which took place on January 9th. Dr. Roberts, who was 68 years of age, had been in failing health for some time. Educated at Glasgow and Aberdeen, Dr. Roberts had been in practice in Chester for 40 years. He attained a great practice, which extended far over the Welsh border. He was medical officer for more than 30 years to the Victoria Lodge of Oddfellows, which numbers more than 1,000 members. He devoted himself to the study of skin diseases, and gained a more than local reputation in this branch of his beneficent calling. He adopted all the most up-to-date remedies, and electrical and other apparatus for treatment of malignant skin affections, including the Finsen light and Röntgen rays. Some 12 or 14 years ago he started a skin dispensary on the Walls, and there hundreds of afflicted persons received the benefit of his skilled attention free. Dr. Roberts came of Welsh parents, and no more enthusiastic son of Cambria ever lived. Anything of a deserving description associated with Wales, whether political, social, or religious, had in him a zealous, patriotic, and generous supporter. He was one of the oldest members of the Town Council, having been elected so far back as November 22nd, 1886. Three years later he was made Sheriff, and he occupied the position of Mayor with much acceptance to all classes and creeds in 1902, being elected alderman at the expiry of his term of office. He rendered invaluable service to the city as a member of the Public Health Committee, of which for many years he was chairman. He held the position of J.P. for the city since November 4th, 1902, and was very assiduous in the discharge of his magisterial duties. Dr. Roberts was a Liberal in politics, but he was of too kindly and unobtrusive a nature to undertake the more public and controversial side of political life.

SPECIAL ARTICLES.

THE DUBLIN MOTOR SHOW.

NOW that motor-cars are entering so largely into the daily work of medical men, no apologies are necessary for discussion in a medical journal of the different improvements in motor-cars as shown at the great annual shows.

The second annual show promoted by the Irish Automobile Club was opened by the Lord Lieutenant at Ball's Bridge on January 4th, and was continued during the past week. Although to a great extent hampered by bad weather, it has proved a great success, and will do much to add to the ever-increasing body of Irish motorists. Although it may seem invidious to say so, it must be admitted that, to medical men as a class, small cars especially appeal, and therefore it is with them that we are here concerned. The important question to nine out of every ten country practitioners is not whether six cylinders are better than four, but rather whether one or two, or even four, cylinders, with a car attached, can convey their owner about his business in a more satisfactory and rapid manner than, and as economically as, a horse and trap. For this reason every improvement in small cars is of vital importance to the hard-worked medical man.

Now by small cars we mean cars up to 10-12 h.p., and perhaps their makers will excuse us if we arbitrarily divide them into two classes—the cheap small car and the more expensive car. The cheap small car may be said to cost anything up to £250, and the more expensive small car from £250 to £350. Perhaps the most prominent members of the former class which were exhibited in Dublin were the Rover, the Chambers, the Ford, the Reo, the Cadillac, the Starling, the Humber, the Swift, and the Shamrock. Of these cars, the Rover, the Swift, and the Humber are, we fancy, the best known. The Rover Company showed their well-known 6 h.p. and 8 h.p. cars, complete ready for delivery. Both are single-cylinder cars, the smaller costing £130 and the larger £210. The Dublin agency is held by Mr. Willkinson, at 23, Westmorland Street, and the larger model especially has given the greatest satisfaction to medical owners. The Swift 10-12 h.p., at £225, has two cylinders, and so is easier-running. It is remarkable for its well-arranged under-frame, and is a very smart car. The Humbers are referred to by a motor contemporary as being surpassed by none at Ball's Bridge. Two of the smaller models were shown, a 10-12 h.p. Coventry Humber two-seated doctor's car, and a 10-12 h.p. Coventry Rotund. The bodywork of these cars is excellent, and their general character is high, but we should have liked to have had the opportunity of examining a chassis. The price of the Coventry Humber was £250, and it has four cylinders. The Chambers car is an all-Irish car, built in Belfast. It possesses many unusual features, not the least valuable of which is the extreme accessibility of its gears and cylinders. It is specially intended for country owners, who have to keep it in order with a minimum of professional assistance. The 10 h.p. model costs £232. The 10 h.p. Cadillac also possesses several unusual features, one of which is a horizontal engine. It is an American two-cylinder car, and costs £231. The Ford is remarkable for its size and price. It is a four-cylinder 15-18 h.p. car, and costs £175. It is made in the States. The Reo and the Starling are also low-priced cars. Both are single-cylinder, the former as a 10 h.p. costing £175, and the latter as an 8 h.p. £150. The Starling was also shown as a 10 h.p. car costing £200. Altogether the number and variety of cars costing below £250 were considerable.

The list of small cars costing from £250 to £350 was not a long one, and perhaps it is a misnomer to call some of them small. We have done so because their horse-power does not exceed 10-12. The two most important cars of this class were the De Dion and the Siddeley. The former was shown in its celebrated 8 h.p. single cylinder model, costing, with a four-seated body, £273, the latter as a two-cylinder 10 h.p. landaulette. This model, which was beautifully finished, is exceptionally well suited for town work, and should be both economical and reliable. We think it is a pity that makers do not show more of the relatively expensive small cars, as there are many excellent makes on the market. One of the best of these, the 10-12 h.p. Clement-Talbot two-cylinder car at £340, which for reliability and for general excellence of workmanship is unbeaten, was not exhibited. The 10 h.p. De Dion, with two cylinders, at £334, is also a first-class model.

In the gallery round the Main Hall the usual collection of motor accessories was shown. Of these many exhibits, perhaps the most interesting were the new Dunlop detachable wheel; the "Sir Oliver Lodge ignition," a most ingenious arrangement in which Leyden jars are used to increase the intensity of the firing spark; the Rushmore head-lights, the generator for which seems to be a long way ahead of its rivals; the E.I.C. generator for lighting the car lamps; and the H.F. vulcaniser, a piece of apparatus which is almost essential to country motorists.

Space prevents our noticing the many other points of interest in the Show.

Dr. Merling, of Berlin, was performing a serious operation on a child, and fell dead from heart disease. The child unfortunately died in the confusion that followed.

REVIEWS OF BOOKS.

THE HAIR AND ITS DISEASE (*a*).

Dr. Walsh's book on "The Hair and Its Diseases" having survived the wave of infantile mortality which engulfs most medical books, has now attained to the puberty stage of a second edition. Its teaching, therefore, was needed. There are a few outlying quarters of the body which still enjoy almost exclusively the attentions of the quack, this being particularly the case with epiblastic modifications such as the hair and the nails. Considering that medicine cures a great deal *de minimis*, as often significant *de maximis*, it cannot be too strongly insisted by medical practitioners that the claims of the hairdresser to treat the hair, or the manicurist to treat hammer-toe, are either ignorant or fraudulent, or both. This book by Dr. Walsh should do much towards accentuating the difference between skilled and unskilled treatment in affections of the hair, and also in pointing out the dangers as well as the pitfalls of the latter. For the hair, being an integral part of the organism, is affected by general conditions of ill-health, as well as by special local circumstances, and the diagnosis, as well as the treatment, can only be undertaken by a man of all-round knowledge and training. We heartily endorse the expression of opinion on p. 6 that "with hair . . . the best all-round physician is the best man to consult." To such a physician this treatise—brief, handy, and businesslike as it is—should prove most serviceable, for all the points he is likely to desire information about will be found succinctly dealt with under the various headings. Indeed, the strong features of the work, to our mind, are the methods of classification and of clear description, which enable the whole subject to be treated of in less than 100 clearly-printed pages, without necessitating the omission of anything material. We note that Dr. Walsh takes a strong view about the bacterial origin of seborrhœa, and insists correspondingly strongly on antiseptic remedies in its treatment. We consider his plan for the treatment of ringworm—viz., rubbing the shaved scalp over with pure turpentine for three or four minutes, washing with carbolic soap, drying, and painting with tincture of iodine, every night for a fortnight, to be unnecessarily severe for any but extensive and rebellious cases; if it were only intended for such cases the fact should have been stated. On page 23 the author tells us, "Such a pitch of perfection" (*i.e.*, as obtains in surgical disinfection) "is neither necessary nor desirable at the barber's," and lower down on the same page he says, "The main thing to be aimed at by the barber is cleanliness—that is to say, in the surgical and not in the ordinary sense of the word."

But, in spite of one or two minor inconsistencies, we feel sure that Dr. Walsh's book will prove exceedingly useful to those practitioners who have hitherto given but little attention to the subject, or have devoted too much attention of the wrong kind.

NAUHEIM TREATMENT OF CARDIAC AFFECTIONS (*a*).

Nauheim, thanks to the ingenuity and enterprise of the Brothers Schott, has won world-wide renown as a centre for the treatment of chronic cardiac disease. Dr. Thorne-Thorne has done well to make known to British practitioners the means whereby the "Schott" exercises and the "Nauheim" baths can be advantageously employed in this country. The fact that his *brochure* has passed into its second edition is evidence that his work has been appreciated. In the present issue the action and administration of both exercises and baths are explicitly detailed, and directions are given for the judicious selection of cases. Clinical particulars are given of patients who have benefited. The chief feature and special value of the manual will be

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(a) "The Hair and its Diseases." By David Walsh, M.D.Edin. Senior Physician Western Skin Hospital, and Physician Kensington General Hospital. Second Edition. London: Baillière, Tindall and Cox.

(*a*) "A Practical Guide to the administration of the Nauheim Treatment of Caronic Diseases of the Heart in England." By Leslie, Thorne-Thorne, M.D., B.S.Durham, M.R.C.S.Eng., L.R.C.P.Lond. Second edition. Pp. vi. 75. London: Baillière, Tindall and Cox. 1906. Price 3s. 6d. net.

found in the excellent series of 28 photographs illustrating the various exercises employed in carrying out the "Schott" exercises. The work will be of practical assistance to many practitioners.

INDEX OF TREATMENT (*a*).

LIVING, as we do, in a tabloid age, indices, ready-reference lists, and dextrinised literary gruel are a necessity of existence, and it is a tribute to the ingenuity of medical authors that they find so many different media through which to supply the needs of their brethren. For ourselves, we confess to a leaning towards the old type of book produced by one master-mind, but it is a fact which must be faced that only a Napoleon of medicine could write single-handed a full, first-hand treatise on the whole medical, surgical, and gynæcological treatment such as that which lies before us. The editors, Dr. Robert Hutchinson and Mr. Stansfield Collier, have secured a good serviceable staff of coadjutors, many of them well-known writers on the subjects they set forth; others—a good proportion—belonging to the younger generation. It is noticeable also that the choice has been pretty catholic, and at a glance there seem to be almost as many contributions from the North as from the South of the Tweed. It was certainly ambitious to hope to compress into 850 pages the whole of treatment, even when, as is here the case, only the proceedings found most successful by each writer are given; but the attempt has proved a success. Everything, except operative details and the management of labour, have been given, and the space allotted is generally sufficient for a fairly adequate presentation of each subject. Naturally, the articles vary much in merit, but the general level is certainly high. It is admittedly difficult to avoid padding, as it is necessary to do in a somewhat condensed work such as this, and yet to be explicit. It thus often happens in the shorter articles that the writers are obliged to lay down a number of cut-and-dried dogmatic rules which can only apply in practice to a certain proportion of cases, but even in some of these articles there is found a good deal of redundance in non-essentials, side by side with parsimony in essentials, and we cannot say that the only offenders are the less practised writers. But, taken as a whole, we think the work a very valuable one, and we have no doubt it will be popular, for it will fill a particular niche which we do not remember to have had an occupant before. It is comprehensive, handy, and accurate; the alphabetical arrangement of subjects and the index at the end make reference easy; and the size and get-up are conducive to pleasant handling. We congratulate both editors and contributors upon having added to medical literature a useful and comprehensive work, which will take its place among the more lasting and solid additions to medical literature.

MEDICAL ETHICS (*b*).

THE man-in-the-street counts matters of "medical etiquette" as "past finding out," and, in spite of the golden rule to direct life's procedure, the fact that Professor Saundby's admirable little "guide" has reached a second edition goes far to demonstrate that even in the realm of medical ethics, exposition, by precept and example, is not uncalled for, and may at least satisfy curiosity, if even it does not direct or rectify conduct. Dr. Saundby has entered where angels might fear to tread, but he has trod the thorny and treacherous path with discerning care and discriminating judgment, and although there are points on which doubtless many will differ from him, and although some may consider his work not altogether guiltless of certain errors of commission rather than blamable from sins of omission, yet the best opinion will, we venture to think, attest that the work is marked by a sound sense of justice, clear knowledge of both the needs and the difficulties of medical practice, and a sympathy with the practitioner as well as a high ideal for the profession of medicine. The work is, as far as we know, unique, and although, of course, written as a personal expression of opinion, is likely to attain an authoritative position as formulating a more or less definite code governing professional opinion and action in the numerous intricate and perplexing problems, from some of which, at least, no practitioner of the healing art can expect to escape. Dr. Saundby's work is one which should be within reach of every practitioner, and will be of particular value and service to those recently qualified.

HYGIENE AND PUBLIC HEALTH (*a*).

SLIGHTLY changed in shape but approximately the same in bulk this, the third edition of Dr. Parke's standard work, has been carefully revised and brought up-to-date. Students of State medicine have indeed much to be thankful for. When the diploma in public health was established the only available work was the Parke-Chaumont treatise on military hygiene, and this, though a splendid achievement in view of the then undeveloped science of public health, left much to be laboriously gleaned from Government reports, Blue Books, and similar publications in which the information had to be perseveringly winnowed. Now, thanks to extended experience and improved statistical methods, the subject has been boiled down and brought within manageable compass. A work of this sort obviously does not exhaust the subject. The student will find it necessary to supplement the information therein contained in many points, but this is inherent to the comprehensive and often highly technical nature of the subject which moreover comprises matter only to be learned from practical work, within and without the laboratory. The work is liberally illustrated and beautifully printed on opaque (non-glossy) paper. It is certain to maintain its popularity with students and practitioners.

INTERNATIONAL CLINICS (*b*).

THE present volume of this well-known quarterly contains a number of practical clinical papers dealing with a variety of subjects, most of which are of interest to the practising physician and surgeon. In the section devoted to gynæcology the first paper deals with the use of collargol in puerperal injections. The writer reviews the history of the use of the drug in septic conditions, and after enumerating the different methods of application describes his own technic of intravenous administration. He prefers to make use of a 1 per cent. solution, injecting about 10 c.c. as a dose, and claims to have had remarkable success. As, however, no account of his cases is given it is impossible to form any independent judgment as to the success he has achieved. The second paper in the same section is on the subject of "Atopomenorrhœa," or vicarious menstruation. The writers have reviewed the literature dealing with the subject, and after eliminating doubtful cases, show that there is sufficient evidence to contravert Bland Sutton's dictum that the existence of such a condition is merely an exploded superstition. The ophthalmological section contains an important paper by Thomson and Buchanan on "Ocular Birth Injury," which is well worthy of perusal, while another short paper on the simple subject of how to turn back the upper eyelid will be read with profit by many. To the surgical section Dr. Saret contributes an article on "The Surgery of the Blood Vessels"; Dr. Loeb one on "The Inoculability of Tumours and the Endemic Occurrence of Cancer"; and Dr. Vaughan a paper on "Inflammation of the Gall Bladder and Gall Ducts." The sections on therapeutics, medicine, and genito-urinary diseases also contain several interesting papers, which space forbids us to enumerate in detail.

(*a*) "An Index of Treatment by Various Writers." Edited by Robert Hutchinson, M.D., F R.C.P., Physician to the London Hospital, and H. Stansfield Collier, F.R.C.S., Surgeon to St Mary's Hospital. Bristol: John Wright and Co. 1907. Price 21s. net.

(*b*) "Medical Ethics: A Guide to Professional Conduct." By Robert Saundby, M.D.Edin., Hon. LL.D., Hon. M.Sc., F.R.C.P., Professor of Medicine in the University of Birmingham Second edition, enlarged and rewritten. Pp. 144. London: Charles Griffin and Company, Limited. 1907.

(*a*) "Hygiene and Public Health." By Louis C. Parkes, M.D., D.P.H. Lond., Consulting Sanitary Adviser to H.M. Office of Works, &c., &c., and H. K. Kenwood, M.B.Edin., D.P.H.Lond., Professor of Hygiene and Public Health at University College Hospital, &c. Third edition. Price 10s. 6d. net.

(*b*) "International Clinics." Vol. iii. Seventeenth Series. Philadelphia and London: J. B. Lippincott and Co. 1907.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Hyperæmia in the Treatment of Tuberculosis of the Peritoneum.—Hertzler (*Surg. Gynæcol. and Obstetrics*, December, 1907).—As a result of a series of experiments conducted on mice, rats, and guinea-pigs, the writer makes the following statements: (1) The result of opening the abdomen is a hyperæmia of the peritoneum and sub-peritoneal tissues, due to the lessening of pressure from without. (2) Hyperæmia has been found of use in tuberculosis elsewhere, and by analogy we may be warranted in assuming the same factor as active in the treatment of tuberculosis in the peritoneum. With these two facts in mind it seems that this is the factor underlying improvement by opening the abdomen in some forms of peritoneal tuberculosis. This assumption finds a clinical support in the fact that it is only the type with exudation that is so benefited. This is easily explained on this theory, for manifestly in the hyperplastic types the vessels cannot dilate to any considerable extent, therefore the operation can be of no use. If this view be correct, the benefit obtained from a single treatment would be much enhanced by a repetition of it. This can be obtained by leaving a silver tube with a flange within the peritoneal cavity, so that air may be admitted into the abdominal cavity at intervals. By this means repeated engorgements can be obtained, just as in the case of treatment of joints, without the danger or inconvenience of repeated laparotomies.

F.

Treatment of Mastitis with Breast Suction.—Zachorios (*Amer. Jour. Obst.*, October, 1907).—The author believes that at the beginning of a case of mastitis this treatment is a sovereign remedy. Only failure of the technique, or beginning the treatment too late, will give unsatisfactory results. In cases, after abscess formation has taken place, no benefit will be received. The method enables the mother to continue nursing her child, while under the old system it was necessary to stop nursing, and on recovery the milk was gone from the breast. Under this treatment lactation is rather a benefit to the mother. The best method of applying the treatment is to begin as soon as there is any rise of temperature, and give three suctions daily of half an hour each. After the temperature has fallen and inflammation disappeared suction is stopped, treatment being needed for two or three days at most. When by the third day the temperature has not fallen to normal we may expect abscess formation. The bell glasses should be large enough to entirely cover the gland, and should not give any pain. In thin patients a little air may get under the bell, and this will give pain, so that some pressure may be needed to keep the bell in contact with the thorax. The bell must be filled gradually with air at the end of the treatment. The treatment should never be put into the patient's own hand to execute.

F.

Deferred Operation for Ruptured Ectopic Gestation.—Simpson (*Surg. Gynæcol. and Obst.*, November, 1907) considers that the teaching of immediate operative interference—no matter how collapsed the patient may be—is most unfortunate, and says facts do not warrant such conclusions. If a woman with a ruptured tubal gestation is sure to bleed to death then an operation is called for at once, but the writer maintains that only a small percentage of ruptured ectopic gestations end in this way. He quotes authorities to show that primary hæmorrhage from the stomach, intestines, lungs, or uterus may be severe, but rarely proves fatal, and he maintains that the same holds good when the hæmorrhage is from a ruptured ectopic gestation. He considers that operation should be at an elective period and under favourable conditions. The elective periods are before rupture, or if rupture has occurred, within as short a time as the most favourable conditions demanded for other elective operations, can be had. The time may be at once when there is little depression, or at any time within several weeks if there has been great collapse. The expectant treatment he adopts is absolute rest in one position without any voluntary movements, and avoidance of examination. He gives small doses of morphia to ensure rest, and gradually increases the fluid in the blood vessels by repeated injections of normal saline solution into a vein. Small doses of adrenalin chloride are given with the injections, and strychnine, camphor and digitalis are administered.

F.

Report of a Case of Ovarian Cyst with Twisted Pedicle, Complicating Pregnancy and Labour (*Surgery, Gynæcology, and Obstetrics*, December, 1907).—Edward P. Davis describes a case of this nature which came under his care in the Jefferson Maternity. The patient, æt. 32, was in her third pregnancy. Her first confinement had been terminated by forceps, the child dying soon after birth. The second pregnancy likewise necessitated forceps to complete delivery, the child succumbing to birth pressure. Becoming pregnant for the third time the patient and her husband expressed a great desire to have a living child, and written permission was obtained to deliver the patient by any method which seemed most likely to save her life and that of her child. The pelvic measurements were as follows:—Inter-spinous, 26.5 cms.; inter-coxal, 27 cms.; inter-trochanteric, 30 cms.; right diagonal, 22 cms.; left diagonal, 21 cms.; external conjugate, 18 cms.; circumference, 82 cms. On examination, the abdomen was found abnormal in contour, the back of the child towards the left, the head not fixed, and a distinct fullness upon the right side. What this was could not be made out, the patient being in labour and the contractions good. The head was found to lie transversely at the brim and not engaged, by vaginal examination. It was decided to perform cœliohysterotomy. On opening the abdomen difficulty was experienced in turning out the uterus, but eventually this was done, and a tumour, which proved to be the right ovary having undergone cystic degeneration, turned out also. The uterus was opened, and a 5lb. 15oz. child extracted alive and vigorous. The uterus was then closed, and the cystic right ovary was clamped off and removed—it was as large as a full term fœtal head. The pedicle was found to be twisted on itself three times from right to left. It was very congested, but not gangrenous. The abdomen was closed without drainage, and the mother and child made an uncomplicated recovery. Dr. Davis points out the following points: The tendency for ovarian cysts to twist their pedicle during pregnancy, for which there seems no adequate explanation. That efforts at a delivery by the vagina are most dangerous, as manipulation most frequently bursts the tumour, giving rise to peritonitis and death. He considers the patient owes her life to the method of delivery, and that wherever it is possible to diagnose the presence of an abdominal or pelvic tumour complicating pregnancy, delivery by abdominal section is the safest procedure. Furthermore, that unless there is distinct evidence of pus or gangrene, the abdomen should be closed without drainage.

H.

Removal of the Placenta.—Hofmeier (*Berliner Klin., Wochensch*, 1907, Nr. 12) agrees with Ahlfeld that the placental stage should be treated altogether expectantly. If there should be hæmorrhage, the first thing to try is expression by Credé's method. In order to measure the amount of blood which is being lost, a clean vessel should be put under the woman immediately after the child has been delivered. If the amount of blood lost exceeds one litre, and attempts at expression even under an anæsthetic fail, the placenta should be manually removed. Before this is done the vagina should be thoroughly soaped, and washed out with lysol or lysoform. The hand of the operator should be covered with a sterile rubber glove. The separation of the placenta is sometimes rendered very difficult by dense adhesions between it and the uterine wall. The author regards this as being due either to a complete atrophy of the decidua basalis or to the deep insertion of the chorionic villi into the uterine wall. It may be difficult to recognise whether the placenta is complete, not only in those cases where dense adhesions have been present, but also when the separation has been very easy, or even when the third stage has apparently been quite normal. If one is uncertain, the uterus should be again examined when the patient is bleeding or when one cannot hope to have the patient under constant observation during the lying-in period. Hofmeier regards the retention of chorion, even of the entire chorion itself, as an occurrence of not very great importance. In such cases he only recommends plenty of ergot, and douching of the vagina occasionally with a weak antiseptic solution. If the physiological signs of separation do not occur, but there is no appearance of hæmorrhage, it is the author's opinion that there is nothing to be gained by putting off the manual removal of the placenta for longer than three to four hours. G.

Spontaneous Intra-Uterine Rupture of the Umbilical Cord due to its Abnormal Shortness.—Walther (*Gynäkol, Rundschau*, 1907, Nr. 10) records the case as follows:—The patient, a primipara, æt. 28 years, complained during her pregnancy of very severe cramps and dragging pains in the abdomen. The labour pains began six weeks before full term, and although they continued for more than two days they did not complete the delivery. It was a case of twins, the brow of the first presented, and this child was delivered in good condition with forceps. There was a good deal of hæmorrhage, which was checked by gentle massage of the uterus. The second bag of membranes ruptured very soon, and the breech of the child appeared. This second child was born very easily without any assistance whatever being given to the mother. The child was alive, and the fact was revealed that the cord had been torn apart about 3 cm. from the umbilicus. The child had a spina bifida, atresia ani et urethræ, an an umbilical hernia. There was no hæmorrhage from the torn cord. The child died after a few hours. There were two separate placentæ with a common chorion. The cord of the first child had a velamentous insertion, and was intact. The cord of the second was inserted into the margin of the placenta, and measured 9 cm. from its insertion to where it was torn. Macroscopically it was quite normal in every other way. Walther believes that the pains during pregnancy were due to the shortness of the cord, and that many cases of so-called rheumatism of the uterus could perhaps be explained in this way. G.

Elisa Dehring, 50, who pleaded guilty last sessions at the Old Bailey to a conspiracy with others that a person should commit an illegal operation on Elsie Herget, came up for sentence on January 8th. Sir Charles Mathews said the parties were Germans, and in June last Herget went to stay with the prisoner, who was a cook in Crediton Street, Hampstead. He explained the steps taken by the prisoner with regard to the illegal operation, and said Herget died from the effects in St. Mary's Hospital. Mr. Gathorne Hardy, for the prisoner, said she had been in custody three months, and Mr. Justice Bigham passed the nominal sentence of two day's imprisonment, so that the prisoner was at once discharged.

Medical News in Brief.

Preservatives in Tinned Foods.

At Bow Street, on January 8th, before Mr. Marsham, Joseph Launay, a provision merchant, of Charing Cross-road, was summoned for selling a 1lb. tin of peeled shrimps containing 43 grains of boric acid. Mr. Rotton supported the summons on behalf of the Westminster City Council; Mr. D. Nimmo defended. Dr. Allan, medical officer of health for Westminster, gave evidence that the amount of boric acid alleged in the summons was sufficient to set up indigestion, and would act as an irritant on the kidneys. For the defence, Dr. W. Griffith stated that if the shrimps were washed when they were taken out of the tin, as was usually done, it would be found that they had absorbed only 1 or 2 per cent., and possibly none at all, of the boric acid. He was of opinion that no ill-effects would result from a person eating half a pound of shrimps containing the percentage of boric acid in question. Mr. Felix C. Kempster, Divisional Surgeon of Police for Battersea, was also called for the defence. He said that he had never traced indigestion to boric acid. A quarter of a pound of tinned shrimps would be a large quantity to take at one meal, and that amount, if it contained the percentage of boric acid alleged in the summons, would not be injurious to health. The defendant said that tinned shrimps were generally used for making sauce, and 2 oz. would flavour sufficient sauce for 50 people. He had since returned his whole stock of tinned shrimps to the firm which supplied him with them. The magistrate said that there was no reason why a person should not consume the whole of the contents of the tin if he felt so disposed, and in that event the amount of boric acid would undoubtedly be injurious to health. He fined the defendant 40s., and ordered him to pay £3 3s. costs. Mr. Nimmo intimated that there would possibly be an appeal.

Assault on a Medical Man.

On January 8th, Henrietta Fitzgerald, 30, a machinist, was indicted for wounding Dr. Ernest Cranmer Hughes with intent to do him some grievous bodily harm. She pleaded "Guilty."

Mr. Justice Bigham (to the prisoner): You plead guilty?

The Prisoner: Yes. It is not right for me to have to fight this case. I cannot get any sleep at Holloway. There is a kitchen over my head, and I cannot get to sleep until 2 in the morning.

Mr. Justice Bigham: You plead guilty to this offence?

The Prisoner: Yes. I had jolly good reason to do him grievous bodily harm.

Dr. Griffiths, Medical Officer of Holloway Prison, said the prisoner had been in Holloway upon the charge since November 22nd, and during most of that time she had been under his observation. As a result of that observation he had formed the opinion that she was insane.

The Prisoner: I am not given a fair chance.

Dr. Griffiths, asked his reasons for that opinion, said she was mentally unstable and had delusions. He had seen some letters written by her which were full of extraordinary statements.

Dr. Griffiths further said the prisoner had threatened what she would do to Dr. Hughes when she came out. Some Easton's Syrup was given to the prisoner at Holloway.

Mr. Curtis Bennett, who appeared for the prosecution, said the prosecutor, Dr. Hughes, was assistant surgeon at the Lock Hospital. The prisoner was a patient there, and she alleged that the doctor had injured her by using a speculum. She met Dr. Hughes outside the hospital and struck him with a hammer. For a time he was in a dangerous condition as a result of the blow.

The prisoner was continuing her remarks, but the learned Judge said he could not listen to her any further.

Mr. Justice Bigham said he was satisfied that she was in a very bad state of health mentally and probably also physically. He should do the best he could for her, and he should send her to prison for twelve months. There she would be properly treated, and he hoped that at the end of that time she would be restored to health.

The Prisoner: You are not going to send me to a lunatic asylum?

Mr. Justice Bigham: No, certainly not. Unless you behave in such a way as to make it necessary to put you into a lunatic asylum you will not be.

The Prisoner: Will you have me removed from Holloway? It is absolute tyranny there.

Mr. Justice Bigham: I am afraid I cannot do that.

The prisoner was then removed.

Mr. Justice Bigham said there was not the slightest reflection on Dr. Hughes.

Brown Dog Meeting at Battersea

A "preliminary mass meeting " was held at Battersea Town Hall, January 10th, to protest against the suggested removal of the Brown Dog anti-vivisection memorial at Battersea. Apart from the large body of stewards there was only a moderate attendance, the lavish display of posters headed "Shall Battersea Lose Its Brown Dog?" having evidently failed to rouse local enthusiasm. Mr. Ewell McAllen presided, and the Mayor of Battersea (Mr. Worthy), with several borough councillors and local Socialist leaders, was on the platform.

The Chairman said the meeting was called by the London and Provincial Anti-Vivisection Association, first, to protest against the iniquitous system of vivisection, and, secondly, to try and instil a little courage into those who were in control of the forces of law and order. He extended a somewhat qualified welcome to the medical students who, he understood, were present. When medical students demonstrated in Trafalgar Square on behalf of the underfed children or against the wretched conditions under which the masses lived they would agree with them. Having referred to the letter of the Commissioner of Police suggesting that the memorial should be removed or that the Battersea Borough Council should pay the £700 a year spent in guarding it, the chairman asserted that it was not due so much to a desire to economize as to certain influences which were at work.

Mr. Willis moved:—"That this meeting condemns the practice of vivisection as being inseparable from cruelty to its dumb victims, and as dishonouring to the nation which encourages and supports it." This, he said, was a declaration against cruelty in every shape or form, and he asked the meeting to pass it unanimously. He read the inscription on the memorial, and maintained that it was true and its continuance was needed as a protest and a reminder.

Mr. Wall, physician and surgeon, of the Battersea Anti-Vivisection Hospital, seconded the resolution, and said a miserable minority of vivisectors dominated the whole medical profession. It was an insult to common sense to assert that experiments on living animals were conducted without the infliction of pain.

Mr. Sidney Trist protested against honours being bestowed on those who had built up a reputation on the sufferings of animals.

There was some cheering when Mr. D. Carmichael, a Socialist, said bludgeons would have been used if the unemployed instead of medical students had attacked the memorial. If the students chose Battersea as a battle ground they would have a warm welcome.

The resolution was carried.

Gift of a Sanatorium.

A munificent gift of a sanatorium, fully endowed, has been made to Bolton, Lancashire, the donor being Mr. Thomas Wilkinson, one of the oldest residents in the town. Owing to the trying industrial conditions, which make consumption exceedingly rife, a sanatorium had become an urgent necessity, but the corporation and other local bodies had hitherto been at a loss to find the means for providing one.

Mr. Wilkinson has set apart for the purpose his large residence on the outskirts of Bolton, standing amidst spacious grounds, with terraces, lawns, and gardens, all of which render it a most desirable place. Its altitude is 700ft.

The donor has had a remarkable career. Starting in very humble circumstances, he developed an important cotton business, and during the American war amassed great wealth in blockade-running.

Protest Against Notification of Births Act at Exeter.

At the meeting of Exeter City Council, on January 8th, the Mayor (Ald. Gadd) presiding, the Town Clerk read a communication from the Local Government Board consenting to the adoption of the Notification of Births Act, 1907, within the city, and fixing January 13th, 1908, as the date on which the Council's resolution of adoption of the Act should come into operation.

A deputation of medical men of the city, consisting of Dr. Davy, Dr. Gordon, Dr. Ransom Pickard, Messrs. Russell Coombe, E. J. Domville, J. Miller and M. Farrant, attended on this subject.

Dr. Davy said medical men disliked the Act extremely, because it violated one of the cardinal principles of the profession, that of preserving secrecy. Up to the present the medical profession had always treated what a patient told them as an absolute secret —a trust which they could not violate by disclosing it to other people. (Hear, hear.) The Act stated that they were to break through this professional secrecy, which they considered one of their most honourable traditions, in all cases in regard to births. Of course, in the case of married women it was a matter of indifference whether or not a birth was notified; but there were constantly cases of illegitimate births, which they knew the endeavour was to keep secret. Medical men objected, as a profession, to have it forced upon them to violate the secrecy which these unfortunate people were bound to confide in their medical man. Of course, the medical profession recognised there was an enormous amount of infanticide which could be prevented, and a large number of deaths among children which could also be prevented. As a profession, they were willing to do everything possible to assist the Legislature and County Councils in aiding towards this desirable result. But in any case it was possible to do it with something like decency.

Mr. E. J. Domville endorsed what Dr. Davy had said relative to the importance of maintaining professional secrecy. Without in any way reflecting on the work of the office of the Sanitary Inspector, there would be a great danger against keeping these things confidential if the notices were sent in the same way as Infectious Disease Notification notices, and were allowed to lie about an office which was used by a large number of people.

Dr. Gordon said the medical profession was quite as anxious as any lay body that the spirit of the Act should be entirely carried out. They did not object to the Act in its intention, but they objected to one part of the Act, that which dealt with the medical profession.

Dr. Ransom Pickard, who also spoke, contended that the secrecy observed by the profession was in the public interest.

The Mayor thanked the deputation, and promised that the matter should have the careful consideration of the Council.

Grant in Aid of Scientific Research.

We are asked to announce that the Odontological Section of the Royal Society of Medicine is prepared to receive applications for grants in aid of the furtherance of scientific research in connection with dentistry. For particulars and forms of application apply to the Hon. Secretary, Scientific Research Committee, Odontological Section, Royal Society of Medicine, 20, Hanover Square, London, W.

Apothecaries Hall of Ireland.

At a special examination held on the 3rd inst., Edward Magennis, M.D., D.P.H., was admitted a licentiate of the Apothecaries' Hall.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Opsonin.—The correct way to pronounce the word, of course, is opsō-nin, for it is derived from ὀψωνειν (to cater for). In practice, however, the genius of the language has already asserted itself, and opson in is generally used. In a few years any opsō-ninists who survive will be regarded with the same astonishment as we should regard an antisē-ptic pronouncer. In such cases there is no rule except to say the most convenient thing.

Mus.—The number of rat-destroyers grows daily, and we cannot pretend to pronounce on their respective merits. Several of them have very good credentials from experience in temperate climates.

Kind.—The usual rule of calculating doses for children by multiplying the adult dose by the child's age over its age + 12 is a very rough one, and we do not know the genius who invented it. At any rate, his name is blessed to every examinee in prescription-writing. But, beyond the peculiar sensibility of children to certain drugs, such as opium, it seems to be a fact that they are at times more highly susceptible to all drugs than at others. Whether this is related to any opsonic index or not we do not know, but it is certain that at periods of rapid growth, *e.g.*, in convalescence, the susceptibility is more marked than at ordinary times. Troitzki has worked the question out in young animals, guinea-pigs, dogs, and rats, using strychnine, atropine, and pilocarpine, and is of opinion there are certain periods of active growth when sensibility to drugs high in all young animals.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 15TH.

Royal Microscopical Society (20 Hanover Square, W.).—8 p.m.: Mr. W. Wesche: On the Microscope as an Aid to the Study of the Biology of Insects, with Special Reference to the Food. Mr. J. C. Barnard: Exhibition and Description of an Improved Type of Mercury Vapour Lamp for Use with the Microscope.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. P. Daniel: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. C. Mercier: Functional Disease and its Treatment.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

THURSDAY, JANUARY 16TH.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Sir Almroth Wright: Some Points in connexion with Therapeutic Inoculation.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture Demonstration: Dr. G. N. Meachen: Selected Skin Cases.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. W. W. James: Importance of the Care of the Teeth in Childhood.

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell· Bullous and Vesicular Eruptions: V., Herpes; VI., Zoster; VII., Dermatitis Herpetiformis.

FRIDAY, JANUARY 17TH.

Society of Tropical Medicine and Hygiene (20, Hanover Square, W.).—8.30 p.m.: Dr. G. C. Low: The Unequal Distribution of Filariasis in the Tropics. Dr. C. Brown: Biographical Sketch of the late Professor Fritz Schaudinn.

Society for the Study of Disease in Children (11, Chandos Street, Cavendish Square, W.).—4.30 p.m.: Dr. G. Carpenter: Successful Medical Treatment of Congenital Hypertrophic Obstruction of the Pylorus. Dr. E. Cautley: Pathology of Congenital Hypertrophy of the Pylorus in Relation to Treatment. Dr. Whipham, Dr. P. Parkinson, Dr. Carpenter, and others: Cases.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. B. Harman: Clinique. (Eye.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—Lecture:—Dr. C. H. Wilcox: Exophthalmic Goitre.

Appointments.

Badcock, E. R., M.R.C.S., L.R.C.P.Lond., Surgeon to the General Post Office, Wandsworth Sub-district.

Bergin, Frank Gower, L.R.C.P.Lond., M.R.C.S., Medical Officer to the Bristol Dispensary.

Gayner, J. S., L.R.C.P.Lond., M.R.C.S., Anæsthetist to the York County Hospital.

Gray, A. Montague H., M.D., B.S.Lond., M.R.C.P.Lond., Obstetric Registrar to University College Hospital.

Gregor, Alexander, M.D., C.M.Aberd., Medical Officer of Health of Falmouth.

Jewesbury, Reginald C., M.A., M.B., B.Ch.Oxon., M.R.C.P. Lond., Physician to Out-patients at the Victoria Hospital for Children, Chelsea.

McDonald, Gilbert Reginald, L.R.C.P., L.R.C.S., L.M.Irel., District Medical Officer by the Tiverton (Devon) Board of Guardians.

Nobbs, Athelstane, M.D.Edin., Surgeon to the General Post Office, Putney Sub-district.

Price, Florence, M.B., B.S.Edin., to the Bacteriological Department at Swansea Hospital.

Thomas, H. Darby, M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at the Royal Surrey County Hospital, Guildford.

Vise, John Neville Blithe, M.R.C.S., L.R.C.P.Lond., Medical Officer of Health of Chard (Somerset).

Walker, George Francis Clegg, M.B., Ch.B.Vict., Medical Officer of Health for the Haverfordwest (Pembrokeshire) Rural District.

Vacancies.

Joint Counties Lunatic Asylum, Carmarthen.—Assistant Medical Officer. Salary, £200 per annum, with board, lodging, washing, and attendance. Applications to W. Morgan Griffiths (Solicitor), Clerk to the Visitors, Carmarthen.

Somerset County Council.—The County Education Committee.—Chief Medical Inspector of Schools. Salary, £500 per annum, with out-of-pocket expenses. Applications to the County Education Secretary, Weston-super-Mare.

Kent County Asylum, Maidstone.—Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Berry Wood Asylum, Northampton.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Great Northern Central Hospital.—Pathologist and Curator. Salary, £100 per annum. Applications to L. H. Glenton-Kerr, Secretary.

National Maternity Hospital, Dublin.—Indoor Assistant Physician.—Salary, £50 per annum.—Applications to the Secretary.

Births.

Burtchaell.—On Jan. 8th, at 23, Palmerston Road, Dublin, the wife of Lieut.-Colonel C. H. Burtchaell, R.A.M.C., of a daughter.

Lock.—On Jan. 7th, at 12, Huntingdon Road, Cambridge, the wife of Lyonel J. Lock, M.R.C.S., L.R.C.P., of a daughter.

Mennell.—On Jan. 10th, at 57, Holland Park Avenue, London, the wife of Zeb. Mennell, M.B., of a daughter.

White.—On Jan. 8th, at the Dower House, Bugbrooke, Northamptonshire, the wife of Percy Stanhope White, M.R.C.S. and L.R.C.P.Lond., of a daughter.

Marriages.

Fothergill—Gell.—On Jan. 8th, at St. Andrew's, Kingsbury, Claude Francis Fothergill, B.A., M.B., B.C., fifth son of Thomas Rowland Fothergill, to Enid Annesley, younger daughter of the late Major-General John Sherbrooke Gell.

Roderick—Clay.—On Jan. 9th, at Great St. Mary's Church, Cambridge, Henry Buckley Roderick, M.D., son of the late William Roderick, to Hilda Mary, daughter of John Clay, of Burrell's Corner, Cambridge.

Deaths.

Boyce.—On Jan. 3rd, at Fir Grove, Simla, India, Florence, wife of Charles Boyce, M.D., late of Maidstone, Kent.

MacLaurin.—On Jan. 7th, at 155, Macquarie Street, Sydney, N.S.W., Eliza Anne, wife of Sir Normand MacLaurin, M.D., and daughter of the late Dr. Charles Nathan.

Scott.—On Jan. 10th, at High House, Old Charlton, Patrick Cumin Scott, B.A., M.B.Cantab., youngest son of the late James Nairne Scott, of Blackheath, in his 51st year.

Darwent.—On Jan. 6, at Port of Spain, Trinidad, of yellow fever Stella Cecilia, the beloved wife of Dr. Darwent, and youngest daughter of the late Thomas Parker Rust, M.R.C.S., L.S.A., of Wells-next-Sea, Norfolk.

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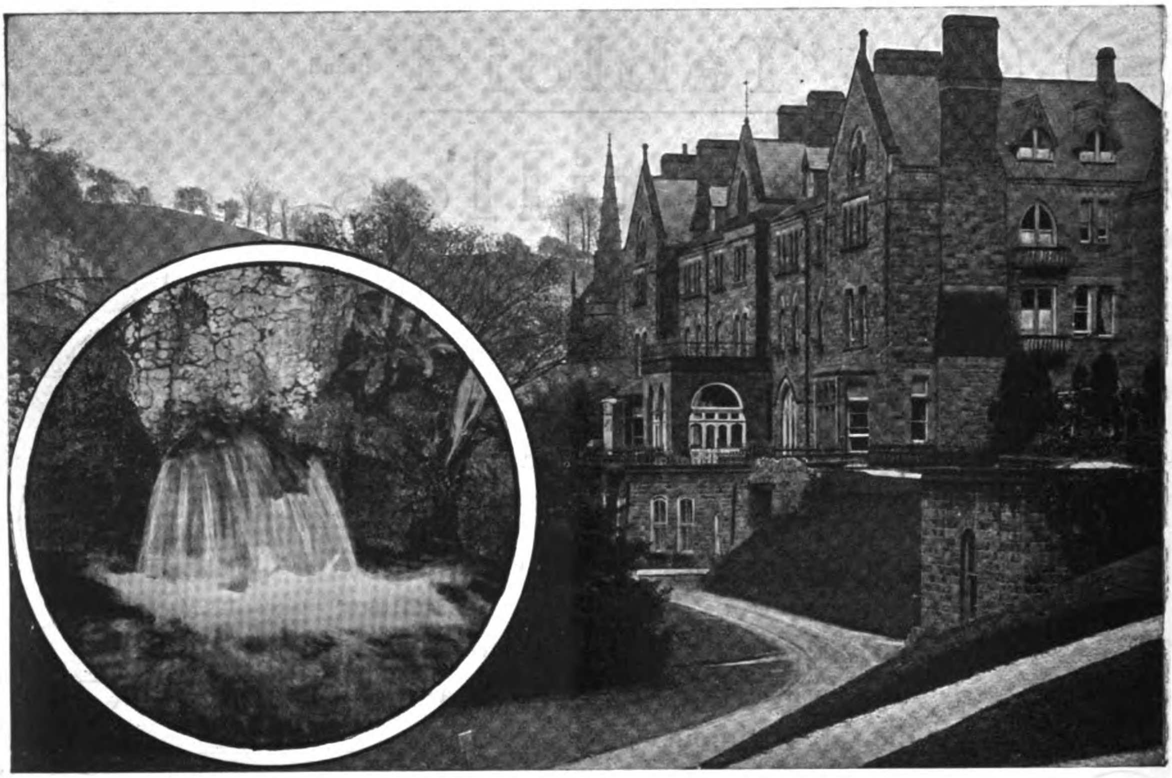

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JAN. 22, 1908. No. 4.

NOTES AND COMMENTS.

The L.G.B. Medical Officership.

THE retirement of Mr. W. H. Power from the post of Medical Officer to the Local Government Board will be a matter of sincere regret to all medical men. Mr. Power has always seemed to us a model of what a man holding that position should be. In scientific eminence, in practical administrative ability, and in common-sense, he is equally eminent, and, like all good civil servants, his modesty and self-effacement have been such that the credit of his good work has never seemed to belong to him. Into his private life he takes the warm admiration and good wishes of the whole profession, and we look forward with confidence to his receiving the titular distinction to which he is so eminently entitled. We think we may say, without risk of being misunderstood, that only the present President of the Board could have been gifted with sufficient imagination to have chosen Dr. Arthur Newsholme as his successor. The ways of the Civil Service are strange, and no doubt it will be disappointing to the distinguished gentlemen in the inspectorate that they will not receive their due promotion; but we may truthfully say that if Mr. Burns wished to go outside the present staff for a chief, he could not have chosen more wisely. Dr. Newsholme has not only great abilities, but great energy, and his work has never flagged for a moment. He is probably the most accomplished sanitarian in the public health service at the present moment, for as clinician, administrator, and statistician he is known and respected. We congratulate the Board on its new Medical Officer, and the new Medical Officer on the honour bestowed upon him. As with Dr. Whitelegge's appointment to the Home Office some years ago, it is well that the district medical officer of health should know that he carries the field marshal's bâton in his knapsack.

College of Preceptors and Hygienic Instruction.

THE late Mr. Spurgeon, when speaking of the religious efforts made to reach different strata of the community, was wont to speak of "the neglected upper classes," and applying the simile to the efforts now being made to bring the care of children and the hygiene of schools to public notice, we cannot but feel that the children of the poor are being affected far more by diffusion of knowledge on these subjects than are the children of the upper classes. True, school hygiene is penetrating some of the large public schools; Dr. Clement Dukes, who was a school hygienist before school hygiene was "discovered," has done yeoman work at Rugby; Canon Lyttleton has sensible ideas to inculcate in his new sphere at Eton; and University College and King's College Schools, in their respective new surroundings, both bear traces of the hand of the reformer. But in the private preparatory and secondary schools the light of the new gospel has yet to dawn, and we welcome very heartily the excellent efforts made by the College of Preceptors to bring it to the masters and mistresses engaged in those spheres by incorporating lectures by well-known teachers on such subjects as the care of school children's eyes, the hygiene of the ear and throat, and the training of the voice, into their meetings for teachers in the winter. The session of these vacation lectures has just closed, and we feel that the instruction therein given cannot but have a far-reaching effect. There is no reason why the upper classes should be "neglected" and we congratulate the College of Preceptors on its far-sighted wisdom in providing such courses. The principle is capable of almost indefinite extension.

Rough on Rats.

"AUTREFOIS le rat de ville,
Invita le rat des champs,"

we all learned in our youth from Lafontaine, but we did not realise all the dread potentialities of plague and other abominations which lay in that exchange of civilities. Time, however, has shown that the urban trend of the rat community has been as marked as that of the British population since the Cobdenite era, and that the rat flourishes amazingly on the off-scourings of human habitations. We have every sympathy with the Society for the Extermination of Vermin, which has lately inaugurated its existence by a public gathering under Sir James Crichton-Browne, and we wish them all success in their efforts, except, perhaps, that of distorting the English language to the extent of making the word "vermin" cover mammals. Nothing in the world is done without enthusiasm, and the task of exterminating rats, or reducing their number to any sensible degree, will make great demands on the amount of that valuable quality possessed by the members of the Society, so that we do not like to throw cold water on the scheme; but we cannot help feeling that the crusade is not without its Quixotic aspect, and that the rat-pursuers are in for a long job. Moreover, they may be in actual peril of prosecution, for the philthereutists who value the lives of animals above those of "humans," may find that rats cannot be pursued without torture or killed without torture, and the destroyer may be publicly pilloried to show what kind-hearted people the pro-ratters are.

Minus = Plus.

IT would certainly be a delicate question to decide as to whether a rat was *feræ naturæ* or not, for while the animal is not wanted for domestic purposes, he certainly makes himself very much at home when he attaches himself to a dwelling; but, happily, it is not necessary now to prove ferocity—have we not recently learned that eggs may be *feræ naturæ*?—and the ratter could probably be haled before the beak if he harried the "vermin." It is estimated, we do not know on what basis, that the London Docks contain six million rats, so that the field is large and the opportunities for distinction many, and we should suggest that Saturday afternoon rat hunts might provide a healthy and congenial pastime to oafs who do not become muddied, but sit watching others who do. However many victims are brought to the slaughter, it is disheartening to relate that no appreciable diminution of the pests is likely to occur, for Mr. Haffkine lately said that with regard to the anti-plague campaign at Tokio, that although nearly five million rats were killed, the slaughter only seemed to prepare more favourable conditions for the multiplication of survivors. Whereas, therefore, a campaign waged with all the panoply of sticks, guns and dogs would give amusement to many, and would result in thousands of casualties, the net effect would, on this analogy, merely lead to the survivors having a better time and more opportunity for breeding. Although we lend our blessing to the cause of extermination, we do so without any illusions about the nature of the task.

International Union of Medical Abstainers.

We have received from Dr. J. J. Ridge, President of the Council of the International Union of Medical Abstainers, a notice setting forth a scheme which that Union has prepared with the object of solving the value of alcohol in lobar pneumonia and enteric fever. "The statistical method can alone accomplish this, as it eliminates the personal element, and the fallacy inevitable *(sic)* due to small numbers and personal prejudice. A large number of cases must be collected, some treated with and some without alcohol." Let us say at once that we should cordially welcome the right solution of the use of alcohol in these diseases, and that we have no doubt that the International Union of Medical Abstainers are animated only by the highest motives. But is it not obvious that any such investigation must be conducted in an unbiassed and purely scientific atmosphere? That is, if it is to be accepted as authoritative by the profession, the work is not one for a partisan organisation to undertake. Everyone knows, *à priori*, how they wish the result to come out, and everybody knows the danger of accepting conclusions arrived at by well-wishers of one side. We may put a publican on a commission to inquire into the amount of drunkenness in the land, but we should be loth to accept the conclusions of a commission composed entirely of brewers. We should give great weight to representations made by the Society for the Prevention of Cruelty to Children in an inquiry as to infant neglect, but we should not, if we wished to make a full and complete inquiry, entrust it solely in the hands of the Society's officials. In a word, professionalism is too strong for even the best of us.

And its Scheme.

Now, although it is true that the question of the value of alcohol can only be settled by the statistical method, it is equally true that Queen Anne no longer exists. All questions can only be solved by the statistical method, that is, the method of collective experience. The difficulty is to get pure figures. Now, the plan laid down by the Union seems to us about as unlikely to obtain pure figures as any that could be devised, and as certain as possible to lead to hopelessly wrong conclusions. It is that the participants in the scheme shall bind themselves for a year to treat each case of pneumonia and typhoid fever in their practice alternately with and without alcohol! May we not take this as an example of the incapacity of any partisan body to arrive at correct conclusions? Every alternate case is to get alcohol, whether it needs it or not, apparently, and the others are to be treated without it, whether they need it or not, also apparently. We have no hesitation in describing an experiment conducted on these lines as opposed to the best traditions of the profession; no man who sets out to treat serious cases on a plan such as this can have the individual interest of the patient as his only motive. That consideration alone is enough to deter anyone from joining the investigation, and if it were not, the fact of having to give alcohol to patients who do not need it in order to keep to the alternate arrangement is a sufficient reason for showing how the results are stultified *ab initio.* We beg the International Union of Medical Abstainers to reconsider this ill-devised scheme.

LEADING ARTICLES.

LAW REFORMS AND THE MEDICAL PROFESSION.

The law of the British realm is a marvellous structure, which has grown by the slow additions of many centuries into a tangled congerie of precedents, statutes and procedure that in their entirety may well constitute the despair of the most expert legal student. For all that, its foundations are so solid and the national character so inherently conservative and law-abiding that the administration of justice in the United Kingdom compares favourably with that of any other country in the world. Signs are not wanting, however, that the day of legal reform is at hand. One of the chief complaints against our national system of judicature is its real costliness, an objection that is fatal to the ideal of justice, for it should be absolutely accessible to every subject in the realm, regardless of his position in society. Turning to medical testimony, with which our readers are more directly concerned, it is of some interest to inquire to what extent their interests are involved in the question of law reforms. The subject is far larger than might at first be anticipated. Medical evidence is required daily and universally in courts of law of all kinds, from the coroners' and police courts up to the King's Bench and Chancery. There are various points with regard to the nature and amount of fees, of the privileges of expert witnesses, of the exacting of gratuitous testimony, of the suppression of the rights of medical witnesses by coroners and by county councils acting through coroners, of the exclusion of medical testimony by unqualified persons, and many other apposite things that demand attention. But of all the coming reforms, there appears to be no single one of more direct and urgent importance than that which asks for some readjustment of the present system whereby opposing expert evidence is now tendered by both parties in a lawsuit. A more costly device for getting at the truth could hardly be imagined than that which brings into court on either side an imposing array of more or less eminent expert witnesses. As regards the status of the medical profession in the eyes of the public the present system is simply deplorable. No suitor need regard his case, however threadbare and forlorn to all appearances it may be, as hopeless, so far as the support that may be forthcoming from members of the medical profession is concerned. Some of the most notorious instances of the kind are to be found in the literature of "railway spine." It is no exaggeration of facts to say that any person who has been present in a railway collision may reckon with confidence on finding a certain number of prominent medical witnesses ready to come forward in court in support of his claim for damages. What wonder if the public looks on with cynical amusement at the spectacle of half a dozen bigwigs in the witness-box flatly contradicting half a dozen colleagues of equal standing upon matters of opinion. Worst of all is the commentary afforded by the lawyers' aphorism that the best treatment for "railway spine" is a swinging award of damages. The question of how so undesirable a position may be remedied is perhaps a little complicated, but it should not be above the wit of the average parliamentarian to suggest some way out of this particular tangle when the whole question of legal reform comes before the legislature. Why should not a body of experts be appointed to sit permanently and decide upon all medical points submitted to them for consideration? Their opinion would come to the courts concerned with the weight of unbiassed authority, a quality that is certainly wanting in the present rough and tumble conflict of expert witnesses who have been retained at great cost by the suitors on either side. Then, again, such an advisory body would naturally be under the control of a medical man of special skill and experience, who would, in point of fact, act as a specially skilled expert judge dealing with one class of evidence. It requires no labouring of the matter to show that his decisions would be infinitely more valuable than those of a judge who has had no medical training, and whose judgment, however clear and well-trained in legal matters, must inevitably fail in the complete and adequate grasp of such highly technical evidence as is necessarily involved in medico-legal issues. In former years the Medical Press and Circular has strongly advocated the institution of some kind of special assessment or judicial board to report upon and submit medical evidence to our courts of law. With the lapse of time the arguments in favour of that proposal have gathered strength, and it is to be hoped in the interests of a dignified and great profession like that of medicine that the matter has actually entered within the range of practical politics.

THE MEDICAL EXAMINATION OF SCHOOL CHILDREN.

The details of the administration of the Act relating to the medical examination of children in the public schools are not likely to be settled without considerable discussion in various parts of the kingdom. The main points around which differences of opinions seem to centre are, first, the cost of the machinery, and, secondly, as to whether the special duties should be performed by a staff of officials appointed *ad hoc* or by local medical practitioners. The County of Durham recently discussed the matter in a large representative meeting held at Durham to consider which of the two methods mentioned above would be preferable. One was that a special medical officer should be appointed to devote his whole time to the work, and the other was that it should be done by various medical men, who should give part of their time only to the work and be paid so much per head. The representatives of the county favoured a scheme by which the county would be divided into five districts, with a medical man appointed to give his whole time to the work in each of the districts. There were objections raised to this method on the ground that it would be too expensive and would mean an increase of officialism. In regard to Sunderland, a delegate suggested that the town should be divided into five districts, and that for each a doctor in ordinary practice should carry out the work and be paid according to his services, and that the whole of the work should be under the supervision of the Medical Officer of Health. This last point is considered an important one, owing to the power it would give to the Medical Officer to go into the homes of the people. There is, of course, something to be said in favour of each proposition. On the whole, that scheme would probably be most widely acceptable which engaged men who are kept in touch with the ailments of children by the contact of daily practice. In any case, the necessity of supervision by the Medical Officer of Health would seem to be an essential to smooth and efficient working of the system. A day or two after the Durham meeting the Stafford Town Council unanimously adopted a strong resolution, which advocated the appointment of local practitioners with no uncertain voice. The resolution ran: "That the Town Council of the Borough of Stafford are much concerned and alarmed at the ever-increasing expenditure of the Education Committee of the county, and hereby protest in the most emphatic manner against the proposal to appoint a staff of medical men to carry out the duties of the Act lately passed, necessitating the periodical medical inspection of school children; that in the opinion of this Council such appointments are extravagant, as they consider that the work can be done by the present medical men in the county quite as efficiently and at a much less cost." The arguments advanced by Alderman Wright, who proposed the motion, are worth reproducing as representing the last word on one side of the question. Local medical men, he submitted, would be far more likely to know the needs, the surroundings, and the probable health of the children. If other medical men were imported there would be a dual medical authority, and the result would be anything but satisfactory, as they would come in conflict with the sanitary authorities, who were responsible for the health of the district. It seemed to him that the County Council had jumped to a conclusion, with their well-known love of luxury and expenditure, of dealing with the matter in the most expensive way. The costs would amount to thousands of pounds per annum. The education rate was formerly 8d. in the pound, and it was now 1s. 5½d. in the pound, and that amount represented an expenditure of £6,000. If the Pottery towns became federated it would mean a large ratepaying area being taken from the county, and the probability was that it would have the effect of largely increasing the education rate. He came to the conclusion that unless the public authority took steps to curb the expenditure and the love of throwing money away lavishly by the Education Committee, they would go on until the rates were unbearable in the town, and residents would have to follow the example set by the tradespeople of Wolverhampton by going out of the town to avoid the heavy rates. From the point of view of the general practitioner it would seem advisable that they should take immediate steps not only to grasp the facts of the situation, but also to communicate them to the fellow-ratepayers of the district in which they reside. Otherwise they may find themselves deprived of the enjoyment of a number of lucrative posts to which they seem *primâ facie* to have some sort of claim. In any case, it seems fairly evident that the ultimate issue will depend to a great extent upon general practitioners themselves. It would be difficult to imagine a practical issue that is more pertinent to the ends and aims of collective defence and advancement of bodies than the disposition of a vast number of public appointments of the kind that must inevitably be created on a large scale within the next few months.

CURRENT TOPICS.

The Ancient Philistines and Rat-borne Plague.

MODERN science is constantly reminded of the ancient saw which asserts that there is nothing new under the sun. If there be one discovery more than another upon which the medical man of to-day plumes himself, it is that which traces the spread of Asiatic plague to the agency of rats. It appears, however, that the connection was recognised by the Philistines of Biblical history. It is recorded, for instance, that they were in the habit of offering in their temples golden boats and golden mice in order to celebrate recovery from the plague. The "mice" of the English translators is used as a generic term, and includes the black rat. A correspondent to the *Manchester Guardian* has drawn attention to the fact that, as was pointed out by a writer in a theological magazine a year or two ago, there is apparently a record of plague in the fifth and sixth chapters of the First Book of Samuel. The mortality among the Philistines was very heavy, and both those who died and who survived had the emerods or swellings. These were evidently the "buboes." The Philistines coupled the emerods and the mice together, taking the connection for granted. "One plague was on you all." Some interesting points on the bibliography of this point will be found in our Notices to Correspondents column.

Quis Custodiet?

THE question of members of the medical profession writing signed letters and articles to lay publications has become more than a mere troubling of the domestic waters. It has strayed into the wider field of public controversy, as many matters of ethical interest are wont to do. The first point raised by extramural journalists is why the general practitioner of Slocum-cum-Podger, who happens to administer first aid to a boy run over by the local butcher's cart, runs the risk of being "solemnly censured and grievously manhandled by the grave and heavy seigneurs who preside over the councils of the British Medical Council?" (*vide Onlooker*, 11th January), while Harley Street Magnates may contribute two signed columns on any medical subject they choose and go unscathed. Is there any truth in this flowery and sarcastic rhetoric? As a matter of fact, many signed articles by leaders of the profession, titled and otherwise, appear in the *Times* and other lay newspapers, and so far from condemning the practice, the Presidents of some of our Royal Colleges now and then join in the fray. Under these circumstances it is difficult to say what is the established ethical law upon the point. If the rule be to abstain from publishing signed communications on professional topics in non-medical journals, it certainly appears to be more honoured in the breach than the observance. If there is to be a law its application should clearly be universal.

"British Journal of Tuberculosis."

THE January number of the *British Journal of Tuberculosis*, which lies before us, maintains the high standard of its predecessors. Its "feature" consists of a series of articles on tuberculosis in the various military services, each written by a responsible and well-informed officer. Fleet-Surgeon Wenmoth Pryn, D.P.H., discusses "Tuberculosis in the Navy, 1860—1906," and completes his article by a very practical series of suggestions as to the construction and ventilation of ships. The idea that the sea is a good calling for the tuberculously-inclined is only true if the conditions of living on board a ship are at least as hygienic as those on land. "Tuberculosis in the Army, 1860—1906," is dealt with by Lieut.-Col. Charles Melville, M.B., D.P.H., who shows that there has been a great and practically continuous fall in the wastage due to tuberculosis in the period under notice, and notices the conditions responsible for the welcome change. Lieut.-Coloned R. J. S. Simpson, C.B., Professor of Tropical Medicine at the R.A.M.C. College, London, gives an analysis of the tuberculosis returns at various foreign stations in his paper on "Tuberculosis in the British Army on Foreign Service"; and Major C. A. Johnson, M.B., D.P.H., writes at some length on "Tuberculosis in the Indian Army." The same subject, as applied to the Egyptian Army, is dealt with by Captain Stevenson L. Cummins, M.B., and some most significant facts about the presence and absence of tuberculosis among native tribes are given. Several original articles by various authors also appear, and the "Health Station" described is Madeira and the Canary Islands. There are also many reviews of books on tuberculosis and preparations suitable for its treatment. Altogether, no one who is interested in the subject (and which of us is not?) can afford to neglect this interesting magazine.

Medical Fees in Probate Actions.

A JUDGMENT deciding a matter of some importance in regard to medical fees was given by the Court of Appeal in Dublin last week. It appears that an action had been heard arising out of a disputed will, and the executors in their table of costs had included two items of four guineas each paid to two medical men for consultation and report on the mental condition of the testator prior to the making of the will. The medical men had not been called on to give evidence in court, and the Taxing Master had disallowed the payments on the grounds that the reports were unnecessary, and "did not appear to have been of any benefit for the case." The executors appealed, and the court unanimously refused the appeal. Of course, the decision may rest on some special circumstances which characterised the case, but from the arguments used it would seem to have been influenced by general considerations. It was stated that neither of the gentlemen was an "expert," and that their relation to the case could only have been as testifying witnesses, speaking in regard to matters of fact which came under their notice. They had been brought into close relation with the testator by the fact that he had been in their hands for surgical operation shortly before his death, and they therefore had good opportunity for judging of his mental capacity. We entirely fail to see how knowledge gained by a professional relation of this sort is to be regarded as that of an ordinary witness, and we do not know why the report is not to be classed as the work of experts. As compared with the public, all medical men are "expert" in matters of their professional knowledge, whether they are specialists or not in the particular subject on which information is sought. The lesson to be learnt from the case is that medical men should insist on getting their fees in advance in all medico-legal cases.

Admission of Women to the London Royal College of Physicians.

An interesting departure was made in the history of the Royal College of Physicians of London on Friday last, under the presidency of Sir Douglas Powell, Bart. After considerable discussion, by a large majority it was determined to admit women to the examinations for the licentiateship and the membership. The matter, however, is not, perhaps, so simple as it looks upon this bare announcement. Under existing conditions the licence cannot be given apart from the membership of the Royal College of Surgeons of England, as the two qualifications are now conjoint and indivisible. The conferring of the licence of the Physicians is therefore conditional upon the co-operation of the sister body in Lincoln's Inn Fields. As a matter of fact, the attitude of the Royal College of Surgeons appears to be by no means favourable to the admission of women. We understand that a circular letter has been sent to members in order to ascertain their views upon the matter. At present there are practically two avenues of approach to the membership, one being through the licence. Supposing that to be blocked by the Royal College of Surgeons, the remaining avenue, namely, that which throws open the membership examination to graduates of a recognised university, is now open to women. The avenue to fellowship is solely by election. A fresh complication is here introduced, inasmuch as the Fellows exercise some kind of disciplinary function over licentiates and members, and no women have been hitherto admitted to any body possessing powers of that kind. On the whole the only definite issue so far of last week's committee is that the membership is now thrown open to women who are graduates of a recognised university.

Lucidity and Scientific Teaching.

The discussion which took place a few weeks ago in the *Times* on the relation of the man of science to the public was one of considerable importance to all who hold that science should have an interest for the many, and not only for the few. The accusation that has been brought against the English mind of being slow to apply scientific knowledge to practical affairs seems to have some justification. In the realms of public health, of education, and even of industry, other countries have been more rapid in applying the results of scientific research. This is not due to any poverty of scientific intellect in these countries, for our men of science—as men of science—stand as high as those of any country. There are various grounds for it, but one, which seems capable of alteration, is the lack of interest shown by the public in matters of science. For this lack of interest men of science are to some extent to blame, for they often act and speak as if science were something esoteric, and not to be communicated to the vulgar. As a nation we have peculiarly few scientific teachers possessed of the gift of lucidity in exposition. A comparison of our leading reviews with those of France will show how poor in scientific articles are the former, and how deficient in literary grace are the articles which appear. We require more teachers like Tyndall and Huxley, men who were not merely leaders of scientific thought, but are also great writers and expositors. Even in the past few decades we seem to see a falling-off in the literary abilities of writers on scientific subjects, and there are few medical men, for instance, writing in English at the present day possessed of the style of Paget, of Wendell Holmes, or, to mention one still with us, of Weir Mitchell. The power of lucid exposition will have to be cultivated if science is to take its rightful place in the practical affairs of the nation.

PERSONAL.

Dr. Joseph Beard has been appointed School Medical Officer to the Bootle Town Council.

Dr. A. K. Chalmers has been appointed Examiner in Vital Statistics to the University of Glasgow.

Mr. T. H. Bickerton has been elected President of the Liverpool Medical Institution, and Dr. John Hay Editor of its journal.

Mr. Robert E. Kelly has been appointed Assistant-Surgeon to the Liverpool Royal Infirmary, in place of Mr. R. A. Bickersteth.

Col. David Bruce, C.B., D.Sc., F.R.S., will lecture at the Royal Institution next Friday on "The Extinction of Malta Fever."

Dr. T. G. Nasmyth has resigned his position as Medical Officer of Health of the Counties of Fife, Kinross, and Clackmannan.

Professor Kleine, for many years assistant to Professor Koch, is being sent by the German Government to East Africa to study sleeping sickness.

Dr. F. J. Henry, on leaving Glasgow to take up the post of Medical Superintendent to the Highfield Infirmary, Liverpool, has been presented by his colleagues with a gold watch and chain.

The President of the Local Government Board has appointed Dr. Arthur Newsholme, F.R.C.P.Lond., as Medical Officer to the Board, on the retirement from that office of Mr. W. H. Power, C.B., F.R.S.

The annual dinner of the Royal College of Surgeons in Ireland will take place on Saturday, February 1st. Tickets, one guinea each, may be obtained of Mr. G. F. Blake, Registrar.

Yesterday the Lord Mayor of Liverpool, on behalf of the Royal Humane Society, presented Dr. Peters with a medal for pluckily saving a person from drowning last summer at Amlwch, Anglesey.

The Secretary of State for the Colonies has appointed Dr. W. J. Simpson, Professor of Hygiene at King's College, London, and Lecturer in Tropical Hygiene at the London School of Tropical Medicine, to proceed to the Gold Coast to assist in combating the present outbreak of bubonic plague at Accra.

A CLINICAL LECTURE
ON
EMBOLISM CONSEQUENT UPON LESIONS OF THE LEFT HEART.

By PROFESSOR PAUL CLAISSE, M.D.,
Physician to the Pitie Hospital, Paris.

[Specially Reported for this Journal.]

A person has an attack of rheumatic endocarditis somewhere about the fifteenth year, inflicting permanent, incurable damage, and since that time there has been shortness of breath on exertion. Ten years later he has fugitive hemiplegia, which clears up in a few hours. Then, more recently, there is another attack of right hemiplegia, with aphasia.

These few words sum up the history of one of our patients whom you have just seen. On examining her, we find well-marked mitral stenosis, and we are driven to the conclusion: cerebral embolism following mitral stenosis. With a few differences, much the same condition of things obtains in the patient in the next bed, and only a day or two since another one succumbed under much the same circumstances, the pathological specimens whereof are before me.

You see, then, that in a single ward, within a few weeks, we have had three cases of embolism following mitral lesions.

This is consequently a clinical fact of, so to speak, daily occurrence, one with which we ought to be perfectly familiar. Everyone ought to have very clear ideas as to its origin, the mechanism of its production, and its consequences, in order to be in a position to formulate rational prognosis and treatment.

Yet, when we go into the question rather more deeply, we find that the text-books only give very brief details concerning it, and we are fain to glean our information from various publications, among which I may mention the recent theses of Grabias, Gireaux (1904), Guillaumin (1905), Boutin (1907), Ginsburg's work (a), and an excellent article by Barié (b).

Lesions of the left heart are frequently the source of emboli, and Ginsburg, who investigated a large number of heart cases from the point of view of embolism, estimates the proportion at something like 34 per cent. of all cases of embolism. It must, therefore, be regarded as a very important clinical circumstance with which we must familiarise ourselves in all its phases, in the striking cases of large arterial obstructions as well as in its occasionally more discrete manifestations in the form of visceral localisations.

This complication is not equally common in all forms of heart disease, and the same statistician tabulates the following figures: mitral stenosis, 43 cases; regurgitation, 11; double mitral lesion, 6; aortic lesion, 5.

To what must we attribute the preponderating part played by mitral stenosis? In order to understand this, let us inquire into the origin of the embolus.

Sources of the Embolus.

The solid mass, the embolus, which is about to be thrown into the arterial circulation, is sometimes formed of endocarditic vegetations, pathological products more or less of old standing, of variable size, torn from the ventricular walls by the blood current. This endocarditic embolus is common to all forms of heart disease, and is met with just as well in mitral as in aortic lesions. As a rule it is rather small, and is not the cause of the grand syndrome of arterial obstruction. The latter results usually from the migration of a cruoric or fibrinous clot of uncertain age. Now the formation of clots is a very complex phenomenon, and is the outcome of three different sets of conditions.

1. *Coagulability of the Blood.*—This varies within wide limits in different subjects, and even in the same individual under changing conditions (inter-current disease, influenza, typhoid fever, etc., the action of drugs, such as chloride of calcium, gelatine, etc.). I do not propose on this occasion to tackle this big subject. I will merely remark that in a subject who is predisposed by heart disease such circumstances may decide the matter, and pave the way to the formation of a clot. We may draw one practical conclusion therefrom—viz., that in the event of hæmorrhage in a cardiac subject we must avoid all measures for the arrest of the bleeding, which would have for effect to exaggerate the coagulability of the blood, consequently we shall not prescribe either gelatine or chloride of calcium.

2. *Changes in the Walls.*—Experiment has proved that blood coagulates more readily if, instead of running over a smooth surface, it comes into contact with a rough wall that has been damaged by previous changes.

3. *Blood Stasis* is the true determining cause of clot formation, the causes just mentioned, after all, only predisposing thereto.

Now these three conditions are not equally fulfilled in all forms of heart disease. The first two, which comprise changes in the fluids and walls, are not specially associated with this or that structural change, and may exist just as well in connection with mitral as with aortic lesions. Blood stasis, on the other hand, is hardly likely to be present save in mitral stenosis. We know as a fact that any diminution of the calibre of the mitral valve has for immediate effect to provoke dilatation of the left auricle, the pouch thus formed not being able to empty itself at each presystole. Eddies take place in the mass of blood in the axis of the orifices and the peripheral parts of this sphere of blood, which are not properly renewed, are in a state of comparative stasis. Very different is the state of the blood within the ventricle in the subjects of mitral or aortic regurgitation. Here, on the contrary, in addition to the natural propulsion, there is a to-and-fro movement that increases the churning of the blood. The blood stasis caused by mitral stenosis is therefore the principal cause of the tendency to clot formation, and thus we get the relationship of cause and effect between mitral stenosis and embolism in the aortic domain.

Migration of the Embolus.—The clot thus formed may be expelled forthwith, or, on the contrary, it may become adherent to the walls; attached for a time to endocarditic vegetations, it may become organised and fibrinous. This distinction between recent cruoric clots and old fibrinous clots is not without its importance, as will be shown later.

Well, then, the clot leaves the heart, becomes an embolus, and wends its way into the aortic territory. Its size will decide the distance it is to travel. If of very large size it will be caught by the spur of the first bifurcation—that is to say, in the abdominal aorta. If of less dimensions it will take up its residence in the carotids, the brachial or the femoral artery. Small clots will plug the Sylvian artery, the arteries of the forearm or leg, or some visceral artery. Lastly, there are extremely minute capillary emboli which also call for notice.

I need not dilate on the symptomatology of massive obstructions of the large arteries of limbs, which are fully described in text-books. We are familiar with the syndrome characterised by sudden pain, which may be of agonising severity, associated with tingling, a sensation of cold, functional impotence, and abolition of the pulse in the affected area.

(a) *Deutsch. Archiv. fur Klin. Med.*, 1901.
(b) *Presse Medicale.* Feb. 3rd. 1906.

We are also familiar with the common clinical picture of rapidly fatal cerebral ictus, or, as in this case, of hemiplegia, usually on the right side, with aphasia, or, again, with sensory disturbances corresponding to arterial obstruction in the centres or in the organ of sight or hearing.

In short, embolic obstructions of the arteries of limbs and also of the brain are, as a rule, easy enough to diagnose.

This is by no means the case in visceral embolism, which may readily be overlooked or be mistaken for something else.

Renal embolism, for instance, which is by far the commonest form, is very often overlooked, and provides us with a surprise post-mortem. Sometimes it is ushered in by a violent feeling of something giving way in the lumbar region, like the pain of nephritic colic, but it often happens that the pain is altogether wanting. Albuminuria, hæmaturia, and anuria are also inconstant signs.

Whatever renal symptom may be observed, the only thing we can rely upon for the diagnosis is the suddenness of its occurrence in a cardiac subject. No one sign possesses a pathognomonic value, and we are often reduced to hypothesis.

The same remark applies to splenic embolism. Sometimes it is quite latent; sometimes, on the other hand, it gives rise to intense organic reaction. Boutin records a case of splenic embolism characterised by severe abdominal pain, tympanites, vomiting, and rapid pulse, which was diagnosed as peritonitis.

Large emboli of the liver or stomach are of rare occurrence. As to small emboli, they, no doubt, play their part in the digestive pathology of cardiac subjects; but it is difficult to specify what part they play in view of the predominance of hepatic, venous congestion, which may mask all secondary lesions of minor importance.

Mesenteric embolism gives rise to striking clinical phenomena, and I can recall a very interesting example thereof in this ward. A woman, suffering from mitral stenosis, had been admitted a few days previously, when "she was suddenly seized with extremely severe symptoms, complained of intolerable pain in the belly in the middle line, near the umbilicus, which radiated into the iliac fossæ and even into the lower limbs. It was so severe that the patient, bent double and incapable of the slightest movement, positively howled with the pain. After a time the patient passed a diarrhœic motion, floating on which were shreds of intestinal blood-stained mucous membrane. There was tympanites, she broke out in cold sweats, the extremities became cyanosed, and she died in the afternoon."

This sudden, violent abdominal pain, followed by glairy hæmorrhagic diarrhœa, is usually met with in cases of mesenteric embolism, and enable us to arrive at the diagnosis when the victim is the subject of heart disease.

Results of the Embolism.—Embolism is followed either by total, permanent obliteration of a whole arterial territory (if it be a terminal or very big vessel), or merely by interference with the local circulation, should there be collateral vessels capable of relieving the results of vascular obstruction. In the first case we get dry or moist gangrene, by a combination of aseptic necrosis and secondary infection, a process which I recently discussed in connection with diabetic gangrene. Secondary infection of the embolised territory by surface microbes explains the enormous differences that obtain between various kinds of embolism. Let us take the kidney and spleen, for example, these being aseptic organs without any natural communication, with a possibly microbial focus. If any one of their arterial areas is obstructed by an embolus, degenerative lesions will follow: simple necrosis or infarctus, which then passes through the usual stages of retrogression. Then let us consider an arterial area bounded on one side by an infected surface (skin or intestinal mucosa). Here the transformation of the infarctus into a putrefactive area is the rule, because these areas, cut off from the circulation (and consequently from oxygen), constitute an excellent culture medium for the anaerobic microbes of putrefaction.

In some cases gangrene supervenes forthwith with remarkable promptness, and appears to be the direct consequence of the embolism by the migration of septic organisms. These septic emboli, too, explain certain cases of deep suppuration, of visceral abscess of the kidney, or perirenal connective tissue, etc. We may be able occasionally to detect them, so to speak, in the act, in certain cases of infective purpura in which pneumococcal or streptococcal endocarditis gives rise to small microbial metastases which can be distinguished in sections of the skin after biopsia.

The *Prognosis* depends on the size of the embolus, its seat, and, lastly, on its nature. It is obvious that the gravity of the disturbance will be proportional to the extent of the obstructed area, and that a big clot is more formidable than a small one. But the *seat* of the embolism has an important bearing on the prognosis. Even a very small clot may quickly cause death; medullary embolism, for instance, is lightning-like. The course is not quite so rapid in the case of the intestine, but is pretty certain to culminate in gangrene of the walls. Renal and splenic embolism, on the other hand, if not too extensive, may be tolerated, possibly, indeed, without much reaction. In embolism of the limbs several things may happen. If the obstruction is situated at the root of the limb, gangrene is unavoidable, and will carry off the patient sooner or later, or necessitate a major operation. If lower down, below the junction with a collateral vessel, if, for instance, it leaves the deep femoral intact, the situation is not so grave, and a complementary circulation may be set up in time.

Then, too, the *nature* of the clot has a bearing on the prognosis. You must not suppose that every arterial obstruction is for good and all. This may be the case in respect of obstructions due to endocarditic vegetations and old fibrinous clots, but recent, freshly-formed clots may merely cause temporary blockage, subsequently breaking up and disappearing. This explains how it is that we see the blood current re-established in a limb that has become cold, numb, and inert, and why total hemiplegia suddenly disappears. This favourable termination is frequent. The patient we examined had had total hemiplegia some months since, which only lasted a few hours. These ephemeral obstructions, indeed, are tolerably common. Obviously no such result is to be anticipated if the embolism be of some standing, but in recent cases we must bear this capital fact in mind in respect of both prognosis and treatment.

Treatment.—Treatment can only be palliative in embolism of the viscera. Much more can be done in embolism of the limbs. If the lesion be recent, aware, as we are, of the possibility of absorption, we must do our best to promote the process, acting as rapidly and as energetically as may be possible. We may hesitate to move or massage a limb with a damaged artery, just because we are in the habit of enjoining strict immobility in a limb afflicted with phlebitis. But you will perceive, on reflection, that the two things are quite different. The venous clot, a centripetal embolus, if mobilised, passes into the right heart, and will give rise to the ofttimes grave disturbances of pulmonary embolism. The loosening of an arterial clot, which, on the contrary, is a centrifugal embolus, can only have good effects, since it will free the lumen of the large artery, and the fragments of clot can, after all, not go further than the capillary barrier.

In cases of recent embolism, therefore, energetic massage is strictly indicated. Giraux relates a case in which Gautru, in Merklen's wards, was enabled to re-establish the circulation in the femoral artery by several hours' massage.

If the embolism be of old standing, such measures are useless, and all we can do is to watch the progress of the lesions in order to decide at what moment and at what spot surgical intervention is necessary.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Robert Hutchinson, M.D., F.R.C.P. Lond., Physician to the London Hospital, Assistant Physician to the Hospital for Sick Children, Gt. Ormond Street. Subject: "Modern Theories of Diet in their Relation to Practice."*

ORIGINAL PAPERS.

THE SURGERY OF THE HEART AND PERICARDIUM.

BY R. REHN, M.D.,

Professor of Surgery, Frankfort-on-Main.

1. Diagnosis of Wounds of the Heart.—If after an injury of any kind the pericardium fills rapidly and becomes tense with symptoms of cardiac pressure, the diagnosis of wound of the heart is certain. The symptoms of tension are pains in the left arm, a feeling of oppression, precordial pain, especially on expiration, which is made worse by pressure over the heart. Often there are violent, especially left-sided, pains in the abdomen, pronounced reflex muscular tension of the upper abdominal muscles, and shortness of breath, although the lungs are free. The pressure on the heart causes cyanosis from the slightest to the most extreme degree, the cervical veins being more or less filled. The pulse is thin, sometimes even to vanishing. Face and extremities are cold. The shortness of breath gets worse, and becomes dyspnœa. The patient at last becomes soporose, or falls into a deep faint.

Free continued hæmorrhage from an external wound in the cardiac region points to extra-pleural wound of the heart, whilst a stream of frothy blood only points to hæmorrhage from the interior of the chest.

If the results of percussion in the early stages of filling-up of the pericardium are uncertain, Röntgen illumination, especially the stereoscopic, may lead to decisive conclusions. It distinctly shows the enlarged area of cardiac dulness and the presence of foreign bodies.

We may assume a wound of the heart with great probability when the external wound corresponds and the kind and direction of it allow such a conclusion, when, along with a hæmo- or hæmo-pneumo-thorax, abnormal sounds can be heard.

The sounds may originate extra- as well as intra-pericardially; even the signs of a pneumo-pericardium are not a proof of a wound of the heart. The diagnosis gains in certainty the more the precordial wound approaches the sternum—*i.e.*, the more fixed portion of the heart, or when the sternum is penetrated. A systolic rushing sound is of great diagnostic value, but is not heard too frequently.

2. The condition under the various wounds, and, above all, when foreign bodies remain sticking in the heart.

Injuries of the heart by needles are not without danger. A needle penetrating from without should be extracted as quickly as possible, and if one has broken off in the wound an attempt should certainly be made to extract it. But, on the other hand, a broken-off knife tip, or dagger, or other similar weapon, should be left undisturbed until the operator has exposed the parts sufficiently, as violent hæmorrhage immediately follows the extraction, and this may be fatal. Even in deep unconsciousness—without narcosis—the heart should be exposed, as on the pericardium being emptied of blood it usually begins to act well, and the faint passes off.

All injuries with symptoms of severe cardiac pressure demand at least pericardiotomy. The chief indication is the arrest of the hæmorrhage. In case of threatening internal hæmorrhage, even if there is no cardiac pressure, the pericardium should be exposed and an attempt be made to arrest the hæmorrhage, whatever the kind of wound may be.

There are a number of injuries where a wound of the heart is probable, without there being any urgent indication for operation. It is always better, however, to do an exploratory pericardiotomy, even if useless, than to overlook a wound of the heart.

Spontaneous recovery may take place in a certain percentage of cases. Wounds from needles afford a better prognosis than punctured wounds, the latter better than gunshot wounds; non-perforating wounds heal better than perforating ones. Nevertheless, a wound of the heart left to itself entails many dangers (purulent and non-purulent pericarditis, extensive adhesions, the danger of secondary hæmorrhage, bad, yielding cicatrices of the healed wound, so that it may break down or an aneurysm may form). A man whose heart has been sutured is therefore in a more favourable position than one whose wound has healed spontaneously.

The operation must be approached, however, with the greatest caution. In operations for gunshot wounds of the heart, it should be borne in mind that considerable injuries of the heart take place without perforation of the pericardium.

3. Exposing the heart and exploratory pericardiotomy.

Our procedure in exposing the heart is influenced by:—

1. The greater or lesser state of danger in which the patient happens to be.
2. The kind of wound and the position of the external one, whether right or left on the sternum, or at the side, at the back, or through the abdomen, or the absence of wounds and only contusions.
3. The accompanying hæmo-pneumothorax, or tension pneumothorax.
4. Elasticity or stiff rigidity of the thoracic walls, wide or narrow rib spaces.
5. Regard to the retention of a bony covering for the heart; this must stand in the front line.

It is of the greatest advantage to be able to perform the operation in a Sauerbruch's chamber or on a Brauer's table.

The ruling principle, however, must be to expose the heart in the most sparing manner possible. The use of the bone flap method should be restricted as much as possible. Bone flaps take it out of patients so much, and expose to great risk of infection. We should always try to attain our object at the least expense to the patient's safety, and nothing should be attempted at the expense of safe arrest of the hæmorrhage.

In other cases we must proceed more cautiously still. In a not inconsiderable number of cases the diagnosis is not quite certain. In a case, for example, where the external wound lies at a distance from the heart, exploratory pericardiotomy must be performed in such a way as will afford the greatest safety to the pleura, as well as for satisfactory evacuation of the pericardium.

The following plan fulfils these conditions:—

A crescentic incision runs along the lower border of the seventh left rib, about 6 cm. in length, towards the base of the ensiform cartilage and across it. The incision is deepened so that the costal cartilage of the seventh rib can be cut through just at its sternal insertion. The mammary artery is left untouched. Pushing the soft tissues aside, the finger is passed under the rib, and so between the musculus triangularis sterni and the sternal part of the diaphragm. The sterno-pericardial ligament is a good guide. With the cutting forceps a piece of the sternum and the cartilage of the seventh rib are resected. If, drawing back the rib and the sternum, the finger is passed directly upwards into the cellular tissue, the finger comes upon the pericardium, lying under a more or less thick layer of fat, and at a point where it is most likely to be free of diaphragmatic tissue. The more the pericardium is distended the easier the operation. But the operator must pass on upwards underneath the sternum in order to avoid opening the peritoneal cavity. It is extraordinarily easy to open the pericardium here, examine its contents, and thoroughly drain. The cavity may be emptied either to the right or the left, as from the same incision a drainage tube may be inserted from the right to left over the inferior vena cava. In this way the pericardium will also have been opened at its lowest part.

If whilst performing the pericardiotomy the operator has gained the impression that the heart itself has been wounded, he can proceed at once to lay open the heart by resecting the sixth rib at its cartilaginous origin.

Of the numerous methods of exposing the heart, I prefer the following:—First, an incision between the ribs, carefully observing the course of the external wound, passing from the sternum outwards. In case of a distant external wound, or of contusions, the incision may be made in the fifth internal costal space. In case of hæmo- or tense pneumothorax, the incision passes into the pleural cavity at once, the lung is grasped and drawn outwards, the ribs being drawn widely apart. The incision may be extended outwardly at pleasure. It will then be seen whether resection of one or more ribs will suffice, or whether partial resection of the sternum will be required. If it is found that the heart must be made still more accessible, as through free hæmorrhage from a wound below the sternum, then a longitudinal incision must be made in the sternum, and the soft parts freed. According to circumstances, the incision begins at the level of the upper border of the third rib, and ends at the upper border of the sixth. The costal cartilages of the ribs affected are cut through close to the sternum, and the bony flaps, along with the soft parts, are drawn forcibly upwards and downwards. The mammary artery need not be touched. If the pericardium is now opened by a vertical or a crucial incision, a good view will be obtained, and may be made more extensive by cutting off the border of the sternum. The heart can now be drawn so far forwards that the greater part of the right auricle, the coronary sulcus, the large arteries, the ventricles of both sides, and also the left auricle in part may be got at. If it is the intention to spare the pleura, the incision at the margin of the sternum must be made deeper, and the costal pleura and that of the pericardium must be separated step by step, the ribs separated from the sternum, and, if need be, resected. The pleura must be separated from the pericardium with the greatest caution, and in this way, in favourable cases, wounding of the pleura may be avoided.

4. Arrest of hæmorrhage in large wounds of the heart and suture of the heart.

When the heart has been exposed, in whatever way it may have been done, on opening the pericardium free bleeding may be expected. For the purpose of recognising the conditions that may be met with, the wound in the heart, a possible foreign body, and for passing the sutures properly, the parts should, if possible, be bloodless. In many cases where the bleeding is slight, it can be controlled by the finger; in other cases it may be so severe that there is danger of the patient bleeding to death, or of infection taking place. The possibility of being able to operate with but little or no blood in the way depends on the behaviour of the cardiac muscles, and the most sensitive nerve centres on diminished or entirely arrested blood supply. Experiments performed on dogs in the Pharmacological Institute, Heidelberg, have given the following results in regard to this:—

1. The bleeding from any wound of the heart may be arrested by compression of the right auricle, and by incomplete compression it may be mastered so that the sutures will pass through nearly bloodless tissues.

2. The dog's heart bears incomplete compression for four minutes with certainty, probably still longer; it bears complete compression for a minute and a half with certainty, but not longer than that.

3. The human heart will doubtless bear much more. In the dog's heart the flickering tremor is the deleterious feature, a sign of muscular insufficiency that can scarcely ever be recovered from in dogs; in rabbits and cats it is only fleeting.

Animal experiment, therefore, as well as experiences in treating the human heart, justify us in compressing the right atrium venosum in moments of extreme danger from hæmorrhage. It is best done by the finger. Whilst the heart is gently raised out of the pericardium with the right hand, the left hand is passed into the pericardium below it. The inferior vena cava, and its opening into the right auricle, are at once felt. It can be easily compressed between the ring and index fingers. By pushing up the finger the opening of the superior vena cava is closed. It is best, in passing the finger upwards, to go close to the inferior vena cava, so as not to close the vena magna cordis.

We have now the power of limiting or of completely arresting the blood current, and by means of this compression we can control the most rapid bleedings from the heart at once.

As regards suture of the heart, we can demand a good deal, but we must proceed as sparingly as possible. To grasp it with clamps or forceps would be serious. To bring the heart up to the chest wall by drawing on the pericardium is the most sparing method of bringing the heart into position for suturing. Too little of the side walls should not be grasped in doing so. If the heart is brittle the pericardium must be sutured along with it. Neither continuous suture nor wire should be made use of. The best is the interrupted suture with fine silk. A pause for rest should be given to a heart that is beating irregularly from exhaustion.

5. Statistics.—Of 124 cases of suture of the heart, 49 recovered, 75 died. Besides these, operations were performed on the heart without suturing in 10 cases, 6 for gunshot wounds, 4 for stabs, eight times with a favourable result, twice with a fatal one. Punctured and bullet wounds gave almost the same results. Wounds of the left ventricle were rather more frequent, and gave a rather higher percentage of recoveries; 16 patients had two wounds of the heart; in 1 case there were eight punctured wounds of the left ventricle, two of which were penetrating ones; in 12 cases the wounds did not penetrate, or it was not certain that they did so. The pleura escaped injury both from the wound and the operation in 9 cases (3 recoveries). The left coronary artery was ligatured or acupressed twice; both patients died of infection. If the case requires it, ligature of the main stem of the coronary artery must be attempted. A wound of the vena magna cordis must be treated by suture of its wall.

In regard to the question of drainage, the 90 available cases afford no distinct conclusion. The cases operated on extra-pleurally with drainage of the pericardium were the worst (all died); drainage of both cavities gave the best results.

It is always best to close the pleural cavity primarily, so long as bleeding that cannot be arrested does not call for tamponade. Before closing, the pleural cavity must be carefully emptied; during the first few days any air or fluid that has not been absorbed should be removed by aspiration.

The pericardium was closed in 50 cases (24 recovered, 26 died). It was drained in 40 cases (20 died and 20 recovered). In three of the cases of primary closure, the pericardium had to be opened and drained later on. Drainage by tampons led several times to retention of secretion, and once to strangulation of the heart with threatening symptoms. Rubber tubing is therefore best for drainage. The question to be weighed in each case after opening the pericardium is whether it will be better to close up or drain. If closure is decided on, the pericardium and the xyphoid cartilage should be sutured together so that the parts can be opened up and drained at any time. Complete closure of the pericardium with the pleura open is very dangerous on account of extension of infection.

As regards the complications in the cases that recovered (49), the after-treatment was more or less troublesome. Recoveries in 10 or 12 days are rare. The complications are pericarditis, which is very frequent, serous pleuritis, which occurred in several cases, pneumonia, empyæma in 6 cases, several times requiring puncture, resection of ribs and pleurotomy, delirium, psychoses, convulsive attacks, and pulmonary infarcts; secondary suture of the external wound, and a plastic operation on the chest wall, were each performed twice. As regards the complications and causes of death in the fatal cases, out of 75 patients, 16 died on the operating table, or within a few hours of the operation; 17 from within a few hours to two days after, from loss of blood and collapse, equalling 44 per cent.; 30 died from infection, or 40 per cent. The total mortality was therefore 84 per cent. In the future, infection will be avoided better by the use of Sauerbruch's process. The complications of pericarditis and pleurisy occurred in nearly 30 cases; in 12 of these the pericardium was closed primarily. Other complications were abscesses of the lungs, with pleuritis purulenta, pericardial adhesions, pulmonary infarcts with empyæma, phlebitis, purulent meningitis, five months after the operation, following cerebral abscess and encapsuled purulent pleuritic collection; partial subphrenic purulent peritonitis with purulent mediastinitis, commencing sero-fibrinous pericarditis, broncho-pneumonia, pneumonia, chronic myocarditis. Wounds were further found in the inter-ventricular space, and division of a thick papillary muscle of the tricuspid valve. In one case death took place suddenly, as from pulmonary embolism, although the patient appeared to be quite well on the morning after the operation. In another case there was embolism of the shot in the right subclavian artery, and ischæmic paralysis in the right forearm. In one case the projectile had passed through a vein of the lungs, had passed the heart, and been driven into the crural artery. One patient died on the eleventh day from tamponade of the heart, from a blood clot that had formed over a spot where a suture had been inserted; another one on the fifty-third day in consequence of unexpected hæmorrhage. On inquiry from other surgeons regarding the results in cases of suture of the heart, it was found that some patients could not be traced; some were dead from inter-current diseases. A post-mortem examination in one case showed almost complete adhesion of the pericardium to the heart; in another there were no adhesions at all. In a number of cases the patients were found, on later examination, to be perfectly strong and healthy. In one case examined ten months after operation it was ascertained that palpitation and occasional pain were complained of over the cardiac region, and the cardiac dulness was slightly extended on both sides. In another case a diastolic murmur was heard, and a partial aneurysm of the heart diagnosed two months after the operation.

As a casuistic contribution, the following case is given: A man stabbed himself in the region of the heart with a knife, 2 cm. of the tip of the blade being broken off. The conditions observed intra and post-vitam were the following: Extensive bleeding into the left pleural cavity, with compression of the left lung in connection with wound of the anterior wall and septum of the right ventricle at the commencement of the conus pulmonalis. The heart was sutured. There was slight thrombotic deposit over the inner surface of the right ventricle, acute sero-fibrinous pericarditis with left-sided pleurisy. The pericardium was sutured. The fourth and fifth costal cartilages were divided, with secondary reunion of the fourth afterwards. Excessive meteorism of both stomach and intestines, œdema of the lungs, commencing inflammatory œdema in the left lower lobe, circumscribed atelektasis of the right lower lobe, caseous tuberculous patches and cicatrices of the right apex of the lung, anæmia of all organs.

LUMBAR PUNCTURE IN AFFECTIONS OF THE NERVOUS SYSTEM.

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[Specially Reported for this Journal.]

Introduced for therapeutical purposes, lumbar puncture has become a means of diagnosis capable of rendering very great service in many affections of the nervous system. It enables us to establish the existence and the nature of attacks of meningitis, and it reveals the slightest disturbance of the cerebro-spinal axis and its membranes. It is now in constant use, and the *modus operandi* should be familiar to every practitioner. To Quincke, a Kiel practitioner, is due the credit of having first practised lumbar puncture, in 1890. Between the terminal cone of the spinal cord, covered by the pia mater, which stops opposite the second lumbar vertebra, and the cul-de-sac of the dura mater which ends behind the second sacral vertebra, there is a sort of reservoir, measuring from 20 to 25 centimetres in length, and 2 centimetres in width, filled with cerebro-spinal fluid in which float the nerves of the cauda equina. A trocar introduced through the third, fourth, or fifth lumbar spaces may be pushed into this cavity without any risk of injuring the cord. Quincke used to withdraw a certain quantity of fluid in cases of hydrocephalus in order to reduce the intra-ventricular pressure, and thereby abolish the symptoms to which this pressure gave rise. As a mode of cure this intervention was soon found to be of [illegible] value, and applicable in comparatively few [illegible] lumbar puncture would no doubt have been given up had not certain observers (Furbinger, Stadellmann, Bonome, Netter, Widal, Sicard and Ravaut), in the course of investigations on the normal properties of cerebro-spinal fluid and pathological modifications of the same, converted it into a means of diagnosis in affections of the nerve axis and its membranes. It has since been rendered an easy and trustworthy method of investigation which has come into daily use.

Technique.

The technical procedure is simple enough. With the patient in the sitting posture and slightly bent forward, or lying on his side with his head on a cushion, the thighs well flexed on the abdomen and the body bent forwards, the spinal processes are separated from each other, leaving a space of about half an inch. The sitting posture, recommended by some observers, is objected to by others on the ground that it allows of the too rapid escape of the fluid, fatigues the patient, and tends to set up muscular contraction. All that is required is an iridio-platinum needle, 3½ to 4 inches long, and 1-30th of an inch in thickness. One end is bevel-pointed, and the other fits on to the nozzle of a hypodermic syringe. The needle is sterilised by boiling or in the autoclave, and the skin over the selected spot is carefully disinfected by washing with soap and water, followed by ether and alcohol. The operator, placing his first finger as a guide over the fourth lumbar spinal process, which is just below a line drawn from between the two iliac crests, plunges the needle into the fourth space, just below the left index, about a fifth of an inch from the middle line, directing it slightly upwards and inwards. It successively pierces the sacro-lumbar muscles, the ligamentum sub-flavum, the vertebral canal, and the dura mater, entering the sub-arachnoid space.

The operation is peculiarly easy in the child, whose spinal column is more flexible, the ligaments less resistant, and the intervals between the vertebral arches comparatively much wider than in the adult. All we have to do is to plunge the needle boldly in the middle line, bearing in mind that in the child the cord comes down to the third lumbar vertebra. Even in the adult the median puncture is feasible, and is now often resorted to. The liquid having been allowed to escape, the needle is quickly withdrawn and the small orifice closed with a collodion dressing.

Should the needle butt against the wing or the base of the spinal process, all we have to do is to turn the point somewhat downwards and outwards, when it will go in readily enough. Should it strike the body of the vertebra, it must be withdrawn a little way, when we shall fall into the cavity. Should it get blocked, the lumen may be cleared by running a sterilised piece of wire through it. The first few drops of liquid are often tinged with blood, but the liquid soon becomes clear again. If it does not, the needle should be withdrawn and introduced afresh.

The patient may complain of sharp pain in one or both sides due to traction on some fibres of the cauda equina, but it soon passes off. If we take the precaution to place the patient on his back and to allow the escape of only a small quantity of fluid, we avoid the risk of possibly fatal syncope or other troublesome manifestation. Under ordinary circumstances slight headache is the worst that happens, and in bed this is not long in passing off.

Persons suffering from meningitis and, in general, those with excessive pressure of cerebro-spinal fluid, bear lumbar puncture better than the others, and complications are very rare with them. On the contrary, their symptoms are *pro tanto* improved. By modifying the intra-cranial pressure, lumbar puncture obviates its effects. Comatose patients regain consciousness and ask for food, convulsions cease, and actual aphasia may disappear completely and at once. In meningitis lumbar puncture does not act exclusively by relieving pressure, for the withdrawal of even a small quantity of the fluid, whatever its actual virulence, diminishes the infection and promotes organic resistance.

But the therapeutical action of lumbar puncture, whether palliative or curative, is insignificant compared with its diagnostic importance. Under the influence of bacteriological research, there has been a return to humoral views. Investigators have studied the composition of the various fluids of the organism in order to determine their normal properties and their morbid reactions, and they have obtained some highly valuable diagnostic data. The study of the cerebro-spinal fluid in particular has yielded a whole series of means of investigation of the greatest utility in the observation of meningeal lesions, and especially in tuberculous meningitis.

Normally, the cerebro-spinal fluid is alkaline, clear as crystal, containing but a small proportion of saline constituents, and not spontaneously coagulable; sp. grav., 1,003 to 1,004. Wolff gives the following analysis:—

Water, 985.64; chlorides of soda and potash, 8.01; albumen, 0.88; osmazone, 4.74; mineral salts and free phosphate of lime, 0.36; carbonate of soda and phosphate of lime, 0.17.

It contains no cellular elements. It is hypertonic compared with blood serum. Its freezing point varies from 0.58° to 0.75°. Quincke estimates its pressure at 40 to 60 millimetres of water; Leukowicz at from 20 to 25 m.m. of mercury. The physical and chemical characters of cerebro-spinal fluid vary in different pathological states.

Macroscopical Appearances.

The liquid may remain clear; this is usually the case in tuberculous meningitis, sometimes even in acute meningitis, almost always so in the meningeal processes associated with tabes, general paralysis, etc. It is often turbid and even purulent, as in most instances of acute meningitis. Lastly, it may be yellow or blood-stained. Apart from the presence of blood due to puncture of a cutaneous, muscular, or rhachidian vein, the presence of red corpuscles in the cerebro-spinal fluid is indicative of intra-meningeal hæmorrhage, the source of which may be elicited by inquiry—fractured skull, cerebral hæmorrhage, etc. In cases of hemiplegia the existence of this blood-stained fluid enables us to discard the hypothesis of softening, which is not accompanied by meningeal hæmorrhage. Simple yellow colouration does not justify a diagnosis of hæmorrhage of the neuraxis or its adnexa, for it is also met with in jaundice and in certain cases of meningitis.

Permeability of the Meninges.

Certain substances, when ingested or injected beneath the skin (iodide of potassium, methylene blue, salicylate of soda, etc.), only find their way into the cerebro-spinal fluid in certain meningeal inflammations. Widal, Sicard, and Monod have discovered iodide of potassium in the cerebro-spinal fluid in the course of acute meningitis, while Griffon and others have failed to find it in cerebro-spinal meningitis. In reality this permeability of the meninges, according to the theory of the earlier writers, does not possess any absolute diagnostic value. When it exists it indicates a meningeal reaction, probably, but not certainly, tuberculous, for it has also been met with in acute syphilitic meningitis. Its absence does not prove anything, for it is only present in half the cases of tuberculous meningitis.

Cryoscopy.—The cerebro-spinal fluid is often hypotonic compared with blood serum in acute meningitis, and especially in tuberculous meningitis. This hypotonicity is inconstant, and varies from day to day even in the same subject.

Tension.—The pressure of the cerebro-spinal fluid is measured by the manometer, or, roughly, by the jet when punctured. It is increased in certain meningeal irritations (acute meningitis and syphilitic meningitis), and in affections such as cerebral uræmia, secondary syphilitic headache, cerebral tumour, hydrocephalus, etc. The relief afforded by puncture to the headache suggests that the excessive pressure was the underlying cause of the latter. In short, the pressure of the fluid possesses a pathogenic and therapeutical rather than a semiological interest.

Chemical Composition.—The proportion of chlorides may be reduced in cases of meningitis. The proportion of albumen increases in presence of inflammation, especially of the meninges. It consists in that case principally of serine, whereas normally it is *mostly* globuline. The fibrin is increased in meningitis, urea in uræmia, and sugar has been found in the cerebro-spinal fluid of diabetics.

Cytoscopy.—The cytoscopic examination of the cerebro-spinal fluid affords valuable information. The presence of leucocytes in great numbers (50 to 100 and upwards per cubic millimetre) constitutes anatomical evidence of a meningeal lesion—(*a*) acute—when the infection that has set up the meningeal reaction is massive and brutal in its action, there is an outpouring of leucocytes which are the fighting cells; when it is sub-acute from the onset, or when it is retrogressing towards recovery, there is lymphocytosis. In tuberculous meningitis lymphocytosis is usually present, sometimes associated with polynucleosis, due, no doubt, to its microbial associations. Moreover, if we stain the preparations by Ziehl's method, in about half the cases one discovers a few tubercle bacilli, and that, of course, establishes the diagnosis.

In acute non-tuberculous meningitis there is usually polynucleosis, while in meningitis tending towards recovery, in acute syphilitic meningitis and in typhoid meningitis we may find lymphocytosis. It will be seen, then, that lumbar puncture allows us to distinguish meningitis from the nervous phenomena of uræmia, from tetanus, from meningeal hæmorrhage, and from cerebral tumours. It enables us, moreover, to diagnose tuberculous meningitis, which is accompanied by lymphocytosis when fully established, and from cerebro-spinal meningitis, which is characterised by polynucleosis, except during the periods of remission. We also meet with cells in the cerebro-spinal fluid when cerebral complications supervene in the course of suppurating otorrhœa, from typhoid fever, from mumps, pneumonia, broncho-pneumonia, etc. Lastly, cells have been met with in the cerebro-spinal fluid in various infectious diseases—infantile paralysis, zona, herpes, etc., etc.

Sub-Acute and Chronic Attacks.

Lumbar puncture, a genuine bioscopy of the meninges, renders great service in the diagnosis of tabes. We are familiar with the protean aspects of this disease, which is apt to run an irregular or abortive course. When we suspect tabes in the victim of syphilis of old standing, and on examination we find evidence of meningeal lymphocytosis, we may unhesitatingly affirm the existence of sclerosis of the posterior columns. This lymphocytosis proves the existence of a meningitis which, far from being the consequence of the parenchymatous lesions of tabes, precedes the latter, and in a sense determines their supervention (Nageotte).

In general paralysis we sometimes meet with lymphocytosis, and this reaction, though inconstant, permits us to distinguish general paralysis from alcoholism, neurasthenia, and brain softening. Should polynucleosis occur, we may suspect the existence of a secondary affection.

An inconstant lypmhocytosis has also been observed in the secondary stage of syphilis parallel with the intensity of the secondary cutaneous symptoms. Syphilitic hemiplegia is also associated with copious lymphocytosis, which distinguishes it from hysterical hemiplegia and the organic forms due to hæmorrhage and softening of the brain. It will be seen from what precedes the valuable assistance that examination of the cerebro-spinal fluid may render in the diagnosis of affections of the nervous system.

But lumbar puncture is also available therapeutically. It is methodically had recourse to in the treatment of cerebro-spinal meningitis. The withdrawal every two or three days of from 5 to 15 cubic centimetres of the purulent liquid surrounding the neuraxis mitigates the symptoms due to cerebro-spinal hypertension, and reduces the meningeal infection. Hot baths, local counter-irritation, and the administration of antispasmodics complete the treatment.

In cases of cerebral tumour lumbar puncture attenuates or relieves the vomiting, headache, and pupillary stasis due to the pressure of the cerebro-spinal fluid in hypertension. In the same way it diminishes the intense headache of the secondary period of syphilis, and Babinski and Boisseau state that it cures urinary incontinence. It was Babinski who, having been induced by observations of voltaic vertigo to practise rhachicentesis in cases of Menière's disease, erected this procedure into a remarkable method of treatment. A single puncture often suffices to quiet all the symptoms, the vertigo disappearing altogether. The noises in the ears are, as a rule, only attenuated, and not abolished, but the symptom on which the operation appears to exert least effect is the deafness.

A Note on the Rôle of

CONSERVATIVE VITAL REACTION IN PATHOLOGICAL ANATOMY,

Particularly in regard to certain Chronic Rheumatoid and Gouty Changes.

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It is now generally admitted that the limiting fibrosis about old tuberculous lesions in the lungs and elsewhere, is to be regarded as conservative in nature, but it is not quite so obvious that the same explanation applies likewise to the keloid-like scars resulting from tuberculous glandular abscesses in the neck and elsewhere, and to the scar tissue in ordinary fibro-caseous forms of chronic pulmonary tuberculosis. So also, whilst everyone agrees that the fibrosis about old tertiary syphilitic lesions in the liver is evidence of a conservative vital reaction, many will not readily consent to the view that the fibrosis in all cases of hepatic cirrhosis is likewise of essentially the same nature. (*a*)

In the same way, I believe it is not yet generally admitted that the lipping, synovial overgrowth, and capsular or periarticular fibrous thickening of chronic rheumatoid and gouty joints, and the development of subcutaneous fibrous nodules (with or without tophaceous deposit in them), are essentially manifestations of conservative vital reaction.

In order to make myself clear, I shall first have to explain what I mean by "action" and "vital reaction." The words action, reaction, agent and re-agent are employed in chemistry, physical geography, etc., but in all non-vital processes and phenomena there seems to be very little difference between action and reaction, one reaction serving as, or producing, an agent which provokes another reaction, and so on. Moreover, "vital reactions," which, in the broadest sense of the term, include all those manifestations of irritability which distinguish living from non-living bodies, often (perhaps always) differ from non-vital reactions in being useful (*i.e.*, beneficial for the organism manifesting them), or "conservative" in nature, as if they were purposeful.

In regard to human life and human pathology, I would divide all vital reactions into:—

(1) Mental or voluntary nervous reactions.

(2) Reflex or involuntary nervous reactions.

(3) Vital reactions other than nervous reactions.

Reactions of the third class may manifest themselves (a) by chemical changes, etc., *e.g.*, production of antitoxins, and (b) by anatomical (macroscopic and microscopic) changes. It is only with reactions of this second division of the third class that we are now concerned.

Typical examples of anatomical conservative or compensatory reactions are: (1) the increase of the polymorphonuclear leucocytes in the blood consequent on streptoccocal infections, etc.; (2) the increase of the red blood-cells connected with imperfect oxygenation of the blood in chronic cardiac and pulmonary diseases; (3) growth of skeletal muscles consequent on increased functional activity; (4) myocardial hypertrophy in conditions throwing abnormal work on the whole or a portion of the heart musculature; (5) thickening of the skin and subcutaneous tissue from intermittent pressure or friction; (6) hypertrophy of one kidney after removal or disease of the other kidney; (7) the phenomena of the healing of a wound caused by chemical, physical or mechanical agents, with or without infective (microbic) complications. In all such cases, the "agent" (whether chemical, physical, mechanical or "functional") provoking the reaction, and the conservative or compensatory nature of the reaction are obvious, and no difficulties in teleological interpretation can arise.

Difficulties in interpretation, when they arise, are chiefly due to:—

(1) Uncertainty as to the nature of the morbid agent or agents. For instance, in tuberculous affections, before the tubercle bacillus was discovered by Koch as the exciting cause of tuberculosis, the conservative nature of the fibrosis around chronic lesions could of course be but imperfectly guessed at.

(2) Multiplicity of the agents. For instance, in the case of wounds, the reactive processes necessary for aseptic healing were formerly generally associated with the processes due to the infection of the wound with pathogenic microbes, and before the nature of septic inflammation was thoroughly recognised, the phenomena of healing were necessarily confused with those of reaction towards septic infection.

(3) Confusion between the phenomena of the action with those of the reaction. (*a*) For instance, in chronic tuberculosis, the process of cell-necrosis due to the agent (*i.e.*, to the local presence of the tubercle bacillus) proceeds side by side in the infected animal with reactive attempts at local repair and limitation.

(4) Differences in reaction due to differences of "soil." In human beings, as doubtless in other animals, there are differences in reaction due to individual peculiarity ("idiosyncrasy"), race, sex, age, previous habits, and general nutrition. Children offer a "virgin soil" for the growth of pathogenic microbes. They are infected easily, and the struggle between the morbid agent (the invading microbes) and the infected organism is acute, but usually relatively short. In elderly persons the tissues have, from previous practice, acquired the power of at once resisting many infections, or of yielding less suddenly than the tissues of young persons to certain diseases, such as tuberculosis. It is especially in chronic tuberculosis in adults, where the battle has been very slow and prolonged, that the anatomical results of morbid action are most intimately mingled with the conservative changes due to reaction.

I will now return to the question of the subcutaneous fibrous nodules occasionally met with in rheumatoid conditions in adults. These differ from the well-known "rheumatic" nodules" met with in children suffering from true articular rheumatism, chorea, or rheumatic endocarditis. They are sometimes larger and disappear less readily. The "rheumatic nodules" of children, at least the central portions of the nodules, seem to consist of a more fluid, less organised exudate (*b*), and can, therefore, be more readily absorbed. These differences may, however, be due to differences in re-

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(*a*) The hypertrophic adenoma-like nodules of the hepatic parenchyma in hob-nail livers are of course to be regarded as an attempt at compensatory over-growth, and are therefore likewise the result of a "conservative" reaction.

(*a*) Cf. F. P. Weber, "A Note on Action and Reaction in Pathology and Therapeutics," "St. Bart's. Hospital Reports," vol. 39 p. 139.

(*b*) See F. J. Poynton and G. F. Still, "The Histology of the Rheumatic Nodule." "Transactions of the Pathological Society," London, 1899, vol. 50, p. 324.

action towards irritation, that is to say, whatever the nature of the local irritation may be (microbes of rheumatism, necrotic foci, etc.), and irrespective of the question whether there are one or several different causes for the irritation, the tissues of adults may react in a more persistent and "fibrous" manner than those of children. The local reaction resulting in the development of the subcutaneous nodules might in both instances be supposed to be "conservative" in nature, that in adults, however, more nearly resembling the local "fibrous" reaction so often seen about chronic tuberculous foci. One might further suppose that many gouty tophaceous nodules are really of the same nature, the only difference being that, owing to some peculiar local or general chemical state, more or less uratic deposit has occurred into the devitalised tissue of the nodule.

It seems to me also that the lipping, synovial overgrowth, and capsular or periarticular fibrous thickening met with in chronic rheumatoid and gouty joints are to be explained in essentially the same way, that is to say, as representing a chronic vital reaction (of a "conservative" nature) towards various more or less unknown sources of local irritation. Amongst the local sources of irritation (probably chiefly microbic or toxæmic), I should certainly include the wearing away of articular cartilages owing to devitalisation from old age (in senile osteo-arthritis) and debilitating illnesses, or owing to relatively excessive use. I would consider wear of the articular surfaces as a "source of local irritation" whenever, by reason of devitalisation or excessive function, it exceeds repair. No doubt, however, the disorderly overgrowth sometimes met with is due to nervous influences, and is analogous to the new-bone-formation which sometimes occurs about and in the neighbourhood of joints in cases of spinal arthropathies (*i.e.*, in tabes and syringomyelia).

OPERATING THEATRES.

PADDINGTON-GREEN CHILDREN'S HOSPITAL.

SINUS THROMBOSIS SECONDARY TO MASTOID ABSCESS.—**MR. ARTHUR EDMUNDS** operated on a child, æt. 5, who had been suffering for several months from a discharge from the right ear. Her adenoids had been removed with a view of relieving this discharge, but this object had not been obtained. Three weeks after the operation for the adenoids the child was admitted with all the signs and symptoms of an acute mastoid abscess. The temperature was especially high, namely, 106.4°, otherwise the case presented nothing of unusual importance. The ear was still discharging, and there was tenderness over the McEwen triangle, but there was no thrombosis or tenderness along the jugular vein. Accordingly, an incision was made behind the ear, the pinna turned forward, and the bone over the mastoid exposed. There are, Mr. Edmunds said, many ways of opening the mastoid. Some surgeons employ a hammer and chisel; others prefer an electrically driven burr; while a third section, apparently a small minority, use a hand gouge. The present operation was practically performed entirely with the latter instrument, which he contended was the simplest and safest method of operating. To perform any bone operation, especially a mastoid, with a gouge, it is necessary for the surgeon to be able to use both hands. The gouge must be of appropriate shape and size, and should be fairly sharp; the best way to obtain such an instrument was to go to the instrument makers and to select a gouge whose handle fits comfortably into the surgeon's palm; the forefinger is laid along the blade of the gouge, which is then cut off level with the tip of the forefinger and re-sharpened. With such an instrument it is possible to perform a complete mastoid operation in about half an hour, and, moreover, to remove all overhanging portions of bone so that the mastoid antrum becomes simply a depression on the side of the head. It is sometimes a little difficult to remove the bridge of bone between the antrum and the middle ear, but this is easily cut through with a couple of strokes of the chisel. The employment of a hammer and chisel very commonly produces concussion, which sometimes lasts two or three days. It is not surprising that this should occur; indeed, it is remarkable that patients are able to stand the prolonged hammering over the side of the head to which they are so commonly subjected during this operation. The electric burr is not, it is true, open to this objection, but all such complicated and elaborate mechanical devices have disadvantages inseparable from their construction. The gouge is held in the hand with the finger pulp resting over its cutting edge; the tip of the finger is laid upon the bone, and, by a sort of rocking movement, the bone is shaved away, the shavings of bone being held between the finger and the tool. The present operation was completed in the usual way, a large flap being cut from the pinna to fill up the upper portion of the bony cavity. All drainage was conducted through the external auditory meatus, the wound behind the ear being completely sutured. The next morning the temperature had fallen to normal, and the general condition of the child was much improved. Towards evening, however, the temperature again rose, and for the next four days oscillated between 100° and 105°. In spite of this, the child remained perfectly comfortable, and took her food well. At the end of this period, it was decided to operate again, and search for further mischief; but on arriving at the hospital prepared to operate, Mr. Edmunds found that the temperature had again sunk to normal, and, moreover, that the pulse, which previously had not followed the temperature, had dropped also much lower than it had been since the operation. Operation was accordingly postponed for another 48 hours, but then, as the temperature had again gone up, it was decided to reopen the wound and remove some more bone. The wound behind the ear was accordingly re-opened, and on shaving away more bone towards the posterior aspect, a small extra dural abscess containing a few drops of pus was opened. This abscess lay between the posterior wall of the antrum and the lateral sinus, and its contents were under considerable pressure. The lateral sinus did not seem to be in any way affected. The abscess was drained behind the ear, and the patient put back to bed. The operation, however, did not improve the child's condition in the very least. The temperature continued to swing as before, but the girl still remained comparatively comfortable. Three days later the jugular vein was tied, and the lateral sinus opened up. There was a small amount of thrombosis in the sinus, and the thrombi were removed until the upper portion of the vein bled freely. Hæmorrhage was then arrested by packing. This operation was again disappointing; the temperature remained as before, but the patient was, if anything, a little weaker, and was becoming distinctly drowsy. There was no optic neuritis and no symptoms of intracranial pressure. The wound was dressed next day under an anæsthetic, and from this time onwards the child's strength began to fail. The next day slight optic neuritis was noticed, and shortly after this the eye on the affected side became slightly prominent. A diagnosis of thrombosis of the cavernous sinus was then made, and it was decided that the case was beyond further operative treatment. The symptoms progressed, and the child died about 48 hours later.

At the post-mortem it was found that thrombosis had extended very little from the lateral sinus on the affected side, but that there was thrombosis of both cavernous sinuses, which had affected the opposite lateral sinus; moreover, there was an area of the petrosal sinus on the affected side which was quite free from clots. There was no cerebral abscess. Mr. Edmunds said it was quite obvious in this case that the spread from the mastoid antrum was not due to any gross defect in the bony capsule of the ear, the organisms passing by lymphatic structures and by the small communicating veins, so that in all probability infection of the cavernous and other sinuses was present from the commencement. This theory explained the fact that, although at each operation pus was definitely found and evacuated, none of the operations afforded any relief to the patient.

ROYAL SOUTHERN HOSPITAL, LIVERPOOL.

Palmar Aneurysm.—**Mr. Newbolt** operated upon a case of palmar aneurysm in a male, æt. 32, who had noticed a swelling in the centre of the palm of his left hand for two months. This swelling was spherical, and about an inch in diameter, and had followed the wound caused by a chisel. On examination it was bluish in colour, and of elastic consistency, reducible on deep pressure, but filling rapidly when the pressure was released. Pulsation could only be stopped by compression of both radial and ulnar arteries. The veins of the hand and arm were not distended. There were pain and numbness of both index and middle fingers. Under ether, a tourniquet having been applied, a longitudinal incision was made over the swelling, the skin, palmaris brevis, and palmar fascia, were divided, and the sac was exposed. It was opened, a black, non-adherent clot turned out, and the sac wall dissected away from the superficial tendons and digital nerves. Three arteries were tied—*i.e.*, the superficialis volæ, the ulnar, and a communication with the deep arch. The wound was closed with deep sutures and silkworm gut. It healed soundly, and early movement of the fingers was practised. One month after operation movement of the fingers is perfect, but there is still some numbness of the two fingers at first involved. Mr. Newbolt said that these aneurysms were very rare —it was the only one he had seen in a surgical experience of 24 years. He considered that the best treatment was to deal directly, if possible, with the sac, and not to tie the ulnar and radial or ulnar alone above the wrist. Though the latter methods were efficacious, yet they occasionally left a hard matted nodule, which interfered with the free use of the flexor tendons or involved the digital nerves. The sac was formed by the matting of the surrounding tissues with the tendon sheaths and digital nerves. It was necessary to dissect the latter out very carefully, and for this purpose the use of the tourniquet to render the parts bloodless was essential. Considering how commonly the palm of the hand was wounded, it was surprising that aneurisms did not occur more frequently. In this case, in all probability, the vessel was only partially severed at the time of the accident. As the patient wished to be cured as speedily as possible, other methods of treatment, such as direct pressure, were not considered.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held Thursday, January 9th, 1908.

The President, Dr. **Herbert Spencer**, in the Chair.

Dr. Herbert Williamson read a short communication on a case of enucleation, during the seventh month of pregnancy, of a uterine fibro-myoma weighing 17½ lbs., which was followed by premature labour two days later. The patient was a primigravida, æt. 32. When four months pregnant she suffered from repeated attacks of acute abdominal pain, and became emaciated with some fever and the distension of the abdomen was so great that she was unable to lie down in bed. At the time of the operation the tumour, which could be felt distinct from the gravid uterus, was thought to be a malignant growth of the ovary, but it was found to be a uterine fibro-myoma undergoing necrotic degeneration. The area of attachment of the tumour to the uterus was rather narrow, but required enucleation. A premature child was expelled three days later, but the patient made an uninterrupted recovery.

Norman C. Carver, M.B., and **John S. Fairbairn**, M.B., read a case of

HÆMORRHAGE INTO THE PONS VAROLII AS THE IMMEDIATE CAUSE OF DEATH IN THE ECLAMPSIA OF PREGNANCY, WITH ILLUSTRATIVE CASES.

The authors record the case of a primigravida, æt. 24, who, after exhibiting signs of impending eclampsia, was found unconscious and straightway admitted to hospital. In view of the history of the illness and the presence of œdema and a high degree of albuminuria, the case was thought to be one of eclampsia, and, as the patient was in a state of deep coma, with Cheyne-Stokes respiration, rapid dilatation of the cervix was done, followed by the extraction of a fœtus of between five and six months development. The patient died a few hours later, and at the autopsy death was found to be due to an extensive hæmorrhage into the pons varolii. The authors argue that although the immediate cause of death was a pontine hæmorrhage, the case was primarily one of eclampsia, and in support of this quote four recorded cases of a similar nature, in which an unsuspected cerebral hæmorrhage was found post-mortem. Details of these cases are given, and, from an analysis of the symptoms presented by them and the authors' case, attention is drawn to such features in them as may serve to arouse a suspicion of the occurrence of apoplexy in the course of an eclamptic attack. These are, briefly, deep coma, and cyanosis, with marked respiratory disturbance, occurring in a young patient presenting the urinary and other signs of eclampsia, and they are especially suggestive when the attack is unaccompanied by the usual eclamptic convulsions.

The **President** (Dr. Herbert Spencer) thanked the authors for the interesting paper. He had not met with a case of hæmorrhage into the pons varolii in eclampsia, but he could recall two cases of hæmorrhage into the substance of the brain, one observed at a post-mortem examination and the other in which hemiplegia occurred, from which the patient slowly recovered. He thought that apoplexy was a well-known cause of death in eclampsia, and was surprised that the authors had not found more cases recorded, although they did not claim that their paper was exhaustive. In view of the possibility of the occurrence of cerebral hæmorrhage in eclampsia, the intravenous injection of a large quantity of saline fluid would appear to be not unattended with risk.

Dr. **Macnaughton-Jones** recalled the fact that the "apoplectiform" was one of the old writers' division of eclampsia, and in which sanguineous and serous effusion occurred into the ventricles. The symptoms were such as described in this case. He dwelt on the importance of early anticipation of the eclampsia, especially through the ocular symptoms and signs which were often present, and in which an ophthalmoscopic examination afforded most valuable evidence of the approaching danger. One of the most valuable therapeutical means they possessed to control the increased blood pressure in these cases of threatening cerebral hæmorrhage he believed to be the employment of weak doses of pilocarpin, which was also useful in checking the convulsions. If necessary, its full physiological action might be neutralised by 1-100th of a grain of atropin. He had known eclampsia ending fatally occur as early as the fourth month of pregnancy.

Mr. A. **Lionel Smith** said he had seen three cases of cerebral hæmorrhage complicating eclampsia or toxæmia of pregnancy, in all of which the diagnosis was confirmed at the necropsy. In one of them the hæmorrhage occurred in association with eclamptic convulsions after delivery, but in the other two the patients were not in labour, and had only reached about the 30th week of pregnancy.

Dr. **Amand Routh** had not had an opportunity of seeing a post-mortem examination of any case dying of puerperal eclampsia where cerebral hæmorrhage had been found, but thought the authors had shown how often such hæmorrhage might supervene and be the immediate cause of death. He thought it unwise to increase arterial tension, as must have been done in the first case reported, when 10 oz. of blood were removed, and 40 oz. of saline infusion injected. This may well have increased the tendency to hæmorrhage. He presumed that saline infusion in these cases is given to dilute the toxines at each given point, and to increase the leucocytosis to combat the toxines; but it was doubtful if it should be given when it increased arterial pressure. On the other hand, he considered that the suggestion to give pilocarpin (at all events in the doses usually prescribed—viz., 1-5th gr.) was fraught with grave danger. He considered it should never be given in cases where apoplectic symptoms, or coma, was present, for he had seen patients under its influence suffocated by the enormous quantity of ropy mucus secreted by their salivary and broncho-pharyngeal glands. He was interested in the fact that epigastric pain had been mentioned as a precursor of eclampsia in some of these cases of albuminuria of pregnancy. He considered this sign, following ocular evidences of high arterial tension, increasing albuminuria, and diminishing excretion of urea, a valuable indication that eclampsia was impending, and that steps should be taken to induce labour without needless delay.

Dr. D. C. **Rayner** referred to a case of eclampsia under his care, in which a fatal termination was due to cerebral hæmorrhage. The patient was in the eighth month of her third pregnancy when convulsions set in. They were frequent, and seemed more marked on the right side. The pupils were also noticed to be unequal. The urine contained albumen, and the patient was not in labour. Coma deepened, and the patient died in a few hours. There was extensive hæmorrhage into the right corpus striatum and optic thalamus.

Dr. R. H. **Hodgson** said that he thought the lesson to be learnt from this instructive paper was, in all cases of eclampsia in pregnant women, empty the uterus. He had done so in six cases he had, and in all the women recovered, five very rapidly, and one in whom some slight convulsions continued for five days, was quite well after one injection of pilocarpin. Emptying the uterus causes the blood to flow to the portal system, and thus lessens the danger of cerebral hæmorrhage. He did not understand the object of the saline injection.

Dr. **Fairbairn**, in reply, said no attempt had been made to make an exhaustive collection of cases of apoplexy as the cause of death in eclampsia, and the cases collected were those of hæmorrhage into the pons or base of the brain without unilateral symptoms to suggest apoplexy. Large cerebral hæmorrhages were not frequent in eclampsia, as was shown by the statistics quoted in the paper. The cases recorded were undoubtedly rare, but the possibility of a deeply comatose and cyanosed eclamptic patient having also a cerebral hæmorrhage ought not to be lost sight of, especially in giving a prognosis.

The following specimens were shown:—

Dr. J. P. Hedley:—(1) Hydrosalpinx with torsion of the pedicle; (2) double hæmorrhagic cysts of ovaries.

Dr. Harold Sington:—Tumour of the fœtal head.

Dr. Lewers:—Cancer of the cervix (advanced); hysterectomy by Wertheim's method.

Alderman J. Rubie, Chairman, presided at the recent fortnightly meeting of the Bath Sanitary Committee held at the Guildhall on Monday. The Midwives Sub-Committee's recommendation was adopted as regards the appointment of Miss Hilda Lea as Lady Health Visitor, to act under the direction of the Medical Officer of Health, and generally to assist him in his duties, under the Midwives Act, 1902, and in preventing infantile mortality, in accordance with the schedule of duties already approved.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

Meeting held Friday, January 10th, 1908.

The President, A. R. **Parsons**, M.D., in the Chair.

SEPTIC ENDOCARDITIS.

Dr. **Bewley** said the case was one of a young man born in 1885. In 1898 he had suffered from rheumatic fever, being laid up for six months, and his heart being, he believed, then affected. During the following three years he had further attacks. He came into hospital in February, 1905, suffering from breathlessness and palpitation. He was found to have a hypertrophied heart, double aortic disease, and mitral regurgitation. During the time the patient was under his care he never suffered from fever; the main clinical feature was the regurgitation. About the middle of October last he came to see him (Dr. Bewley), looking very ill, his heart beating 130 to 140 per minute. He was admitted to hospital on October 19th, and died on December 16th. His last illness had begun in the previous June with feverishness, occasional sweatings, and loss of strength. While in hospital his evening temperature ran to 101° and 102°, and his morning temperature varied from normal to 100°. The condition of the heart was much the same as before, and sometimes a presystolic thrill was felt. He had also a slight hemiplegic seizure, from which he recovered in a few days. The diagnosis was septic endocarditis. About the middle of November a tender spot came on one side of his head. For four or five days it was swollen, and gradually subsided. The temporal artery might be felt as far as the spot, but could not be traced beyond it. No abscess occurred, showing that the infection was very mild. The same symptoms occurred on the other side at the same spot. At the post-mortem the heart was found very much enlarged, and the pericardium was found to be universally adherent—a condition of which there was no clinical sign whatever. The right cavities of the heart were comparatively small, the left ventricle was enormous, and both the mitral and aortic valves were festooned with soft pink vegetations. The kidneys were enlarged; the spleen was very much enlarged, and there was an abscess in connection with an infarct in the spleen. Dr. Harvey made an examination of one of the vegetations, which showed enormous numbers of cocci of the streptococcus type. The case, then, was one of endocarditis, with an organism of extremely mild virulence; the sepsis had lasted fully six months.

The **Secretary** said that, considering no cultures had been made, it was difficult to tell from the section alone whether they were dealing with streptococci. He believed they were not streptococci, but were rather diplococci of the pneumococcus type.

The **President** asked Dr. Bewley if he thought the final attack was a separate and distinct infection, or did he consider that the patient was carrying the organisms in his system all the time, and they simply found a suitable opportunity to develop?

Dr. **Bewley**, in reply, said it seemed to him that the final infection was a distinct and new one, but, of course, he could not prove it to be so.

Dr. **Harvey** mentioned that he looked on the cocci as streptococci.

INTRA-THORACIC TUMOUR.

Dr. **Travers Smith** gave the main clinical facts of the case, of which Dr. Earl would show post-mortem specimens. The patient, a man, æt. 56, was admitted to hospital on April 23rd, 1907, and died in about six weeks. A few months before admission he received a heavy blow on the chest, but one could not say how much that had to do with the growth in his thorax and its extreme distribution. About two months before admission he noticed a swelling, which extended into his right arm and right side of his chest. About four weeks previously he noticed the veins of his chest getting prominent, and his right ear getting rather blue. On examination he found his right arm and neck, especially on the right side, œdematous, and not pitting on pressure. The enlargement of the veins of the chest on the right side did not extend below the thoracic margin. They came to the conclusion that there was something obstructing the blood return through the right innominate vein, and, perhaps, to a less degree, through the left, and that the obstruction was due to pressure from an intra-thoracic tumour. In about a week the same symptoms appeared on his left side. An effusion in the patient's right pleural sac accumulated rapidly, and on tapping it they found it had the character of a passive effusion, with poverty of albumen and cellular elements. He had to be tapped several times. Cyanosis was now very remarkable, and he began to breathe with a slight stridor. About a week before his death he became very œdematous in his lower extremities, and some fluid formed in the peritoneum. Examination of his heart and pulse prevented attributing the condition to general cardiac weakness. One day the patient complained of violent pain in his right axilla, and they concluded that a vein had burst. He was given a small hypodermic of morphia to relieve the pain, and died six or seven hours afterwards from respiratory embarrassment.

Dr. **Earl**, in exhibiting the post-morten specimen, said the tumour involved all the structures in the thorax. The whole of the superior vena cava was absolutely filled with it, and it grew high up and into the innominate vein. It projected into the right auricle of the heart, and filled it up, and projected into the ventricle. There were no growths elsewhere, and the tumour had the structure of a lympho-sarcoma.

INTRA-THORACIC LYMPHO-SARCOMA.

Dr. **Earl** exhibited a second specimen of extensive lympho-sarcoma in the upper parts of the thorax, but lying more in front of the structures than surrounding them. It grew down on to the pericardium, and the heart was covered all over with a thick layer of tumour. It extended to the left pleura, and from it into the lung. There were also several globular secondary growths in the liver of the same structure.

AORTIC ANEURYSM.

Dr. **Boxwell** exhibited a specimen taken from a male, æt. 33. He was admitted to the Meath Hospital on October 11th, 1907, with a provisional diagnosis of "paroxysmal asthma," with, possibly, "pneumonia." When seen, the patient was sitting up in bed. The face was livid, his head drooped between his shoulders, suffering from violent dyspnœa, and streaming with perspiration. The larynx was evidently obstructed above, and the loud stridor at the root of the neck pointed also to obstruction in this region. The pupils were regular. There was no œdema of the upper extremity, and the pulses, though extremely feeble, showed no perceptible difference. There was, however, a patch of dulness under the right sterno-clavicular articulation, and a heaving pulsation palpable just above this point at the root of the neck. *Diagnosis:* Innominate aneurysm. The relief given by morphia and amyl-nitrite was short-lived, and the patient died on the morning of October 13th, 1907. At the post-mortem examination, the aorta was found to be the seat of a saccular aneurysm, the size of a duck's egg. The innominate artery was involved in the aneurysm, while the left carotid and subclavian opened directly into the sac. The aneurysm lay directly under the right sterno-clavicular articulation, and caused a partial dislocation of the joint. The sac was crossed in front by the left innominate vein, which was incorporated in its wall, and nearly obliterated, its function having been taken on by an enlarged left superior intercostal. Both recurrent nerves must have been subjected to considerable pressure, as were also the trachea and œsophagus.

ANEURYSMS OF AORTA.

Dr. **Earl** showed (1) an aneurysm of the aorta. It was situated about the junction of the descending part of the arch, with the thoracic aorta, and was about one and a half inches in diameter. It projected to the left side, and was adherent to the periosteum of the vertebræ, and to the œsophagus, which it had flattened out somewhat. It also pressed on the left side of the trachea, and slightly flattened it. Its opening into the aorta was about ¾ in. in diameter. The aneurysm was almost filled by a firm clot. It was taken from the body of a man, æt. 40, who died of tuberculosis of the lungs. He had had syphilis 16 years before his death. The aorta was atheromatous, but not dilated.

(2) An aneurysm in same position with a wide opening into the aorta. The aorta was considerably dilated and atheromatous.

The wall of the aneurysm was adherent to the periosteum of the vertebræ and to the œsophagus. The part adherent to the œsophagus was deeply ulcerated, so that one ulcer had gone right through the wall, and had affected the muscular coat of the œsophagus.

BLOOD SLIDES SHOWING MARKED EOSINOPHILIA.

Dr. **Earl** said the blood was from a gentleman returned from somewhere on the West Coast of Africa. There was a strong suspicion that he had malarial disease. He was struck with the number of coarse granular cells in the blood. He selected a thick part of the film in order to get a good many leucocytes, and in the field there were three eosinophile cells and some of polynuclear and neutrophile cells. The condition was not very uncommon, but was more particularly noticed in cases of worms of different sorts, though it occurred in other conditions.

Dr. **Moorhead** said he had a case of simple endocarditis with rheumatic endocarditis, and every attack of rheumatism was accompanied by eosinophilia. He thought at first that there was some intestinal infection, but had not been able to detect any.

The **President** recalled a communicaion which he had made to the Medical Section of the Academy on two cases of enormous enlargement of the spleen, accompanied by marked eosinophilia.

Dr. **Earl** replied.

TWO CASES OF POISONING BY CRUDE PHENOL.

Dr. **Boxwell** showed two specimens. Case I.—Stomach and spleen of a girl, æt. 15, who was poisoned by drinking four ounces of crude carbolic. She was dead when brought to hospital, and the post-mortem was made about 24 hours after, no attempt having been made to counteract the poison. *Naked eye appearance.*—Stomach of leathery consistence; serous surface dull, and of a bright cherry-red colour. The same appearances were noticeable on the contiguous surface of the spleen. The mucosa of the stomach and œsophagus was hard and brittle, dull greyish-white in colour, with whiter points, resembling incrustations, as if roughly painted with white lead. There was no evidence of this necrosis on the tongue or fauces, although in the latter an œdematous condition of the mucous membrane was very remarkable. Case II.—Viscera, including tongue, pharynx and œsophagus, of a child, æt. 12 months, poisoned with crude phenol. In this case the amount of acid swallowed could not be accurately ascertained. The child was made to take a good drink of it, but was still alive when removed to hospital. The points emphasised here were:—(1) That about four ounces of whiskey were administered within a few minutes of the dose of acid, followed by a copious irrigation with whiskey and water. There was no other antidote used. And (2) whereas enough had been already absorbed to produce a fatal depression of the heart's action, the amount of coagulation necrosis was not great, the stomach bearing a marked contrast to that of the previous case. The condition of the pharynx and œsophagus in the two cases was much the same. Some details of a third case were also given, where a woman, æt. 27, had swallowed eight ounces of the crude acid. She also was treated with whiskey, whiskey and water, and glycerine and water given through a stomach tube. A considerable quantity of brown fluid smelling strongly of carbolic acid was syphoned off with the initial dose of whiskey, and, as a result of the treatment, the woman is doing well. It is a remarkable fact that within a few minutes of the administration of whiskey she recovered consciousness, and within an hour was vomiting naturally.

ROUND WORM IN LARYNX AND TRACHEA.

The **Secretary** exhibited an old museum specimen with a round worm doubled up in the trachea and larynx of a child.

The new wing which has been added to Stanley Hospital was formally opened on January 13th by Lord Derby.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

Meeting held January 17th, 1908.

The President, Dr. Walker Downie, in the Chair.

Dr. Alexander MacLennan showed two cases of "Congenital Dislocation of the Patella." The patients were sisters, and they had a brother who was the subject of a congenital dislocation of the hip. In the elder girl the dislocation affected both patellæ, but in the younger girl the deformity was unilateral. A skiagram of the elder girl's lower limbs showed the abnormal position of the patellæ and their relations with the bones entering into the formation of the knee-joint. In all cases the patella was displaced outwards, and caused considerable lameness. The occurrence of congenital dislocation in three members of the same family is interesting.

Dr. MacLennan hoped to show these cases after treatment had been carried out. This consists of an operation, the essential part of which is splitting the insertion of the semi-membranous muscle and attaching a part of this to the inner side of the patella. This he has found a very satisfactory method of getting rid of the deformity, and increasing the usefulness of the limb.

Dr. W. S. Syme showed a boy who had undergone the "Radical Mastoid Operation," and described the case. This was remarkable for the absence of pain and other symptoms till a very short time before operation was thought necessary. There was suppuration of the middle ear, which lead to thrombosis of the lateral sinus. Both of these conditions were treated, but their result was not satisfactory till the internal jugular vein was subsequently tied, and the contents of the lateral sinus again evacuated and the wound drained. The success attending this procedure has been very marked. Partial facial paralysis followed the operation, and is not yet recovered from; while optic neuritis, which accompanied the acute condition, is now passing off.

Dr. Syme then showed two cases in which he had operated for "Disease of the Frontal Sinus," and gave a description of the various methods employed in the treatment of the various accessory nasal sinuses. He laid emphasis on the importance of exhausting all intra-nasal methods of treatment before resorting to an external operation. The patients shown demonstrated the fact that the deformity resulting from the falling in of the anterior wall of the frontal sinus can be almost entirely removed by the injection of paraffin.

Another case was referred to by Dr. Syme, in which he removed the stump of a tooth from the maxillary antrum. Six years previously an attempt had been made to extract the tooth when the crown was broken off. The stump was presumably subsequently pushed into the antrum during efforts to remove the stump, which was supposed to be extracted as it had disappeared from the alveolus. After this time it lead to the symptoms which caused the patient to seek relief.

Dr. G. Burnside Buchanan read notes of a case of "Injury to the Motor Area of the Brain." The injury was caused by a block of wood, one square foot in thickness and three feet in length, falling on a dockyard worker's head. The result of this was a compound, depressed, and comminuted fracture of the skull in the region covering the right fissure of Rolando. The wound was cleansed, splinters of bone removed, and a considerable portion of the brain substance of the motor area destroyed. The recovery of the patient from the immediate effects of the operation was good; but the resulting paralysis of the left side shows no sign of improvement. The interest of this case centred round several conditions such as the absence of suppuration during the healing of the wound; the slight amount of damage to the patient's general condition caused by the loss of a large amount of brain substance. There is also an entire absence of Jacksonian epilepsy, though this condition usually does not supervene till the scar of the wound is old and much contracted. Dr. Buchanan pointed out that in spite of this the prognosis in such cases is not favourable, his patient being bedridden, suffering from insomnia, and the mental condition not so good as when the injury was recovered from.

Dr. A. N. MacGregor described a

NEW METHOD OF DETERMINING AND RECORDING THE EFFICIENT OUTFLOW OF URINE IN CASES OF STRICTURE OF THE URETHRA,

and exhibited by means of lantern slides several comparative charts of illustrative cases. Dr. MacGregor gave an account of the circumstances which led him to adopt this means of learning the condition of a stricture of the urethra. He showed that the condition of a stricture can be recorded graphically upon a chart by indicating the efficiency of the urethra as a channel for the passage of urine from the bladder. He then described the method, which is briefly thus:—The patient is provided with a watch, by which he can measure time in seconds, a glass vessel graduated in drachms for measuring the quantity of urine; and a chart ruled with vertical and horizontal lines like a clinical chart. The vertical lines divide the chart into periods of time, months, weeks, and days, which are counted from left to right. Horizontal lines represent drachms of urine passed in periods of five seconds, and the numbers increase from a zero line upwards from 1 to 30. The patient, while micturating without any special effort, allows the urine during a period of five seconds to fall into the graduated vessel. The number of drachms is then recorded, with the date of the observation, by placing a dot in the proper square on the chart. A line joining the dots thus made gives a graphic record of the efficiency of the urethra as a channel for the passage of urine during the time in which observations are made in this manner. Dr. MacGregor, when showing some charts that had been made in this way, expressed the opinion that this method had a greater amount of practical utility than any or all of the mechanical means at our disposal for the measurement of the patency of the urethra in cases of stricture, as the chart showed the effect of passing bougies through the stricture, and indicated the size of these instruments, and the frequency with which they should be used.

CENTRAL MIDWIVES BOARD.

Meeting held Thursday, January 16th.

The President, Dr. Champneys, in the Chair.

TRAINING SCHOOLS.—THE COOMBE HOSPITAL.

A deputation from the guardians and directors of the Coombe Hospital, consisting of Dr. M. J. Gibson, the Master, Mr. W. H. F. Verschoyle, a member of the Board of the Hospital, and Mr. G. Perry, the Honorary Secretary, attended and presented a memorial praying the Board to rescind its resolution of December 19th removing the name of the Coombe Hospital from the list of recognised training schools. The memorial was supported by letters from the Very Rev. Canon Scally, P.P., the Rev. J. D. Smylie, and Sir Charles A. Cameron, Medical Officer of Health for the City of Dublin, and by a statutory declaration made by the Registrar of the Coombe Hospital as to the circumstances under which the Board of the hospital first learned of the correspondence between the Secretary, Dr. Stevens, and the Registrar on December 30th.

The members of the deputation severally addressed the Board in support of the memorial.

Dr. M. J. Gibson made application in due form for approval as a teacher.

The deputation then withdrew and the Committee deliberated.

Having fully considered all the evidence and arguments submitted to them by the deputation, the Committee took no action on the memorial, but recommended that Dr. Gibson be approved as a teacher. This was carried.

Letters were read from Dr. Stevens, late Master of the Coombe Hospital, Dublin, and from Messrs. D. and T. Fitzgerald, his solicitors, asking the Board to reconsider its decision not to accept any certificate signed by him in future. The Board, however, declined to reconsider its decision.

A letter was read from the Registrar of the General Medical Council asking whether it was the intention of the Board to take proceedings under Section 12 of the Midwives Act against Dr. Stevens and Miss Myerscough. The recommendation of the Committee was adopted that the General Medical Council be informed that the Board does not contemplate taking proceedings in the above cases.

A letter was read from Dr. W. Arnold Evans, Medical Officer of Health for Bradford, as to advertising by midwives. It was agreed that Dr. Evans be informed that the Board has no power to prohibit advertising by midwives.

The names of four women were removed from the roll on the grounds of old age, ill-health, or inability to comply with the rules. Mildred M. Burgess, M.D., and W. Cunliffe, L.R.C.P., L.R.C.S., were approved as teachers.

A motion down on the agenda referring to the payment of fees to medical men was postponed, as Mr. Ward Cousins, who was to have proposed it, was absent on account of illness.

The Secretary's report of the December examination showed that a total number of 213 candidates entered, of whom 179 passed, the percentage of failures being considerably less than heretofore. The number of those intending to practice as midwives was 106, showing an increase in this division.

The financial report contained a statement from Mr. Fordham that the balance in hand was sufficient to cover the present year; but the Committee, after full deliberation, had come to the conclusion that, owing to the failure of many of the County or Borough Councils to comply with the rules of the Act, the present condition of affairs was unworkable and impossible to continue. It was decided to report this matter to the Privy Council, giving a list of the defaulters.

The date of the next meeting was fixed for February 13th.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 19th, 1908.

Serum Therapy.

Serum therapy in its various applications is destined to play an important rôle in the modern treatment of disease. The different saline solutions representing physiological serum, anti-diphtheritic, tetanic, streptococcic serums have long entered common practice, while that of Quinton or marine serum lays claim to be a panacea for many affections, although of dissimilar natures; eczema, varicose ulcers, psoriasis, enteritis, constipation troubles of the menopause, and tuberculosis (?).

Dr. Quinton has formulated precise rules that should govern the employ of his serum, and which may be of interest to mention.

In the first instance, the doses should not be too large as a too active reaction might follow, which, although without danger, might fatigue the patient uselessly. On the other hand if the dose was too small, the marine plasma would have no appreciable effect.

The injection should be repeated at least twice a week, and in some cases three times a week.

The dose employed for adults in every affection, except for eczema, is generally from one ounce and a half to three ounces. The first four injections, at the rate of three a week, should be of the smaller dose, and ten succeeding injections of the full dose given twice a week.

In *eczema* the dose for adults should never exceed one ounce, twice a week. Improvement is generally immediate (decrease of the itching, secretion, etc.). If after two or three injections no improvement is observed, the injections should be made three times a week or every two days.

For varicose ulcers accompanied with eczema the dose should be the same as for eczema, but in simple ulcers from one and a half to three ounces might be injected. The same may be said of psoriasis.

In all other affections: Muco-membranous enteritis, inveterate constipation, pulmonary tuberculosis, osseous and cutaneous, dysmenorrhœa, chlorosis, lymphatism, etc., the first four injections should be always of one ounce and a half, and afterwards increased to the maximum dose.

In infantile gastro-enteritis, the doses should not exceed one ounce every three days, except in very grave cases, when the injections should be repeated every two days.

In eczema of children, the dose should never exceed two drachms, repeated every two or three days.

The first injections of marine plasma may provoke a passing reaction manifested by either a great prostration or, on the contrary, by a period of excitation with a rise in the temperature; the phenomenon lasts a few hours. Far from being a cause of uneasiness a favourable prognosis should be drawn from this reaction. If, however, the reaction was too intense, it proved that the proper dose had been exceeded, and less should be given the next time.

As to the duration of the treatment, M. Quinton says that although the effect is immediate in many cases, especially in eczema and infantile gastro-enteritis, yet in order to effect a permanent cure from 12 to 15 injections should be given. In chronic affections, such as tuberculosis, there is no limit to the treatment. A series of 20 injections should be made, and the treatment interrupted during a month, when a new series might be repeated.

Paratoxine.

MM. Gérard and Lemoine, of Lille, made a communication at a recent meeting of the Académie de Médecine on a substance obtained by the action of ether of petroleum on the liver and the bile, to which they gave the name of paratoxine. Having made experiments on animals, they tried on man, and it seemed to them to possess a controlling action on tuberculous disease.

The results of nearly 300 cases were so favourable and so constant that they warranted publication.

We administer, they said, paratoxine in subcutaneous and intra-laryngeal injections, or by the mouth. The average dose is one cubic centimetre, but it might, if needs be, be increased to three or four cubic centimetres.

By the mouth the paratoxine is given either in the natural state, or in pills. From 5 to 20 cubic centimetres daily may be given in urgent cases, such as profuse diarrhœa, with rapid results. The treatment by injection should be continued until the appetite was improved, weight regained and improvement in the physical signs was observed, that is to say, from two to three months.

Intra-laryngeal injections are indicated in tuberculous laryngitis at the dose of from two to five cubic centimetres, repeated every day or every two days.

Under the influence of the treatment the pain of deglutition disappears, the voice recovers its tonicity, and the ulcerations heal.

The general effects of paratoxine in the treatment of pulmonary consumption might be resumed as follows: Improvement in the general condition, the patient feels better, the appetite increases considerably as well as the weight of the patient; dyspnœa diminishes and frequently disappears, strength returns to a certain extent, while the cough, as well as the expectoration, becomes more rare and the temperature diminishes gradually, while the bacilli decrease in number in the expectoration. Patients in the third stage of the malady, however, derive no benefit from the treatment.

GERMANY.

Berlin, Jan. 19th, 1908.

At the Verein für Innere Medizin, Hr. v. Leyden communicated a note on

Hemisystole.

He had already, he said, published a number of observations on hemisystole, or, as he had called it in his earlier publications, non-simultaneous contractions of the two ventricles. The first case occurred in 1868. A lady of middle age suffered from cardiac mischief, and showed the above-named peculiarities. Before this she had suffered from acute rheumatism; there was then considerable cardiac hypertrophy, with systolic murmurs. The apical impulse was double, with a short distance between the two (the one a little farther out than the other). By auscultation a systolic murmur, a diastolic sound, and a systolic murmur were heard; with two contractions there was but one cardiac impulse and one pulse beat at the radius. From this the speaker concluded that the contractions of the two ventricles were not synchronous. The profession scarcely took notice of these observations at the time. In 1875 the speaker published two similar cases (Virchow's Archiv., Bd. 65), on one of which an autopsy was performed. There was considerable insufficiency of the mitral valve and excessive dilatation of both auricles. These cases also failed to obtain recognition at the hands of the profession. Fraentzel characterised the condition as "bigeminy," and Riegel followed him. Traube had seen the phenomenon several times, and also in animals who were dying. These observations did not fit V. Leyden's cases which were under observation for lengthened periods. The term "bigeminy" was simply a naming of the condition, and did not express any diagnosis of the cause. A discussion took place on the subject in that Society in 1903. Not long ago the speaker was in a position to publish a similar case which he had had under observation for over a year, and which he had examined repeatedly. It was the case of a man of about 30 years of age who came to the clinic in May, 1906, with cardiac symptoms. He had formerly suffered from acute rheumatism, and for some years some mitral insufficiency had been known to exist. The patient now lay almost altogether in bed, was difficult to move, had a good deal of dyspnœa, but neither cyanosis nor dropsy. There was very extensive cardiac dulness over the anterior thoracic wall that occupied almost all the other thoracic space. The other symptoms were not very pronounced; the urine was normal; the pulse normal, between 77-80. If the hand was placed over the cardiac region, however, a quick impulse was felt. Auscultation gave a re-duplication of the systolic sound, but the radial pulse responded to the first one only. By Röntgen illumination the form of the heart was seen to correspond to that shown by percussion. Diagnosis: mitral disease, from the systolic murmur and its relation to hemisystole, like the previous cases. The patient became gradually weaker; gastric spasms appeared, with much nausea and occasional vomiting. The speaker believed the vomiting to be due to compression of the œsophagus. Death took place in February last. The autopsy showed very considerable enlargement of the heart, considerable dilatation of the mitral orifice, so that it allowed the passage of several fingers; the mitral valves were contracted and hard. The aortic valves were sound, the left ventricle but little, the right ventricle and right auricle, on the other hand, very much dilated. As regarded the significance of the condition, the unusual degree of mitral insufficiency must be looked on as the cause, along with the excessive dilatation of the mitral orifice. The whole process must be looked on as a sort of compensating arrangement. With every systole, when there was mitral insufficiency, a backward wave was started in the pulmonary artery, and the right ventricle could not be completely emptied. At the succeeding diastole the right ventricle was immediately refilled and excited to a new contraction at a time when the left ventricle, on account of the exaggerated tension in the pulmonary region, was not yet quite filled. This, therefore, did not yet take part in the second contraction. The second contraction of the right ventricle was, however, more effective, and made up by a repeated contraction for the extra work thrown on it by the left.

The speaker then passed on to discuss the origin of systole. According to some authors, it had a myogenic origin. Engelmann had pronounced in favour of this view. According to this, the muscles of the heart did not contain any nerves, but they were excited to contraction from the auricle. According to other authors, nerves had been seen in the cardiac muscles and also ganglionic cells as centres for contraction. It was a matter of indifference whether the blood pressure in the ventricles acted on the muscles or the nerves.

AUSTRIA.

Vienna, Jan. 19th, 1908.

Pressure Treatment in Urology.

Kornfeld exhibited an instrument he has devised for the treatment of enlarged prostate, constriction in rectum, stricture in urethra, and effusions in perimetritis. The instrument is of a heart shape or fiddle form, "Kolpeurynter." The manner of using it in the rectum is to insert it like a pessary, and then fill it with air, water, or mercury, according to the resistance required. For an enlarged prostate a vibratory or shock movement can be obtained by applying greater force on the syringe. When used for a stricture a catheter is first inserted and allowed to remain two or three minutes and then withdrawn, and the instrument applied with a fine sound. After being placed in the required position, the air, water, or mercury is pressed into the fine "Kolpeurynter" and caught with a screw or clamp, which maintains the pressure. This pressure is kept up for ten or twenty minutes before it is released, which often leaves a free channel the next day. In cases of enuresis nocturna, Kornfeld has obtained excellent results in six cases on whom he had used the instrument. The treatment was simply mechanical. Care should be taken that too much shock should not be given, as it has a powerful effect on the system when carelessly applied. Frankl asked how the patient should lie when the "Kolpeurynter" was applied per rectum. If the patient were on the back, the pressure of the mercury would be downwards, and therefore not on the prostate. With this object in view it would be better if the patient lay on his face. Halben was of opinion that in cases of exudation from perimetritis the patient should not lie on her back, but on that side of the pelvis in which the exudation lay. Foges believed this distension was highly satisfactory in rectal strictures, and had used a similar instrument called a pneumatic proptoscope with great advantage.

Kornfeld replied that his method of using the instrument in prostatitis and perimetritis was to put the patient on the knees and elbows.

Ultra-Microscopic Blood.

Reicher showed specimens of blood taken from a narcotised dog to demonstrate his opinion given in a former paper. The dog was kept without food for a day and a half before the experiment, and specimens of the blood taken for confirmation. In the blood for demonstration fine particles with a distinct molecular movement were visible, which were rarely to be found before the animal was narcotised. In place of one or two in the field, as often occurs, an innumerable quantity could be seen moving about under the influence of the Brownian molecular movement.

Convulsions and Cramps.

Benedikt next gave a long rehearsal of convulsive and choreic movements, and affirmed that epilepsy was primarily a psychical disease. The epileptic attack commences with an irritability and terminates with a discharge, which acts as a shock, followed by choreic movements. In apoplexy of the brain these epileptic contractions also occur, which leads one to conclude that the attacks are due to a vasomotor shock. Beyond this hypothesis he thought it unwise to venture. During the period of repose the patient should have very little medicine given, but when symptoms of a storm are presaged the drug should be pushed energetically. In many cases the disease is located in the external coverings of the brain, and exists from childhood. Operative results are very disappointing, and not to be commended, as the attacks often continue after extirpation of the centre. In one of his cases hemiparesis followed the operation, but in others he has had recovery, which hardly compensates the labour and risk.

Frankl agreed with Benedikt in the treatment, but thought if the motor centre were proved to be in the brain it should be removed, although hemiparesis should supervene, as contractions and crampings are to be expected. The best case he had to record was one operated on 10 years after the first attack. After the operation the fits disappeared entirely, with no bad effects.

Eiselsberg thought that cases of epilepsy of the Jacksonian type were the only ones suitable for operation. Teleky suggested removing all tumours; though paresis did occur, it was better than the fits. Redlich brought up the poison theory, and could not see where operation would do any good in genuine epilepsy.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Small-pox in Leith.—During the past week 10 cases of small-pox have been notified in Leith, and 4 cases in Edinburgh. All the cases have been traced to a single source—a patient attacked about three weeks ago. He was a sailor who arrived in port on December 24th, and sickened three days later. For a time there was difficulty in tracing all contacts, but lately the Medical Officer of Health discovered that two lady canvassers visited the house two days before the patient was removed to hospital. These canvassers had afterwards made a number of business calls at different houses, and have evidently served as the carriers of infection, for all the persons attacked have either been visited by the canvassers or by some person with whom the canvassers had come in contact. The Edinburgh cases are traceable to the same source. Several cases of cerebro-spinal fever have also occurred in Edinburgh this week. It may be remembered that it was towards the end of January last year that the malady became prevalent.

Infectious Disease in Glasgow.—The Medical Officer of Health reports that during the past fortnight there have occurred 1,288 cases of measles, the number of cases of the disease in the hospital being greater than ever before. The localised epidemic of enteric fever traceable to infected milk from a Lanarkshire dairy has accounted for nearly 60 cases, of which several have proved fatal. From September to December inclusive, 13 cases of meningitis were bacteriologically investigated, with positive results in 5; during the same period 23 contacts were examined for the presence of the meningococcus in the nasopharynx, with 3 positive results. There were 6 cases of suspected plague, of which 2 were genuine, one a young woman who died on August 31st, and the other a boy, admitted to Belvidere Hospital in October. Of 94 rats examined, taken from the city and from shipboard, only one was found to be infected. The citizens of Glasgow have been greatly agitated over the dismissal of three medical assistants of Ruchill Fever Hospital, one of the Corporation hospitals for the treatment of infectious diseases. It appears that there has been considerable friction for some time past among the staff. The nurses say they have been overworked, and that the hospital is understaffed. The dismissed assistants are alleged to have disregarded some of the regulations relating to this office, drawn up some years ago. They, however, complain that: (1) there are "an insufficient number of nurses in certain wards"; (2) "an insufficient number of sisters or charge nurses"; (3) "inexperienced nurses in charge of wards"; (4) "inefficient ambulance administration." The Local Government Board have instituted a preliminary investigation into the conduct of the hospital by Professor Henry Littlejohn, of Edinburgh University.

Lord Rectorship of Glasgow University.—The Liberal candidate is the Prime Minister, the Right Hon. Sir Henry Campbell-Bannerman, while the Unionists have adopted Lord Curzon as their representative.

Lord Rectorship of Edinburgh University.—The names of the candidates cannot be definitely announced as yet. The Unionists are understood to be negotiating with Lord Milner, while the Liberals have met with a disappointment in the refusal of Mr. R. B. Haldane to allow himself to be nominated for a second term. It is understood that Mr. John Morley will now be approached, and, failing him, a selection may be made from among the names of Lord Loreburn, Sir Edward Grey, Mr. Asquith, and Mr. L. Harcourt. Sir Frederick Treves's name has also come up, but in selecting him there could be no political contest, which is regarded as undesirable.

Seaforth Sanatorium.—This sanatorium, gifted to the counties of Ross and Cromarty by Colonel and Mrs. Stewart Mackenzie, of Seaforth, who have not only built and equipped it, but endowed it for all time with a gift of £100,000, was formally opened on January 16th. The institution is for the treatment of early phthisis, and the tests for admission are inability to be treated in commercially conducted sanatoria, and residence in the county of Ross or Cromarty. Twenty-four cases can be treated, and there is a possibility of providing for 30 or 40 patients ultimately. The opening ceremony was performed by Mrs. Stewart Mackenzie, and Colonel Stewart Mackenzie, in a short speech, intimated he had appointed Dr. Maclean, Fortrose, as medical superintendent. He read a telegram from the King wishing the sanatorium all success, and another of congratulatory nature from the Local Government Board. The architect of the sanatorium was Mr. MacBeth, Inverness.

Students' Disturbance at Glasgow.—At the Glasgow University Court, a letter was read from the Students' Representative Council offering to repair the damage done at the recent graduation ceremony by a payment of £10 or £12. A long discussion followed, the outcome being that Dr. McVail's motion declining to reopen the matter was carried against a single vote that the offer be accepted. The feeling was, that it was unwise to create the impression that the students might do what damage they liked provided they paid for it.

BELFAST.

Medical Meeting at Downpatrick.—A meeting of medical men was held at Downpatrick last week to consider whether, and to what extent, they would identify themselves with the anti-tuberculosis movement. The chair was occupied by Dr. Wybrants Olpherts, and practically all the local members of the profession were present, or sent apologies. A resolution was passed agreeing to wait on the District Council and ask their co-operation in the matter, and also to ask the members of the veterinary profession to give their help. The meeting seems to have been a most harmonious one, and sets an excellent example to other districts, for there can be no doubt that the advent of tuberculosis exhibitions, meetings, etc., in many places has stirred up a good deal of jealousy and bad feeling, accusations of advertising and other unethical proceedings being freely made.

Medical Men and Municipal Politics.—The municipal elections last week resulted in the return of two more medical men, in addition to the already considerable number in the Corporation. Dr. Andrew Trimble was returned for Dock Ward as the nominee of the Citizens' and Conservative Associations, and Dr. Robert Thompson for Cromac Ward as an Independent. The recent Local Government Board inquiry into the health of the city has called attention to health matters in a way that has never been known before, and the health reformers have practically swept the board at these elections. A few more such elections would cleanse municipal politics of its worst elements, and would immensely improve the social conditions of the working classes of the city.

Public Health.—During the past week the death-rate has continued abnormally high, being 28 from all causes, and 3.8 from zymotic diseases. Measles and whooping-cough are specially prevalent.

LETTERS TO THE EDITOR.

THE *STAR* AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—I must thank the Editor of the *Star* for his courteous reply to my letter. It is evidently not necessary to continue a controversy in your pages. Everyone of your readers can now judge for himself, from what the Editor has written, how far he is qualified to speak with any authority on the question upon which he dogmatises. They will, I believe, all agree with me that the Editor displays that little knowledge of the subject which is so extremely dangerous a thing. The Editor's unfortunate bias against the profession is exemplified by his innuendo in relation to the vaccination of infants "before the reduced fees came into operation." It is perfectly absurd to suggest that the whole medical profession, having had the results of vaccination before them from the days of Jenner till now, should have failed to recognise any evil effects that the process could bring about. The Editor ignores the mass of bacteriological knowledge accumulated within recent years, which gives a solid foundation of science to the necessarily empirical observations of Jenner; and prefers to rely upon the opinions of the very rare anti-vaccinist practitioners, most of whom have no claim by pathological research or by clinical experience to any position of authority whatever. Professor Crookshank's work was discredited years ago. The quotation used by the Editor of the *Star* speaks of the "*futility* of the practice," not of its harmfulness. The *utility* of the operation has been demonstrated on the biggest scale a million times, and sufficiently in small-pox hospitals, where vaccinated attendants never take the disease, whilst the unprotected mostly do. In the old days of arm-to-arm vaccination the number of cases followed by any untoward result was so small as to be almost negligible; since the introduction of the calf lymph system the danger has been entirely done away with. Small-pox is extinguished wherever vaccination is effectively carried out; and even had the operation been attended by the remote dangers imputed to it by its reasonable opponents, the risk would have been well worth incurring, in view of the incalculable benefits Jenner's discovery has conferred upon mankind.

I am, Sir, yours truly,
January 16th, 1908. A Surrey Doctor.

To the Editor of The Medical Press and Circular.

Sir,—The astounding reply in your last issue from the Editor of the *Star* to a Surrey doctor's letter almost recalls the nursery rhyme, "Twinkle, twinkle, little star, how I wonder what you are." However, as the Editor appears to treat the matter seriously, and thinks the reason why the majority of medical men have heir own children vaccinated can be accounted for as due to "ignorance" on their part, may I ask what evidence he can produce to support his idea that ignorance on the subject prevails amongst the vast majority? In a case reported in the *Daily Telegraph* (January 10th, 1905) in which a "conscientious objector claimed exemption on the ground that the profession were not unanimous," and as it might enlighten your correspondent as to a judicial opinion on the weight of evidence on the question I venture to reproduce it.

The Magistrate's Argument.

An applicant for a vaccination exemption certificate at Westminster repeated the usual formula, "I conscientiously believe that vaccination will be prejudicial to the health of my child."

Mr. Curtis Bennett: On what do you base that statement?

Applicant: On the fact that the medical opinion of the country is divided as to the efficacy of the operation.

Mr. Curtis Bennett: I do not think so. Doctors are nearly all agreed. If ninety-nine out of one hundred say that a thing is right they are more likely to be correct than the one who differs. Have you any other ground?

Applicant: You refuse a certificate?

Mr. Curtis Bennett: I do.

I am, Sir, yours truly,
Brighton, January 18th, 1908. C. H. S.

INHERITED SYPHILIS.

To the Editor of The Medical Press and Circular.

Sir.—Dr. Walsh must kindly be satisfied with the assurance that my name would add no weight to my facts; and as it could not strengthen my arguments, I prefer to remain unknown. The opinions which I put forth years ago in your pages, and have reiterated at intervals since, have been strengthened by accumulating experience—the experience of an average practitioner, not closely engaged in the treatment of syphilis; merely one who has kept eyes and ears open to receive the knowledge of that disease which is thrust upon everyone engaged in any department of practice. Laymen do not read medical papers, and I do not think—as Dr. Walsh seems to fear—that any practitioner would abate his zeal in the treatment of a syphilitic patient because of a doubt about the danger of conveyance of infection to wife and progeny. With regard to treatment, I believe the only cases that come to grief are those who do not undergo systematic and sufficiently prolonged mercurial treatment, those with bad constitutions, and those who lead intemperate and dissolute lives. I believe that syphilis is virtually a curable disease in patients of sound constitutions who will submit in every way and throughout to the guidance and treatment of their medical adviser. I have never seen syphilitic children begotten of fathers of this type after lapse of sufficient time. There cannot be the least doubt that large numbers of children among the poor are labelled syphilitic who have no valid claim to such a vile distinction. Rickets, tuberculosis, and malnutrition, alone or combined, often produce a type closely resembling the syphilitic. The teeth are often honeycombed or spinous, and are mistaken for the typical syphilitic teeth of Hutchinson. The teeth of Hutchinson are not present even in 5 per cent. of children with other unequivocal signs of the inherited taint. So with eye diseases and diseases of the bones. Syphilitic keratitis is rare, and simple necrosis and tubercular disease are often mistaken for syphilitic affections of the bones.

I am, Sir, yours truly,
An Average Practitioner.
January 16th, 1908.

THE BROWN DOG INCIDENT

To the Editor of The Medical Press and Circular.

Sir,—Will you very kindly allow me to reply to "A Surrey Doctor," who has vehemently and bitterly attacked my letter on "Medical Students and Vivisection"? It is easy, but not courteous, to shower abuse and make accusations of "false statements"; but, while heartily welcoming the evident horror and indignation with which "A Surrey Doctor" repudiates the possibility of scientists and doctors being guilty of cruelty to animals, I refer him to the *Journal of Physiology* and other professional journals, in which he will find recorded by the vivisectors themselves the most "terrible and revolting" tortures inflicted by them upon dogs and other animals.

With regard to the humanity of physiologists, I may point out that the absolute callousness and refined cruelty of many noted vivisectors is so well known as to be beyond dispute; that an eminent vivisector stated before the Royal Commission on Vivisection in 1876 that he only used anæsthetics for his own convenience, and that he had "no regard at all" for the sufferings of his victims; also that it has been said by a prominent licensed vivisector before the present Royal Commission on Vivisection that experimenters who should operate *without anæsthetics* would be worthy of all praise and admiration! (Question 4,160, Blue Book, Minutes of Evidence).

It is, of course, impossible for a man with humane feelings to become a vivisector. That vivisection is to the last degree demoralising in its effects no reasonable, unprejudiced person can doubt. Dr. S. Haughton stated to the Commission of 1876 that to accustom medical students to witnessing vivisection would be to let loose upon the world "a set of young devils." How far that prognostication has been verified by the recent riotous, insulting and ungentlemanly behaviour of certain medical students I leave the public to judge. Unquestionably no other class of young men would be capable of such conduct.

Those medical men who desire to help to cleanse their profession from the stain of inhumanity should follow the excellent, noble, and *manly* example of the

1,250 doctors who have signed a petition praying that dogs may not be vivisected; join the ranks of the many doctors who are making a determined stand against vivisection in any shape or form, and enrol themselves in the newly-formed International Medical Anti-Vivisection Association.

Public opinion will not much longer sanction experimentation upon living animals—torture. The Paris Faculty of Medicine has grandly led the way by rejecting the offer of a chair for vivisection. England, ever in the forefront of humane movements, *cannot*, without crushing shame, tolerate what another nation denounces as immoral and inhuman. England must now go on even beyond the lead given by France, and must at once sweep the vile and horrible practice out of her Universities and abolish it altogether, or be for ever disgraced before the whole world.

I am, Sir, yours truly,
C. A. M. Bailey,
Hon. Secretary National Canine Defence League.
London, S.W., January 17th.

OBITUARY.

C. J. WRIGHT, M.R.C.S., L.S.A.

A well-known Leeds surgeon has passed away through the death of Professor Charles James Wright. He had been seriously ill for only a few days, though visibly failing in health for some time past.

Obstetrics and gynæcology were the two branches of the healing art to which Mr. Wright particularly applied himself. From 1884 up to the summer of last year he had been Professor of Obstetrics at the Yorkshire College, and so continued when the College emerged into a University, and he sat on the Court of Governors. In the first batch of honorary degrees conferred by the new University upon local medical men of distinction, Mr. Wright was accorded that of a Master of Science. He was a member of the Royal College of Surgeons, England (1864), and licentiate of the Society of Apothecaries (Leeds and Guy's Hospital) (1865), and also a Fellow of the Obstetrical Society, London. When, about six months ago, Mr. Wright placed his resignation in the hands of the Council of the University, after 41 years of continuous service on the teaching staff of the School of Medicine, it was accepted with deep regret, and the Board of the Faculty of Medicine likewise placed on record their sense of obligation to him for his long and sincere work.

Mr. Wright was a native of Wakefield. He was sent to the Leeds School of Medicine, and to Guy's Hospital. It was Mr. Wright's destiny to become closely associated with this establishment, first as Demonstrator of Anatomy, from 1865 to 1870, next as Lecturer on Physiology from 1870 to 1884, and finally as Lecturer on Midwifery.

He had a large influence on the destinies of the Leeds Hospital for Women and Children, to which he was senior honorary surgeon for many years. On the whole, this may well be considered as his most valuable work, for although he had of late years been obliged to limit his service to that of a consulting surgeon, he did much to promote the growth and efficiency of the institution. He had been with it during all its changes and developments, and it must have been very gratifying to him to see it move from a poorly equipped into a thoroughly up-to-date establishment. Genial and kind-hearted, Mr. Wright was much liked by the other officials and the patients, and, even when not in very robust health himself, he sacrificed much of his time in ministering to the needs of others.

DR. PATRICK CANNING.

We regret to record the death of Dr. Patrick Canning, which took place in Dublin during the past week. Dr. Canning, who was only 35, had been ailing only a couple of days. He visited Dublin to undergo a slight operation, but was attacked with pneumonia, and died after a brief illness. At the Royal University, Dr. Canning had a distinguished career, and the ability which marked his subsequent career was shown at an early stage at the Mater Hospital and the Catholic University Medical School. Some years ago he was appointed Physician to Maynooth College.

Medical News in Brief.

Royal College of Surgeons of England.

A quarterly meeting of the Council of the College was held on Thursday last, Mr. Henry Morris, President, in the chair.

Members and Hospital Appointments.—A report from the committee on the annual report of the Council was read with reference to the resolutions carried at the recent meeting of fellows and members. With regard to the resolution asking the Council to use their moral influence with hospital authorities to recognise members of the college as having equal rights with Provincial, Scotch, and Irish Graduates to become candidates for hospital appointments, the Council decided to refer back the recommendations of the committee for further consideration.

Members on the Council.—Regarding the question of the representation of members on the Council, it was decided to inform the mover and seconder that the resolution had been laid before the Council, and that the views of the Council upon the question referred to would be found in the last annual report of the Council. The suggestion that a poll of fellows and members should be taken upon the proposal for the direct representation of members upon the Council was also considered, and the Council saw no reason to adopt the suggestion.

Question of Hoods.—The Council also decided not to comply with the request contained in the resolution regarding the addition of a hood to the gown already worn by fellows and members. The committee reported on this subject as follows:—"The committee believe that the hood is generally understood to be distinctive of a degree. In this sense it forms part of the academic costume of a University, but would not be appropriate for a college. For this reason, and as hoods do not appear to be in general use among colleges of similar standing to the Royal College of Surgeons of England, the committee recommend the Council not to comply with the request."

With reference to the resolution asking the Council to report as to their willingness to join the Royal College of Surgeons and its work with the University of London, the Council determined to inform the mover and seconder that the matter had been much discussed in the past, and still occupies their attention.

The President reported that he had given evidence on behalf of the College before the Home Office Committee on the London Street Ambulance, and a vote of thanks was given to the President for the able and efficient manner in which he had represented the College in the matter, and for the valuable information obtained and submitted by him regarding the ambulance systems in Paris, Berlin and Boston.

The revised standing rules relating to the office of conservator of the museum were approved, and it was determined to proceed to the election of a conservator in the vacancy occasioned by the death of Professor Stewart, at the next meeting of the Council on February 13th.

Mr. Henry Morris was appointed Hunterian Orator for the year 1909, and Mr. Thomas Bryant, ex-President, was re-elected the representative of the College upon the Council of Queen Victoria's Jubilee Institute for Nurses.

A committee was appointed to prepare a circular to the fellows and members upon the question as to whether women should be admitted to examination for the diplomas of the college. A suggestion that arrangements should be made for serving tea to readers in the library was adopted.

Mr. J. L. Graham-Jones, B.A., Cambridge and St. Thomas's Hospital, and Mr. C. H. Smith, Liverpool, having passed the required examinations and conformed to the by-laws, were admitted members of the College. Diplomas of the license in dental surgery were granted to Mr. S. S. Parkinson and Mr. Wilton Thew, of Charing Cross and Royal Dental Hospitals.

Society for Relief of Widows and Orphans of Medical Men.

A QUARTERLY Court of Directors of the above Society was held on Wednesday, January 8th, at 5.30 p.m., at 11, Chandos Street, Cavendish Square, Dr. Blandford (President) in the chair. Twelve members of the Court were present. Applications for membership were received from five medical men, and they were duly elected members of the Society. Since the last Court, one of the annuitants of the Society, æt. 91, had died. She had been in receipt of grants since 1866, and had received £2,824 from the Society. Her husband had paid in subscriptions £27 6s. Three letters had been received from the widows of medical men, asking for relief, but this had to be refused, as their husbands had not been members of the Society. £534 was distributed as a special Christmas present amongst the annuitants of the charity in December, each widow receiving £10, each orphan £3, and those in receipt of grants under the Copeland Fund, £5 each. The sum of £1,257 10s. was voted for the payment of the half-yearly grants to the 48 widows and 16 orphans at present on the books of the Society. Relief is only given to the widows or orphans of deceased members. Membership is open to any registered medical practitioner who at the time of his election is residing within a 20-mile radius of Charing Cross. Full particulars of the work of this valuable Society, and application forms, may be obtained from the Secretary at the offices of the Society, 11, Chandos Street, Cavendish Square, W.

Sleeping Sickness in Rhodesia.

A REPORT just received in Liverpool from the expedition of the Liverpool School of Tropical Medicine despatched to Rhodesia for the purpose of endeavouring to check the spread of sleeping sickness in Central Africa, of studying the disease, and of investigating the distribution of biting flies, says that the fly Glossina palpalis is found along both banks of the Luapula from a point near Kapwepwi's village. Glossina palpalis (possibly another species) is found scattered over practically the whole of the Luapula division. "Only one case of human trypanosomiasis has been found as yet. The neck glands are very decidedly enlarged, and trypanosomes are present in fairly large numbers in the gland juice. It presents no symptoms of the disease whatever. It is interesting to note that this case is the only one in the village, a fairly large one, although Glossina morsitans is found plentifully in the village and surrounding country. A fair percentage of the natives have distinctly palpable neck glands, but on puncture these are found not to harbour trypanosomes. This means that the recognition of the disease by palpation is one which a medical man alone can apply satisfactorily. The Administration considers the advisability of appointing special travelling medical officers, whose duty it will be to travel constantly through the threatened districts at least—*i.e.*, along the Luapula and along the northern border, looking for cases.

Action Against "Tooth Extractors.

THE extraction of a molar tooth was the basis of an action concluded at the Birmingham County Court on January 10th. The plaintiff, Annie Barlow, domestic servant, claimed damages against Messrs. Cargill and Smith, who described themselves as tooth extractors and adaptors, for personal injuries sustained through the alleged unskilful pulling of a tooth. The operation complained of was performed by Mr Cargill, who was not a registered dentist, but who claimed to have had a long experience both in the service of qualified dentists and in practice on his own account.

Dr. Emery, who saw her four days after the extraction, found bad septic poisoning, which he attributed to the use of unclean forceps. He also stated that the jaw was badly lacerated, and that he had to remove three detached pieces of dead bone.

Experts who examined the patient some time later said the appearances were consistent with a perfectly skilful extraction. The septic poisoning might have been due to other causes than unclean forceps, they declared, and one witness described the mouth as the home of germs. Defendant stated that he carefully sterilised his forceps after operating on a patient.

The jury found for the defendant, and judgment was entered accordingly.

Great Northern Central Hospital—Clinical Lectures.

IT is announced that the attendance at the course of lectures given at the Great Northern Central Hospital, London, has fully justified the action of the medical staff in their attempt to utilise the clinical material at their disposal for teaching purposes. It is therefore proposed to continue the series of lectures and demonstrations during the remainder of the winter months, and it is hoped that it will be possible to arrange them more on the lines of actual clinical lectures than of set addresses. The time of the lectures has been altered from 3 o'clock to 3.30, in order to meet the wishes of those who attend these demonstrations.

The Coombe Hospital and the Central Midwives Board.

WE are glad to learn that the Central Midwives Board has adopted the unanimous report of their Standing Committee recommending that the newly-appointed Master of the Coombe Hospital should be recognised as a teacher of midwives under the rules of the Board. Dr. Gibson's name has accordingly been added to the list of recognised teachers, and pupil midwives can be again trained at the Coombe Hospital in accordance with the rules of the Central Midwives Board. This decision is manifestly in accordance with the dictates of strict justice, as it would have been most unfair to have punished Dr. Gibson for errors committed before he had anything to say to the management of the hospital.

Royal College of Physicians and Surgeons.

AT the First Professional Examination, held on January 7th, 8th, 9th, and 10th, 1908, the following gentlemen were approved in the subjects indicated, viz.:—

Chemistry and Physics.—Gilbert Bailey, Basil F. Beatson, William H. Broughton, Frederick W. Campbell, Rowland B. Campion, Nai Cheune, Henry D. S. Close, Edward P. Drabble, Charles A. R. Gatley, John L. D. Lewis, Victor A. Luna, Leonard R. Pickett, Henry C. Rigg, William A. Thompson, Claude de B. Thomson, Claude W. Treherne, Arnold Viney, and Sydney Wilkinson.

Chemistry.—Ahmed Abdel-Al, Frank C. Cowtan, Alexander R. Esler, Maberly S. Esler, Hassell D. Field, Meredydd Foulkes, Francis H. Guppy, Frank M. Hughes, Gerald N. Martin, David Scott, Ivan L. Waddell, and William N. P. Williams.

Physics.—Allan S. Coalbank, William T. Flooks, Owen Gwatkin, William F. Mason, Eugene A. J. Murphy, Edmund U. Russell, Charles P. C. Sargent, and Henry S. Young.

Biology.—Ramrao Belcrushma Agaskar, George Aspinall-Stivala, Gilbert Bailey, William S. Birch, Herbert Chorley, Arthur G. B. Fenwick, Geoffrey Garland, Charles A. R. Gatley, William E. Hallinan, Leslie P. Harris, John R. Hayman, George B. H. Jones, Edmund T. H. Lea, David Lewis, Victor A. Luna, Alexander Macrae, Reginald V. Martin, Arthur G. Morris, Eugene A. J. Murphy, Frank A. M. Nelson, Jorabhai Bhaibabhai Patel, Montague Pern, George B. Pritchard, Walter A. Reynolds, Henry C. Rigg, Charles P. C. Sargent, Jelal Moochool Shah, Cuthbert Shaw-Crisp, William A. Thompson, Chunilal Bhimbhai Vakil, William C. Whitworth, William N. P. Williams, and William Wörger.

At the Preliminary Science Examination for the Licence in Dental Surgery held this month, the following gentlemen were approved in the subjects indicated, viz.:—

Chemistry and Physics.—Robert R. Adams, Edwin R. Bailey, Henry L. Bailey, Stanley M. Gardner, Robert J. Herley-Mason, Guy W. E. Holloway, Sidney W. Ingram, William H. Keay, Sidney Saxton, Herbert Thornton, and Thomas R. Trounce.

Chemistry.—Ernest W. Bacon, Arthur R. Goddard, Cyril A. Pollard, James S. Robinson, George W. Royle, and James Sharp.

Physics.—Charles R. Faulkner, Thomas L. Fiddick, Roy W. List, William M. Potter, and Frank P. Sturdee.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Pathology of the Cerebro-Spinal Fluid.—Forbes reports the results obtained from bacteriological and cytological examination of the cerebro-spinal fluid from 140 cases of sick children (*Quarterly Journal of Medicine*, vol. i., No. 2, page 1). The series included 57 cases of tuberculous meningitis, 6 of meningo-coccal meningitis, 16 cases in which other organisms, the pneumococcus, streptococcus, staphylococcus, and bacillus coli communis, were found, 3 cases of syphilitic meningitis, 14 cases in which other cerebral conditions, such as abscess, were present, and 14 cases with meningeal symptoms due to such diseases as pertussis and broncho-pneumonia. In the tuberculous cases the bacilli were found in the cerebro-spinal fluid in 27 cases by staining the lymph clot, which formed on standing. Cytological examination showed an excess of lymphocytes in 31 cases, in some of which a differential count showed as much as 97.5 per cent. In severe meningo-coccal cases the cerebro-spinal fluid was found to be turbid with an excess of polynuclear neutrophiles, and to contain a considerable quantity of albumin. Meningococci were obtained from the fluid in all severe cases. In less acute cases the fluid is clear with a faint trace of albumin, and a scanty cell deposit chiefly of neutrophile cells, while in chronic cases no albumin is present, and the only cells found are a few degenerated lymphocytes. The pneumococcus was found in 9 cases, in most of which an excess of neutrophiles was present. In four cases out of five of streptococcal meningitis streptococci were obtained from the fluid during life, and in one case a pure culture of the colon bacillus was found, abundant polynuclear cells being also present in this case. In syphilitic cases the lymphocytes predominated, reaching as high as 92 per cent. of all cells present in one case, while the fluid proved sterile in all cases examined. In eight cases of cerebral symptoms occurring in different diseases the fluid after centrefugalising and evaporation yielded numerous minute colourless rhomboid crystals, but the nature of these and their pathological significance has not been determined. M.

A Ten Years' Study of the Cupar Water Supply.—Dr. Douglas gives an account of his study of the Cupar water supply, and the results are of interest, not only locally, but also from their bearing upon water supplies and water analysis generally (*Edin. Med. Journal*, January, 1908, p. 42). The supply is an upland surface water obtained from numerous feeders from the neighbouring higher levels, the land being cultivated, some of it arable, the rest pasture land. The soil is of limestone formation, and the natural springs in the neighbourhood are of very hard water. It is not so, however, with the water under examination, as repeated analyses over a period of 13 years have shown only about 12 degrees of total hardness. The water is filtered through sand, and then passes through a 7-inch pipe to a small reservoir near Cupar. The pipe, after a series of years, became so narrowed by incrustation as to suggest the necessity of laying down a new pipe. Before doing so, however, the Glenfield patent scraping process was applied, and proved a complete success. Bacteriological examinations were made almost every month, and special attention was paid to the effect of filtration upon the germ content. These observations confirmed the opinion already held that a filter does not act as such until the slime layer of organic deposit has been formed. When this layer is complete, usually over 90 per cent. of organisms were found to be removed by the filtering process. The germ content of the water at the point of delivery was, however, found to be much greater than at the place where it issued from the filter bed, probably owing to the increase in number of organisms in geometrical progression when allowed to stand for a few hours in the pipes. The range of alkalinity of the water was also tested, and appeared to be rather greater in the winter than in the summer, but the difference did not appear to have any effect upon the germ content. The mean germ content of the water as first collected was found to be from 900—1,000 organisms per c.c. M.

Persistent Ductus Arteriosus Associated with Sudden Death.—A woman, æt. 28, who had never previously been ill, and who had passed through a first pregnancy without any symptoms of dyspnœa or cyanosis, died suddenly, just after a second successful delivery (*Bulletin de la Soc. Anat. de Paris*, Feb., 1907). She got an acute attack of dyspnœa, with a sensation of choking and severe cardiac palpitation. Her face became blanched and drawn, the pulse rose to 104, her respirations to 40, and a trace of albumin appeared in the urine, but there was no cyanosis. The apex beat was found in the sixth intercostal space just inside the nipple line; there was no increase of cardiac dulness; no murmur was heard, and though the sounds resembled those of the fœtal heart, there was no arrhythmia. The blood pressure was 160 m.m. Hg. The patient was bled, and 300 c.c. of blood were withdrawn, but without relief to symptoms, and death ensued after an illness of 12 days. At the autopsy the only abnormality found was a persistent ductus arteriosus, 10 m.m. in width, and surrounded at its base with a strong fibrous ring. The aortic and pulmonary walls were of about the same thickness throughout. M.

Changes in Body Temperature Produced in Dogs by Morphia and Ether.—Mills (*Johns Hopkins Hosp. Bulletin*, Dec., 1907, p. 470) reports observations on the following points:—(1) The temperature curves of dogs taken during operations after injection of morphia and anæsthetisation with ether; (2) the effect on temperature of morphia alone; (3) the effect on temperature of ether alone; (4) the variations of morphia and ether temperature curves caused by the application of external heat. The conclusions arrived at were as follows:—(1) The normal temperature of the dog is between 102° F. and 103° F.; (2) injection of ¼ gr. of morphia causes a fall of temperature of from 3° to 5°, the lowest point being reached in about two hours, and the temperature gradually returning to normal as the effects of the drug pass off; (3) ether alone causes a fall of temperature, but the effect rapidly passes off when the drug is discontinued; (4) morphia and ether in combination cause a fall of 6° on the average; (5) if heat be applied externally to dogs under morphia or ether, the fall in temperature is much less, and the temperature may soon return to normal; (6) the amount of fall of temperature does not seem to affect the prognosis; (7) the nature of the operation has no definite bearing on the temperature curve. M.

Opsonic and Agglutinative Reactions in Cerebro-Spinal Fever.—Houston and Rankin publish (*British Medical Journal*, Nov. 16th, 1907) an account of researches made into the opsonic and agglutinative powers of the blood-serum in cerebro-spinal fever as observed during the recent epidemic in Belfast. The following points are brought out:—(1) Opsonic estimation is of value in the diagnosis of suspected cases of cerebro-spinal meningitis. Of the cases examined within the first four days of the disease, only a low percentage gave positive results; on the fifth day, 3 out of 5 gave positive results; from the 6th to the 133rd day, 125 out of 130, or 96.1 per cent., gave positive

results. (2) The opsonic power of normal blood for the meningococcus is extremely low. A mere glance at the preparation was usually sufficient to distinguish the serum of a genuine case of the disease from normal serum. (3) The meningococcus may lose its power of reaction by prolonged growth on artificial media. This result is compared with the observation of Flexner that the meningococcus, under such conditions, may lose its pathogenic properties. (4) The cerebro-spinal fluid has always lower opsonic and agglutinative properties than the blood. (5) In convalescent cases the reaction disappears quickly. (6) The serum of cerebro-spinal fever, when exposed to heat, or kept for some time, loses its opsonic power, but retains its agglutinative power. (7) The opsonic method should prove of value in estimating the potency of proposed therapeutic sera. (8) True cases of epidemic cerebro-spinal fever are always due to a meningococcus having the same agglutinative and opsonic reactions. On the other hand, there is probably a distinct organism for posterior basic meningitis, differing from the meningococcus in its opsonic and agglutinative reactions. The authors obtained and examined cocci obtained from London, Edinburgh, Glasgow, New York, and Hamburg, before coming to these last conclusions. The paper is one of interest and importance, and well repays perusal.
R.

Blood Cultures.—Rhea and Emmons report (*Boston Med. and Surg. Journal*, Dec. 19, 1907) the results of 91 consecutive blood cultures made in the Boston City Hospital as part of the routine of the Pathological Department. Of the 91 cultures, 36 were positive, 55 negative. The following organisms were recovered: streptococcus pyogenes in 13 cases; pneumococcus in 6; staphylococcus pyogenes aureus in 7; gonococcus in 2; staphylococcus pyogenes albus in 2; bacillus mallei in 1; bacillus mucosus capsulatus in 1; bacillus anthracis in 1; bacillus paratyphosus in 1; bacillus aërogenes capsulatus in 1; staphylococcus citreus in 1; bacillus typhosus in 1. Of the 13 patients with streptococcal infection, 8 died; of the 7 patients infected with staphylococcus aureus, 6 died; the 2 patients with gonococcal infection recovered. All the cases of pneumococcal infection were consequent on lobar pneumonia; 5 out of 6 died, 1 recovered. The authors add to the value of their paper by giving notes of the autopsies of many of the fatal cases. R.

Verrucæ Plantaris.—Bowen publishes (*Boston Med. and Surg. Journal*, Dec. 12th, 1907) a careful description of the histology of verrucæ plantaris, which he states to be very common among boys and young men in his practice. He regards the condition as probably infective, slight lesions from irritation offering a path of entrance to the infecting organism. The tumour is most commonly multiple, and may occur either on the palm or on the sole of the foot. Histologically, the growth shows at its periphery the ordinary structure of a wart—papillary enlargement, with downgrowths of the rete, and a marked hyper-keratosis. The granular layer is much increased in thickness. In the centre of the tumour, however, is the characteristic lesion. This is a vacuolation of some of the rete cells, which causes them to assume a rounded form and a larger size than the neighbouring cells. Concurrent with the vacuolation is keratosis round the periphery of the cell. As the vacuolation becomes more marked, the cells fuse together, and an irregular network results, strewn with masses of kerato-hyaline. In many of the cell nuclei bodies were found, whose appearance aroused the suspicion that they might be some form of protozoa. They were small, round bodies, highly refracting, and in some instances apparently concave or crescentic. They were stained by acid reagents, and were easily distinguishable from the nuclei in which they lay. It was, of course, possible that they were the results of some form of cell degeneration. R.

Lice and Relapsing Fever.—Mackie, who has recently investigated an outbreak of relapsing fever in the Basik Mission Settlement, brings forward (*British Medical Journal*, December 14th, 1907) reasons to believe that the body-louse is an important agent in the transmission of the disease. Practically all the boys in the settlement suffered from the disease, while very few of the girls were affected. On examining the conditions under which the two sexes lived, Mackie was astonished to find that whereas the boys' bodies were infested with lice, the girls were almost free. On the other hand the girls' quarters were infested with bugs, from which the boys' quarters were almost free. On dissection of lice taken from the infected wards Mackie found that their bodies contained plentiful living and multiplying spirilla. The stomach of the louse was the chief seat of multiplication, and this was carried on in the face of active digestion, and after the disappearance of all other cellular elements. Other organs became secondarily infected. The secretions expressed from the mouths of infected lice contained numbers of living spirilla. The ovary was frequently infected, but spirilla were not found in deposited ova. As the epidemic subsided the number of infected lice diminished. Attempts were made to infect a monkey by means of lice, but they failed. Dissection of bugs revealed the presence of spirilla in the alimentary tract in small numbers, and only in the presence of fresh blood. They were scarcely more numerous than in the human blood, when allowance was made for the concentration of the blood by absorption of the fluid parts. There was never any sign of multiplication, and no organ, other than the recently filled stomach, was found to contain spirilla.
R.

Nature of the Parathyroids.—Forsyth (*British Medical Journal*, November 23rd, 1907) discusses the nature of the parathyroid glands and their probable relation to the thyroids. (1) He combats the view that the parathyroids are to be regarded as essential to life, as the only evidence in favour of it is inconclusive. It has not been shown, as claimed, that removal of the parathyroids is fatal, while that of the thyroids alone is comparatively harmless; the difficulty of discovering and separating the parathyroids prevents any conclusive proof of this sort. (2) He rejects Sandström's theory that parathyroid tissue is embryonic thyroid tissue. It is a pure assumption. Welsh, Verdner and others distinguished these tissues histologically with ease. Neither has it been shown that parathyroid tissue can develop into thyroid. (3) He puts forward the hypothesis that the parathyroids and thyroids are functionally identical, and that the histological differences are due to differences in the vigour of secretion, and in the lymphatic drainage of the two tissues. In support of this doctrine he points out that the recognisable differences depend on the varying proportions in which epithelial cells and secreted material are present. In both mammals and birds he has met thyroids which possessed parathyroid properties, and intermediate types are comparatively common. These statements are borne out by micro-photographs. R.

The Physiological Relation of the Uterus and Ovaries.—Carmichael and Marshall (*British Medical Journal*, November 30th, 1907) publish the results of experiments performed in order to observe the effects on the uterus of removal of the ovaries, and on the ovaries of removal of the uterus. They came to the following conclusions:—(1) The removal of the ovaries in young animals (rodents) prevents the development of the uterus and Fallopian tubes, which remain in an infantile condition. The subsequent growth of the animal seems to be unaffected. (2) The removal of the ovaries in adult animals leads to fibrous degeneration of the uterus and Fallopian tubes, most marked in the mucous membrane. The animals' health remained good. (3) The removal of the uterus in a young animal has no influence in preventing the further development of the ovaries. (4) The removal of the uterus in an adult animal does not give rise to any degenerative changes in the ovaries if the vascular supply of the latter remains unaffected. It will be seen that the conclusions agree with those drawn from the results of surgical operations on the human subject. R.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

N. E.—The course has already begun. The lectures are given on Thursdays, at 5 p.m., at the Mount Vernon Hospital, in Fitzroy Square, and are free to medical men. The next lecture is to-morrow, and it is given at Fitzroy Square by Dr. G. F. Johnston, on "Pneumococcal Infection."

J. P.—We cannot consider the matter in the light you put it, as the other circumstances put a different complexion upon it. We have not the full details, but our judgment, for what it is worth, would be that active steps can and should be taken.

Surgeon, N.B.—It is a matter for private arrangement before an arbitrator. We cannot possibly deal with it in our columns. It is essentially private, and it would never do to discuss such a matter *coram publico*.

THE CRUSADE AGAINST VERMIN. WHO SAID RATS?

To the Editor of The Medical Press and Circular.

Sir,—

Cancer we think an awful curse,
Tuberculosis tenfold worse,
But cancer sometimes brings a fee
To someone else (if not to thee).
(Our blessings in disguise we see.)
A mine of wealth Appendicitis,
Adenoid growths and Prostatitis.
Now plague produced by rats and vermin
Will form the text for many a sermon.
If everybody lived in flats,
And kept a cat, there'd be no rats;
They'd find such policy to pay,
And all the rats would "flee" away.
But if all rats and mice were dead,
Some other plague would start instead;
Try and get *that* into your head.

Yours, etc.,

London, W. A. D.

DR. SALEEBY AND THE TREATMENT OF CANCER.

A letter of considerable length reached us as we were "at Press" from the pen of Dr. Saleeby, in response to the challenge contained in previous issues of this journal. The length of this communication, and its late arrival, precludes our being able to find space for it in our present number, but we hope to publish it in our next.

M.D. (Motors for Medical Men).—Your letter is unfortunately crowded out "at press"; it will appear in our next.

Dr. O. C. Gruner (Leeds).—See reply to M.D.

Biblical References to the Plague.—A recent correspondent to the *Manchester Guardian* has pointed out these are numerous, and may be found, as indicated by Dr. George Adam Smith in his "Historical Geography of the Holy Land" (published in 1894), in conjunction not only with the Philistines and their offerings of golden boils and golden mice, but with the destruction of the army of Sennacherib (II. Kings, xix. 35) and the "pestilence after the manner of Egypt" (Amos iv. 10), and elsewhere. These are detailed on pp. 157 of the fourth edition of Dr. Smith's book.

Meetings of the Societies, Lectures, &c.

Wednesday, January 22nd.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. A. E. Giles: Displacement of the Pelvic Organs.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

Thursday, January 23rd.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture:—Dr. T. R. Whipham: Pneumonia in Childhood.

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Paratuberculides (due to Tuberculous Toxins): I., Macular; II., Papular; III., Pustular; IV., Pigmentary.

Friday, January 24th.

Royal Society of Medicine (Epidemiological Section) (20, Hanover Square, W.).—8.30 p.m.: Dr. E. W. Goodall and Dr. H. E. Corbin: Rubella.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. W. Stuart-Low: Clinique. (Throat.) 5.15 p.m.: Lecture:—Dr. G. H. Savage: Mental Disorders of Childhood.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. J. H. Horder: Residual Symptoms after Cerebro-spinal Fever.

Tuesday, January 28th.

Royal Society of Medicine (Therapeutical and Pharmacological Section) (Apothecaries' Hall, Blackfriars, E.C.).—4.30 p.m.: Prof. W. E. Dixon: Arterio-sclerosis and its Causation. Prof. A. R. Cushny: Nutmeg Poisoning.

Appointments.

Girvan, Hugh, M.D.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Maybole District of the county of Ayr.

Harker, T. H., M.D.Lond., Certifying Surgeon under the Factory and Workshop Act for the Harwich District of the county of Essex.

Hudson, Bernard, M.D.Cantab., M.R.C.P.Lond., M.R.C.S., Pathologist and Registrar to the East London Hospital for Children, Shadwell, E.

Hutchinson, J. R., M.B., Ch.B., D.P.H.Vict., Assistant Medical Officer of Health of Manchester.

James, William Morgan, B.A.Cantab., L.R.C.P.Lond., M.R.C.S., Medical Officer for the St. Woolos District

Lapage, C. P., M.D.Vict., Medical Registrar to the Manchester Royal Infirmary.

Price, Ernest Henry, L.S.A.Lond., Resident Assistant Medical Officer to the Cardill Workhouse.

Vacancies.

Lurgan Union (Ireland).—Resident Medical Officer. Salary, £80 per annum, with apartments, laundry, and first-class rations. Applications to James Calvert (Clerk of Union), Workhouse, Lurgan. (See Advert.)

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Berry Wood Asylum, Northampton.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, Cambridge.

London Fever Hospital, Liverpool Road, N.—Resident Medical Officer. Salary, £250 per annum, with board and residence. Applications to the Secretary.

Staffordshire Education Committee.—Medical Inspection of School Children.—Senior School Medical Officer. Salary, £300 per annum. Applications to the Director, County Education Offices, Stafford.

Joint Counties Lunatic Asylum, Carmarthen.—Assistant Medical Officer. Salary, £200 per annum, with board, lodging, washing, and attendance. Applications to W. Morgan Griffiths (Solicitor), Carmarthen.

Borough of Eastbourne.—Assistant to the Medical Officer of Health. Salary, £150 per annum. Applications to H. W. Foyargue, Town Clerk, Town Hall, Eastbourne.

Births.

Nathan.—On Jan. 15th, at 50, Harrington Gardens, London, the wife of Sidney Nathan, M.D., of a son.

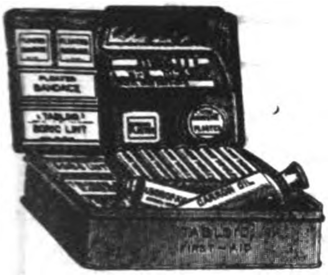
Deaths.

Chaplin.—On Jan. 15th, at 65, Wellington Road, London, Joan, the wife of Arnold Chaplin, M.D., aged 43.

Humble.—On Jan. 15th, at his residence, Corfe Castle, William Edward Humble, M.D., aged 87 years.

Simpson.—On Jan. 16th, suddenly, at Sandy Bank, Sidmouth, James Tracy Simpson, M.D. (Major R.A.M.C. Militia), late of Farnborough, Hants, in his 47th year.

Stevenson.—On Jan. 17th, at Sandhurst Lodge, Streatham, Dame Agnes Stevenson, wife of Sir Thomas Stevenson, M.D., F.R.C.P., aged 68.



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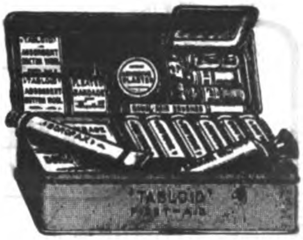

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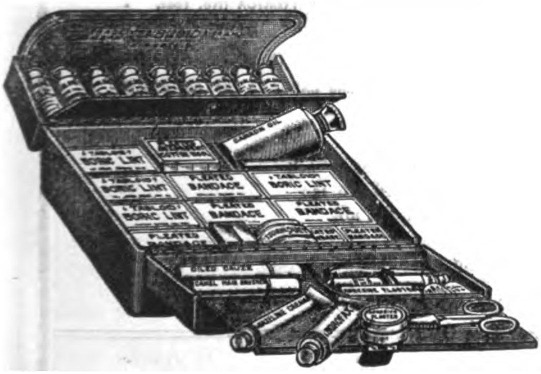

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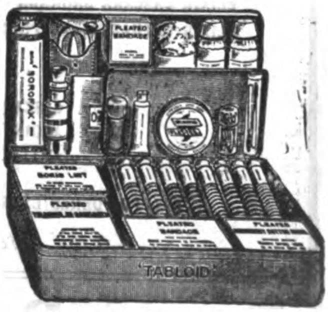

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JAN. 29, 1908. No. 5.

NOTES AND COMMENTS.

The *Lancet* Libel Action.

WE need hardly say that the *Lancet* has no sympathetic condolences in the issue of the libel action brought against it by Mr. A. Q. Tucker. We fear that the probability of an adverse verdict was increased by the fact that the writer of the comment did not speak "by the card," for he assumed that Tucker's Specific was advertised in the usual quack manner, whereas it was asserted in court that this was not so. A tempting argument would have been that "if it was not Homer, it was another fellow of the same name," but that of course could not be admitted in the case where a particular person was challenged. We do not attach any importance to the string of "cures" that appeared in court, for as was shown in Dakhyl *v.* Labouchere, no one argues that irregular practitioners do not benefit somebody; the objection to them is that they injure an undue number in the process of getting a few "cures." A qualified man may be a "quack of the rankest species," as we know, so that a mere procession of believers in a remedy is not in point. In the Tucker case, beside the advantage gained by the fact that he did not adopt the quack practice of advertising, the plaintiff had a number of medical witnesses to prove that they used the "specific" in their practices, and such being the case, it became exceedingly difficult to maintain the original accusation in a way likely to convince the court. Indeed, those two points mainly made the difference between a quack and a drug-trader countenanced and protected by the law, even if indiscriminately selling such poisons as cocaine and atropine.

Medical Reform and Medical Practice.

IT is hopeless for medical reformers and the medical Press to attempt to regularise the sale of remedies if medical practitioners do not support them. It is claimed by every second nostrum-seller that his remedy is approved or prescribed by the medical profession, and there seems to be in some cases this germ of truth in the assertion, namely, that a proportion of medical men are too lazy, or careless, or wanting in therapeutic resource, or principle, to bar nostrums from their practice. What can be thought of a medical man's qualifications if instead of prescribing cocaine and atropine for an asthmatic patient, he gives them A.'s fluid or B.'s extract, containing those commonplace drugs? And what good is it for medical men to prescribe it instead of using the ingredients from which it is made? so far as practitioners are concerned, it should be made perfectly clear that a seller of specifics cannot serve God and Mammon. If he appeals to the public who cannot discriminate between good and evil in the matter of drugs, he should forfeit for ever the countenance of the profession. There is nothing vindictive in that. A drug-seller cannot cheat a medical man—at least, he should find it hard to—by claiming undue merits for his wares; he can cheat the public, and it follows almost inevitably, if he appeals to them, that he does so because his stuff will not stand the critical scrutiny of the medical profession; in other words, that it is valueless, or over-rated, or too high-priced, and probably all three.

Sense and Sensibility.

To revert to the *Lancet* case again, we cannot forbear quoting the exceedingly apropos remarks that appeared in the *Pall Mall.* Said that journal, after arguing the legal question, "At the same time, we feel that the public need to be defended from an enormous number of useless and even mischievous concoctions, and much lighter damages would have sufficed to mark the fact that the *Lancet* had gone astray in this case. If there had been malice in the comment, or if it had caused actual loss to the plaintiff, the question of damages would have stood on quite a different basis. All we can say is that the penalty seems to be unduly severe for errors made in the course of an honest attempt to save the public." It is instructive to place alongside that quotation one from the journal which we have described as "perhaps the most persistent reviler of the medical profession that we have to contend with," and which has repudiated the charge. In a leader on the subject, the *Star* observes: "If the case reduces to more modest proportions the affectations of moral superiority displayed by the medical journals in their lecturings to the lay Press, or convinces the public that curative wisdom does not reside wholly and solely in the medical profession, then it will not have occupied the court in vain." The *Star* is what Mr. Chamberlain would call "a good judge" of libel actions, but it has not sufficient generosity to forgive its brother penman an unfortunate slip; it prefers to take an unsportsmanlike advantage of it to attack the medical profession and to defend its own blatant advertisers.

Unfortunate Bonesetting.

THE extraordinary success in the treatment of injuries which we are accustomed to associate with bonesetters and their "bloodless surgery" has, like its poorer and more legitimate sister, surgery, occasional exceptions. Happily for the art which depends for its continued existence entirely on the self-puffs of its exhibitors, the dissatisfaction which occasionally is experienced by sufferers who have resorted to it seldom finds its way into the Press, and the general public have an idea that the bonesetter's career is a triumphant procession from cure to cure. One of these exceedingly rare instances of disappointment came to light last week, and it has a particular interest for us in that we commented on it in these columns at the time it was first in the public eye. The case was that of Birch, a jockey, who sustained at Gatwick an injury to his back, reported to be a fracture of the spine, and who was under the care of a local practitioner and a well-known London surgeon. As in all such cases the illness was long drawn out, and Birch apparently got tired of his inactivity, and being urged by a judicious friend to place himself in the hands of a bonesetter, finally yielded. Two gentlemen of the craft were eager for the opportunity of restoring him to health, Mr. Rabey and Mr. Barker, and eventually victory lay with the former, who captured his prize, and, strongly against medical advice, moved the patient to his "Home" at Highbury. We remember wondering how long it would be before the "cure" was announced, and after fretting our soul with impatience for some months, we had settled down for a long wait.

Double-edged "Advertisement."

UNEXPECTEDLY the denouement came last week in the shape of the report of an appeal against a decision of the Bloomsbury County Court judge, who had tried an action brought by Rabey against Birch, and dismissed it. The point in dispute was whether Birch was liable for £72 for the benefits he had received at the hands of the bonesetter, and the judge said he was not. This view was upheld in the High Court. Although it is not specifically stated, the presumption is that Birch was not cured of his complaint, and the plea put forward by his counsel to the effect that there was no contract because the appellant undertook to treat the defendant to get an advertisement out of the case, is interesting and instructive. At any rate, the parties seem not to have hit it off, and the world now knows that it is not in bonesetters to command success, even if they do all they know to deserve it. On the point of law we should have thought, apart altogether from the defence put up, that it could have been successfully pleaded that the bonesetter had no *locus standi* to bring a case into court to recover fees for medical attendance, although in the ordinary way he might recover for board, lodgings, and so on. It is rather odd that this defence is not raised in cases where irregular practitioners sue for fees, as no other should be necessary where it is relied upon. One of the blessings attaching to registration under the Medical Acts is supposed to be that the practitioner can sue for fees, whereas otherwise he could not. However, Mr. Rabey seems in this case to have burned his fingers, and with his rivals advertising for all they are worth, he will have some lee-way to make up.

Battalion Chiropodists.

THE luxuries of to-day are the necessities of to-morrow, and modern life has an insatiable maw whose appetite seems to grow by what it feeds on. Manicure and chiropody have hitherto been regarded as luxuries for the wealthy who wished to be relieved of the trouble of trimming their nails and cutting their corns, but now the latter art has been placed by a generous War Minister at the disposal of the private soldier, and a class for instruction of non-commissioned officers and men in chiropody has been formed at Queen Alexandra's Military Hospital, Millbank. As the course is to last twenty-four days we fancy that there must be more in the mystery of chiropody than meets the mere surgical eye, that is, unless chiropody is an innocent sounding name for the surgery of the foot, and the instructed soldiers are to go forth to remove hammer-toes and ingrowing toe-nails from the feet of their less fortunate brethren in the ranks. Perhaps after twenty-four days they will be capable of even more heroic procedures. But it is a little puzzling to consider what rank the chiropodists will hold. We understand they are to be called "Battalion chiropodists," but do not gather if this carries with it a definite status. Perhaps they will remain in the ranks, and their chiropody will be merely an extra accomplishment, like marksmanship or riding, leading to a badge and an increase in pay; or perhaps they will become "specialists," and when they leave the service set up as "Foot- hygienists" or corn-curers, or in some similar line. We know, of course, the trouble that officers have with men who suffer from sore feet, but, after all, is not the boot-contractor the person to reform—or perhaps the system of contracting for boots in bulk? One cannot help wondering if the Tommy of the future is to have his nails polished for review day by the battalion manicurist, his moustache waxed by the battalion hair-dresser, and his teeth scaled by the battalion dentist.

LEADING ARTICLES.

THE LEGAL POSITION OF UNQUALIFIED MEDICAL PRACTICE.

VARIOUS recent decisions in the Law Courts have brought the matter of qualified medical practice into prominence. In some ways the mulcting of the *Lancet* for castigating an American proprietary article for the "cure" of asthma, bronchitis and consumption is the most notable. Medical men, who are wont to regard most forms of asthma and bronchitis as purely sympathetic, will learn with consternation that a man without medical training may now advertise with impunity a single nostrum to cure the maladies mentioned. The verdict is to be appealed against, so that further comment on the case at this stage is undesirable. At the same time, it may be remarked that the evidence brought forward at the trial to the effect that many medical men in the United Kingdom recommend the asthma "specific" to their patients reveals a deplorable lack of ordinary wisdom and prudence on the part of the profession. If these gentlemen were not actually aware of the composition of the nostrum, they may now learn through the medium of the newspaper reports that they have been ordering their patients a strong solution of sulphate of atropine, together with a little cocaine, some antispasmodic of the nitrate group, and other apparently more or less sweet substances. The unhappy persons who acquire a passion for the use of the remedy are probably in the grip of a drug habit. Quite apart from the merits of this particular case, the indiscriminate sale of deadly drugs under the disguise of a patent medicine label can hardly be depended on as conducive to the best interests of the public. The plaintiff, who is styled in the *Times* report under the extraordinary description of an "osteologist," which we take is used as a synonym for "bonesetter," appealed in the King's Bench Division against a nonsuit in the County Court rejecting his claim for £72 2s. alleged to be due to him for attendance and nursing. The plaintiff, a jockey, resisted the appeal successfully. The point as to whether recovery could legally be made by a medically-qualified person for medical attendance does not appear to have been seriously raised, and the case was settled upon the question of the presence or absence of a proper contract. This seems an anomalous position when we reflect that even a duly-qualified man has not the power to receive fees in court unless he has been registered as well as qualified. Far less, then, would it be imagined that an unqualified person should be able to recover fees for practice which he is legally not qualified to perform. Possibly it is legal for any unqualified person to enter into a contract to render certain specified services to a second party on certain terms, even though those services be of such a nature that only registered medical practitioners, acting as such, would be able to recover by legal process. In any event the situation appears farcical, and the sooner the defence unions take steps to get a clear judicial utterance upon the point the better for the medical profession. It is intolerable that an unqualified person be permitted to recover payment for medical attendance where a properly qualified (but unregistered) practitioner would be debarred from any such action. The importance of this matter to the medical profession is considerable, inasmuch as there is hardly any branch of practice which is not encroached upon by the unqualified pretender. Finally we come to a death which is alleged to have taken place after the injection of cocaine into the gum of a patient by a dentist who had no legal professional status in the United Kingdom. The particular case is still under investigation, and we can therefore offer no opinion. At the same time, a few remarks may be made upon the general question involved. We have before now pointed out the extreme danger incurred by any person who, not being medically qualified, administers a local or a general anæsthetic. The occurrence of death under an anæsthetic is at any time an extremely grave affair. Its circumstances, however, become infinitely more complicated when the medical skill of the administrator is not vouched for by the tests demanded by the State for the protection of its subjects. Humanely speaking, it is hard to understand the temerity of mind of any unqualified person who, under such circumstances, is prepared to risk a charge of manslaughter by the administration of an anæsthetic.

CURRENT TOPICS.

The New Medical Officer of Health to the Local Government Board.

The appointment of Dr. Arthur Newsholme to the Medical Officership of the Local Government Board in place of Mr. William Henry Power, marks a new departure in that particular branch of the Civil Service. For many years past the new Chief Officer has been known as the energetic Medical Officer of Health of Brighton, and as a distinguished worker in many branches of State medicine. Mr. John Burns has doubtless reasons satisfactory to himself for going outside the many distinguished men who are at the present moment to be found on the medical staff of the Local Government Board. In the natural order of things the successor to Mr. Power would have been chosen from among the existing staff. As things go, there is little doubt that Dr. Newsholme will find himself received with that spirit of loyal and unselfish co-operation that has always been a special characteristic of the department. Indeed, it is only with a full conviction of the existence of such loyalty that one could view the situation without some qualms as to the future. As it is, a brilliant career may be anticipated for Dr. Newsholme in the office that has been rendered illustrious by the labours of such men as Simon, Buchanan, Thorne Thorne and Power, who have done much to render the department one of the most important in the State.

Medical Men and the Births Notification Act.

The medical men of Aberdeen are up in arms against the Notification of Births Act. Last week they sent a deputation to explain their views to the Town Council, and to ask them to delay their adoption of the matter until an opportunity had been afforded for the amendment of the Act. Their spokesman was Dr. Williamson, President of the Aberdeen Medico-Chirurgical Society. He said the medical profession was ready now, as it had always been, to support the Public Health Department in everything where they thought it was for the benefit of the community, but they objected to being coerced under the threat of a penalty to do anything which they believed was not only unnecessary, but which they thought would be of absolutely no gain to the public, and which would be certainly contrary to the strongly-expressed desire of a section of their patients. The memorandum submitted with the unanimous approval of the Society will be found elsewhere (page 134) in the present issue. The chief objections raised were that the proper person to notify was the husband or the friends of the patient; that the Public Health Department would gain nothing by having their information from medical men; that to notify births would be to betray professional secrecy; and, finally, that the service was unremunerated.

The Fees of Friendly Societies.

The dispute between the Alfreton medical men and the local friendly societies is worthy the attention of the profession. At present there does not appear much probability of a settlement of the matter on one side or the other. The medical men at first demanded four shillings all round for medical attendance on the lodge members, but we understand that they have modified their terms by offering to accept 3s. per head for juveniles. The clubs considered those fees too high, and suggested three shillings and sixpence for adults and three shillings for juveniles where the members are not provided for from other sources; three shillings for adults who are provided for in other clubs; juveniles free up to thirteen years, and two shillings per head from thirteen to the years when they are provided for. It is stated in the local newspapers that the clubs are determined; if there be no settlement, they will proceed to establish a medical aid association and employ their own medical officer. In arriving at that decision it is to be presumed they have made themselves acquainted with the pros and cons of the case from the legal, social, ethical and professional points of view. The fact that the members of a learned profession should be forced to accept such paltry fees as those in question is in itself an unmistakable evidence of the great lack of organisation in their ranks. However, the fact that they have taken a determined stand is reassuring, and with the help of the profession generally, not to mention the medical journals and the General Medical Council, there may yet be a happy issue out of present troubles.

Is Dublin Dirty?

We understand that certain members of the Dublin Municipal Corporation have taken exception to an editorial note which appeared in our issue for Dec. 4th, on the dirty condition of the streets in Dublin. We further understand that the article in question has been referred to a committe for report. We may say at once that we shall be most pleased if our comments are proved to be inaccurate, because it is a most unpleasant thing to live in a city which merits such a description. It is, however, equally unpleasant to live in a fool's paradise, in which we see dirt through the rosiest of glasses. It is bad to be dirty, but it is worse not to know that we are dirty. Knowledge of our faults tends to promote reform; ignorance of them to promote their perpetuation. If Dublin is a clean city, how is it that it possesses an abnormally high death-rate, and how is it that almost every stranger who comes into it is struck by its dirt? We are afraid that no one outside the Corporation of Dublin will disagree with the view of such visitors. At the same time we do not suggest that the Corporation do not spend a large amount of time and an immense amount of money in trying to promote cleanliness, although for some reason or other their efforts do not bear the fruit which might reasonably be expected from the cost. It may be suggested that a large number of the workmen in the City Cleansing Department are physically unable to do what is usually considered a full day's work? We have seen many such at work in the streets who gave us this impression, but if these have not passed their work, then it is time that they were dismissed for laziness.

Sentiment, Sleeping Sickness, and Influenza.

It is curious to note how the human mind is apt to be swayed by sentiment even in the most direct issues of life and death. Tell them of sleeping sickness, that remote malady with the attractive name, or malaria, or any other far-away tropical scourge, and straightway they become filled with the strong wine of human philanthropy, and fit out expeditions and send off the cream of our scientific mankind to fight the foe in his native lair. Yet we have bacterial diseases no less deadly killing our fellow-countrymen here at home. Take influenza, which, for years past, has killed scores of thousands, and which is now sweeping over the country in a fresh epidemic wave. Why not endow our laboratories and employ our best medical brains to stamp out influenza, the microbe of which was recognised a dozen years or more ago? Would it not be a good investment for the Government to spend, say, a million pounds—a sum less than the cost of an ironclad —to find out a cure for influenza, or at least some method of prevention? Let the good folk who give their money to treat the natives of foreign countries be reminded that charity begins at home, and that there are scores of deadly home diseases, such as measles, scarlatina, whooping cough, and influenza, which could be most assuredly vanquished by a properly-endowed system of national scientific research.

The Prevention of Hospital Abuse.

The Board of Management of the Royal Victoria Hospital, Belfast, has just concluded a series of conferences with their medical staff on the subject of the treatment of patients in the extern department of the hospital, with the object of preventing hospital abuse. The first result has been an alteration of the by-laws governing the privileges of subscribers as to the admission of patients. Annual subscribers of a pound can now recommend one intern and two extern necessitous patients for admission. Formerly the word "necessitous" did not appear. The second result is the alteration of the rules for the admission of patients by inserting the words "of the working classes" after the word "patients." Thirdly, a circular has been issued to the working men and women of the city and neighbourhood inviting them to contribute regularly to the funds of the hospital, and offering certain advantages to works from which regular contributions come. These are as follows:—(1) Every subscriber of the working classes employed in the works will be admitted free as an intern patient; (2) any member of a family (not being a wage earner) whose father is a subscriber will be admitted free; (3) any youth who is a subscriber, and who is the support of his mother or other members of the family, will be entitled to the same advantages for them as if he were the head of the family; and (4) every subscriber (of the working classes) or member of his family (not being a wage earner) will be eligible for extern medical advice or surgical treatment free of charge. Lastly, a notice is to be hung in the extern department stating that advice is only for those who are unable to pay for it elsewhere. Whilst quite recognising the importance of this effort to prevent hospital abuse, we are afraid that the proposal relating to regular contributions will entirely vitiate the effect of the other proposals. The fact that a contribution of pennies has been made by an individual to the funds of the hospital under certain conditions will, we fear, render it impossible to prevent his or her admission subsequently on the ground that they are not necessitous.

Inconsistency in Medical Practice.

We are accustomed to flatter ourselves as a profession on our knowledge of modern hygiene, and on the progress which the community is making under our instruction. We all believe in the virtues of cleanliness, of fresh air, and of exercise. In the treatment of our patients we carefully regulate these matters, and a physician who in these days would treat a case of phthisis by the "close" method of a generation ago would rightly be regarded by his fellows as little short of a criminal. It is often said, however, that a doctor makes a bad patient. And in regard to preventive medicine as to curative, the medical man often fails to apply his own precepts to himself. In an article in the current number of the *British Journal of Tuberculosis*, Dr. Leonard Williams rightly calls attention to our inconsistencies in this respect. The physician who instructs his patient carefully in the virtues of fresh air, often furnishes a shocking example by his stuffy consulting-rooms, with its heavy hangings and closed windows. We have often looked at the rows of bedroom windows in a street of professional residences, to see them hermetically sealed, or showing a chink of a few inches. Which of us has not observed the thick and uncomfortable atmosphere which so commonly prevails at medical meetings, and the horror created at the opening of a window by some one of bolder spirit than the rest? These matters are of considerable importance, for until medical men show the way by example as well as by precept, they can hardly wonder if the public is inclined to look with suspicion on their advice.

Medical Incomes.

Nothing is more certain than that the possession of the highest standard medical degrees and qualifications does not necessarily pave the way to fortune. So far from that, many a man who has had a brilliant university career is doomed to spend his life in the drudgery of poorly-remunerated labour and mean and sordid surroundings. It would be well if medical aspirants recognised more generally than is at present the case that in all cases it is desirable to have a certain sum of money wherewith to purchase a practice, or otherwise to enable him to tide over the years of inevitable waiting. The newly-qualified medical man, who has spent all available funds in an expensive training, may look forward, as a rule, to a prolonged encounter with hard times. A settled income of £500 a year is so much of a prize as to cause the keenest competition amongst a large number of candidates. The rush of men bearing distinguished credentials for any fairly-paid post, such as that of medical officer of health, or the superintendency of a lunatic asylum, is simply pathetic. When will the public awaken to the injustice they are doing to the body of honourable, hard-working, highly-skilled men in their midst, whom they are deserting for the quack and the charlatan, for the bonesetter and the herbalist, for the dispensing chemist and the patent medicine vendor. As against the poverty of the learned man of medicine may be placed in sharp contrast the huge fortunes piled up by nostrum vendors who are ignorant of the medical art in any true or extended sense. Only a short while ago it was stated publicly in court that the profits arising from a single so-called "*cure*" for a symptomatic complaint amounted to no less than £17,000 a year. That represents just forty-two medical practitioners at an average of £400 per annum. The irony of the situation is, that the formulæ of the nostrums are derived from medical research, while the sale is begotten of brazen advertisement.

Poison in Cough Lozenges.

The trade in proprietary medicines is capable of being controlled in various directions, were existing laws put into action by the authorities. Not long ago the City of London Coroner called attention to a case in which a person was in the habit of taking certain cough lozenges. It was stated by a medical witness that they probably contained opium, and the foreman of the jury added that those particular lozenges were sold in every street in the City. Now, if that were the fact, every vendor of lozenges containing opium is liable to a prosecution under the Sale of Poisons Act. A common ingredient of cough lozenges is chlorodyne, which contains, among other drugs, chloroform and morphia. Chlorodyne is a proprietary medicine containing one or more of the scheduled poisons, and not being a "patent" medicine, falls within the Act. Lozenges containing chlorodyne must accordingly also fall within the statutory regulations, and any person selling that preparation except under the label "poison," and without an entry in a properly kept book of the name and address and signature of the purchaser, and the purpose for which the poison is required, is liable to penalty. It is most desirable that all cough medicines of any kind whatever should be analysed, and if found to contain scheduled poisons, that they should be brought at once under the control of the Sale of Poisons Act. Many infants and children are killed year by year by the administration of "soothing" nostrums containing deadly narcotic drugs. It is simply farcical to endeavour to protect infant life by a Notification of Births Act while we permit the young of the nation to be decimated by poisons vended under the spurious guise of curative medicines. A little vigorous co-operation between the police and the local sanitary authorities would soon put an end to a good deal of the mischief. Even the most ignorant mother would hesitate before she dosed her baby from a bottle decorated with a red poison label.

PERSONAL.

Sir William Ramsay, F.R.S., will open a discussion on "River Pollution" at the Royal Sanitary Institute, on Wednesday, February 12th, at 8 p.m.

Dr. Lewis C. Bruce is delivering the Morison Lectures at the Royal College of Physicians of Edinburgh on the alternate days of this week.

Sir George T. Beatson, K.C.B., was entertained at a complimentary banquet on January 10th at Glasgow, to celebrate his recent honour. The Duke of Montrose was in the chair.

The annual dinner of the West London Medico-Chirurgical Society will be held at 7.30 p.m., Friday, February 13th, at the Hotel Great Central, the President, Mr. R. Lake, F.R.C.S., in the chair.

Dr. Frederick Rose will read a paper on "The Physical and Educational Aspects of the Open-Air School" at a meeting of the Medical Officers of Schools Association on January 30th, at 3.45 p.m.

Mr. Gerald E. Friend, B.A., Oxon., M.R.C.S., late House Surgeon and House Physician to St. George's Hospital, Hyde Park, has been appointed Superintendent and Resident Medical Officer to that hospital.

Mr. John W. Dowden, F.R.C.S.Ed., has been asked to take charge of the late Professor Annandale's wards at the Royal Infirmary, Edinburgh, and to carry on the lectures of the Chair of Clinical Surgery till the close of the winter session.

Sir Dyce Duckworth and Mr. Thomas Bryant have been re-elected to represent the Royal College of Physicians of London and the Royal College of Surgeons of England respectively on the Council of Queen Victoria's Jubilee Institute for Nurses.

The Finchley District Council have appointed Dr. G. C. Taylor, the Medical Officer of Health, to carry out the medical inspection of school children, at a salary of 100 guineas per annum. They also adopted the Notification of Births Act, and agreed to appoint a lady health visitor, at a salary of £80 per annum.

A CLINICAL LECTURE

ON

MODERN THEORIES OF DIET IN THEIR RELATION TO PRACTICE. (a)

By ROBERT HUTCHISON, M.D., F.R.C.P.Lond.,

Physician to the London Hospital, Assistant Physician to the Hospital for Sick Children, Great Ormond Street.

[Specially Reported for this Journal.]

Gentlemen,—I have chosen this subject to-day because it is one in which I have, for some time, taken considerable interest, and partly because I feel that we still, as a profession, do not attach as much importance to diet as a method of treatment as we ought. That is attributable to various causes, one of which probably is that the medical student is not taught it; consequently men, when entering practice, do not regard it as so important as, for instance, drug treatment. But probably there never was a time when more interest was taken by the laity—especially the educated laity—in the question of dietary, so that almost every patient one sees, in certain classes of society, has his own views on the matter; and it is important that we should be able to meet these people on their own ground, to discuss with them, if necessary, dietetic theories in which they are apt to be posted, owing to the fact that the daily Press devotes so much space to questions of that sort. And one cannot do that without having a physiological basis to go upon, and so I must ask you to allow me to be rather theoretical at the outset, to consider the physiological basis to which all diet theories must be referred, and to which they must conform if they are to hold good.

The physiological basis of diet depends upon two great objects—(1) the conservation of body energy; (2) the conservation of body substance. Food is the income side of the balance-sheet, and therefore the material for the conservation of body substance must come out of the food. These two lines have to be kept clearly apart in discussing dietetic theories, because some theories refer to material, and some to energy. The total expenditure of energy in the body means the amount of food required to maintain the body in a state of balance. On that point we have, from physiology, fairly definite lines to go upon. Calculated in heat units, and taking the ordinary individual, 3,000 calories is the amount of energy contained in the diet of an ordinary individual of average weight and height who is doing an average amount of work. That is easily determined, as it is merely a physical question. There are some people who would have you believe that the principle of the conservation of energy is suspended in the body, and that people can do work on an insufficient amount of food. They cannot have grasped the fact that the amount of energy taken in must correspond to the amount given out. The number of calories varies with individuals and with circumstances; and those circumstances are important, because they make it impossible for a doctor to know exactly how much any individual ought to eat. There are many people who are dissatisfied if you cannot tell them how much, to an ounce or two, they or their children ought to eat. You cannot do that in the case of individuals; you can only say that 3,000 calories applies to an average person. It depends on the age, sex, size, build, and so on. It depends on age, because, within certain limits, the young body is the abode of young inhabitants—in other words, young and active cells—and they use a greater amount of energy. Therefore, young people require more food than do older people. And women require less food than men, probably because their muscles are smaller. Again, the person who has proportionally a large amount of muscle will require more food than one of the same weight who is merely fat, because fat is so much dead weight and is scarcely alive at all. It depends also upon the shape or build, tall, thin people requiring more than short, stout ones, the former having a greater amount of surface from which heat is lost. It is these considerations which explain the anomaly which puzzles many lay people, who say that So-and-So eats a lot but remains thin, whereas So-and-So eats sparingly and yet keeps stout. The amount of work done has a more profound influence than anything else on the total expenditure of energy in the body. Climate has less influence than is often supposed. In cold weather you do not need to eat more than in hot, but the food can often be digested much better. One of the most important things of all is the influence of temperament on the expenditure of energy. The cells of some people seem to be more active and alive than those of others, and so they require to take in more. I have sometimes wondered whether that may be due to variations in the activity of the thyroid. In Graves' disease people have a temperature running up above the normal; they perspire easily, and remain thin. In myxœdema, when the thyroid is inactive, the converse is true. There may be people who are not the subjects of Graves' disease, but have active thyroids, and they require more food than others. Others are not the subjects of myxœdema, but their thyroids are not so active, and they tend more readily to put on fat and require less nutriment. This makes it all the more difficult to dogmatise as to the amount of nutriment required by any one person.

Now as to the other side of metabolism, the conservation of body substance, the preservation of the body intact without losing weight. That is a matter upon which physiologists cannot give us much information. This is unfortunate, because what we need most of all just now is information about the nitrogenous waste in any given space of time. Physiologists have had to fall back on the rough-and-ready method of simply calculating how much nitrogenous material people consumed in 24 hours when in a state of balance. That is how Voit originally got his standard, arriving at 4½ oz. of protein as the amount required in 24 hours by the average individual. Americans particularly have said that that figure is far too high—that less than half that quantity will do. Chittenden, by carefully devised experiments applied to many individuals, showed that in the conditions in which these individuals were living, it was possible to maintain the balance of tissue by only taking half that quantity. And other people, taking up his results, say this is what everybody ought to do; we are eating far too much protein. I will consider that presently. Meanwhile, we can do much towards the solution of this question by watching the effects of diet upon patients.

Now with regard to some of the dietetic theories or systems which you will find people adopting or advising other persons to adopt, and which one finds to have been adopted by patients, sometimes with disastrous results, sometimes with more or less success. According to one theory, *our average intake of energy is too high*; practically stated, it means that we eat too much. From a physiological point of view, how do we know whether a person is eating too much, or not? I only know of one way, and that is when the weight is continually on the increase. If you take in more energy than you give out, it is obvious that you must store it in some form—namely, as fat. Unless that is the case, you have no right to say of a person that he is eating too much. The only way out of that dilemma is to assume—and it is a fair assumption—that many people are carrying about a far greater body weight than is necessary. What is the advantage of body fat? That is not easily answered. We know it serves to keep the body warm to some extent, and as a reserve of nutriment. In the case of pre-historic man, it was a great advantage to have a reserve of fat. But under modern conditions such a reserve may be simply an inconvenience. I would like to hear from practitioners present whether they have noticed that patients' ability to stand bad illnesses is in proportion to their body weight. Is it an advantage or a disadvantage for a patient to be stout? It has been said that such people have a reserve of nourishment to draw upon in an illness; but I think it is difficult to substantiate that, because most people can take milk in illness, and that provides quite enough energy. And if you carry about a stone or so more than you need, that increases your muscular work considerably; there is not only the transport of that extra weight from place to place, but it throws on the organs of assimilation a good deal of unnecessary work. If that is so, what is the optimum degree of fat? To that question I do not think it is possible to reply in the case of any individual. A man must find out at what weight he feels. Amongst the symptoms often exhibited by people who try to maintain a greater body weight than is necessary are those which may be described as "biliousness" or "bilious attacks," and many of these people lose their biliousness if you reduce their body weight a stone or half a stone. It is a method which is always worth trying. But it is a disadvantage to have too low a level of body weight, because it renders a person liable to certain diseases, especially tubercle. I always remember a lady who was one of the "faddy" people, and who restricted herself to one meal a day. She carried her theories to such an extent that she became almost a walking skeleton. I saw her some time afterwards, and found that both her lungs were stuffed with tubercle, and she quickly succumbed.

(a) Delivered at the Prince of Wales' Hospital, Tottenham, on Thursday, January 9th, 1908.

With regard to the second system or theory, there are people who maintain that *the amount of repair material is too high*; these are the followers of Chittenden and his school. That means that people eat too much meat, because meat is the food which contains most protein. But I deny that we eat more meat than our ancestors did. Social history shows that we eat far less, especially in the upper classes. In this matter we have no physiological evidence to guide us. Chittenden tried to see how far he could go without the subjects of experiment losing nitrogen. That is an experiment which the human race has been making for centuries, and there is much to be said for the view that if you find huge masses of people have hit upon this quantity of protein, it is presumptive evidence that it is right. At any rate, it should not be lightly set aside. Chittenden is not a doctor, but a physiologist, and we must keep our eyes open to the disadvantages of his system. It is claimed that on half the quantity of meat you give the kidneys less to do, and—with less reason—that you lessen arterial degeneration, and that you get rid of "gouty" symptoms. Chittenden cured himself of bilious attacks and migraine by his system. But we have to beware lest we tumble into the whirlpool on the other side, because there may be dangers in too small a protein intake—that is, in eating too little meat. There is no question that herbivorous animals are more subject to tubercle than are carnivora, and that disease is rampant in Ireland, where a large part of the population is habitually underfed, especially in regard to animal food. Consumptives also seem to have a dislike for meat. The risk of lowering the resistance to disease by taking too little protein may be greater than the risk of overworking the excretory organs by eating too much. Carnivorous animals do not overwork their excretory organs; neither do Esquimaux, who live mainly on animal food.

Vegetarianism hangs very much on what I have said about the views of Chittenden. It is primarily a religious belief or cult, and it is only recently that people have tried to justify it scientifically. If you require the usual amount of protein, the vegetarian diet needs to be so bulky that it may bring on dyspepsia. But if it is true that we should eat about half the protein we do, there is not the same objection to vegetarianism. In practice, vegetarianism is good in the cases in which the system of Chittenden is to be recommended.

The next theory we have to consider is the *lacto-vegetarian theory*, or the theory of uric acid intoxication. It was introduced in the eighteenth century by Combe, and has lately been advocated by Dr. Haig. It assumes that purins, of which uric acid is the best known example, are specific poisons, and give rise, according to Haig, to gout and many other diseases. He asks us to discard all foods containing purin, such as meat, tea, coffee, and so on, and he would confine us to a diet of vegetables, eggs, milk, and cheese. Experiments show that you may ingest large quantities of uric acid deliberately without any special symptoms. But there are some people who have a difficulty in dealing with purins, and for them such a diet is good. Several chronic conditions are benefited by it, such as chronic gout, and migraine, and other paroxysmal neuroses; some skin diseases, such as chronic eczema; also chronic diarrhœa, and some forms of neurasthenia. I think the benefit of the diet is due to the fact that there is very little intestinal putrefaction from it. Milk is one of the best intestinal antiseptics. But if persevered in for a long time, this diet tends to cause dyspepsia.

The last theory is an ingenious one which has been put forward by Dr. Francis Hare. He calls it *the theory of "hyperæmia."* He does not say we consume too much protein, but too much carbonaceous material, such as carbo-hydrates and fat. He has elaborated his views in two able volumes entitled "The Food Factor in Disease." As the author himself admits, there is no chemical proof of the theory at all. He says if you take more carbonaceous food than you can comfortably break down in the body, it accumulates there in some form, but not fat because the people he talks about are not gaining weight. He says it circulates in the blood, and produces a number of diseases, but he cannot say what form it circulates in. You can treat many cases more successfully by Hare's method than by Chittenden's. The diet he gives consists of 8 to 12 oz. of meat, 1½ oz. of bread, a little butter, green vegetables, tea and coffee. People, of course, lose weight on that. He subsequently gradually adds carbo-hydrate until the patient just maintains his body weight, and leaves him on that. By that means, he says, the person gets rid of the excess of this unknown substance. The diseases, again, which are said to be cured by this, are all forms of biliousness, and particularly migraine, cases which are described by Eustace Smith as "food fever," particularly in young subjects, who show a dirty tongue and mild fever. He says it also cures paroxysmal neuroses, such as asthma. I can confirm Hare's statement that such a diet often cures obstinate migraine.

Now it is a striking thing that all the systems I have mentioned profess to cure the same conditions. I think there are two possible explanations of that common mode of action. They may all act through the intestine; possibly by diminishing intestinal putrefaction.

There is another possibility, and that is, that there are more people than we know who have difficulty in completely oxidising nitrogenous matter—I put it in the broadest way—and that incompletely oxidised material circulates in the blood, causing different forms of disease. You may ask, how, then, will cutting down only their carbonaceous material help them? The explanation may perhaps reside in what is called the doctrine of "protein-sparers." If you have a cell, and into its neighbourhood you bring molecules of sugar and fat and protein equally, the one which the cell grasps most easily and breaks down is protein, because it acts less as a foreign body than the others. But if you bring in a huge mass of molecules of fat, then the preponderance makes itself felt in preventing the selection of protein; the cell is bound to turn its attention to what is in greatest abundance. That is what happens in diets which contain not only much meat, but sugar also. Whereas, if you cut down sugar and fat, even if you leave in the protein, the cell is so much more unembarrassed by the other things that it can combust the protein completely. So it does not matter whether you eliminate the protein-sparers, or cut out the protein and leave very little to be combusted; it may come to the same thing in the end. In conclusion, I believe that the best system is an intelligent omnivorousism, eating everything which comes handy, but not too much of it. There are individuals here and there who may need to go further, and you may have to cut out particular things from their diet very carefully. But they are not normal people; they are pathological, and their diet must be framed accordingly.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by W. I. de Courcy Wheeler, M.D., F.R.C.S.I., &c., &c., Surgeon to the Mercers Hospital, Dublin. Subject: "General Surgical Technique."*

CLINICAL LECTURES FOR 1908

We have been favoured by promises of Clinical Lectures from the following Hospital Teachers and Post-Graduate Lecturers (in addition to the list published in our issue for the 1st inst.), to whom we tender our best thanks:—

Chas. A. K. Ball, M.D., F.R.C.S., Surgeon to Sir Patrick Dun's Hospital, Dublin.

Frank H. Barendt, M.D.Lond., F.R.C.S., Physician for Skin Diseases, Royal Southern Hospital, Hon. Surgeon St. George's Hospital for Skin Diseases, Liverpool.

Prof. Vilmos Coldziecher, M.D., Professor of Ophthalmology in the University of Budapest.

H. J. Hobart, M.D., Surgeon to the North Infirmary and the City of Cork Hospital.

Thos. S. Kirk, M.D., Surgeon to the Belfast Hospital, Surgeon Royal Victoria Hospital.

Prof. R. Kruse, M.D., Professor of Medicine in the University of Bonn.

Chas. G. Lee, Hon. Surgeon to the Liverpool Eye and Ear Infirmary, Aural Surgeon to the Royal Southern Hospital, Liverpool.

Chas. J. Macalister, M.D., C.M., M.R.C.S.Lond., Lecturer on Clinical Medicine University of Liverpool, Physician to the Royal Southern Hospital.

Alfred R. Parsons, M.D., F.R.C.P., Physician to the Royal City of Dublin Hospital.

Nathan Raw, M.D., B.S., F.R.C.S., Consulting Physician to the Walton Workhouse, Liverpool, Visiting Medical Superintendent to the Mill Road Infirmary, Liverpool.

Richard Travers Smith, M.D., F.R.C.P., Physician to the Richmond, Whitworth and Hardwicke Government Hospitals, Dublin.

Arthur J. Wallace, M.D., C.M., Hon. Obstetric Surgeon to the Lying-in-Hospital and the Hospital for Women, Liverpool.

ORIGINAL PAPERS.

HÆMORRHAGE INTO THE PONS VAROLII AS THE IMMEDIATE CAUSE OF DEATH IN THE ECLAMPSIA OF PREGNANCY, WITH ILLUSTRATIVE CASES.

By NORMAN C. CARVER, M.B.,

AND

JOHN S. FAIRBAIRN, M.B.

The case which forms the basis of this paper was admitted to St. Thomas's Hospital as one of eclampsia with coma; it was treated as such, and the extensive hæmorrhage into the pons varolii, which was the immediate cause of death, remained unsuspected until it was revealed at the post-mortem examination. This unexpected discovery of the nature of the coma in a case which we had considered to be one of the ordinary eclampsia of pregnancy led us to look into the question of the occurrence of such hæmorrhages in fatal cases of eclampsia, and we have thought that our experience in this case, and the results of our investigations into the similar cases already recorded are of sufficient interest to merit discussion before the section.

We will begin with an account of our own case. The patient, who lived in the hospital out-door maternity district, was a primigravida, æt. 24, about five months pregnant. On the evening of March 23rd, 1905, her card was sent up to the hospital as she was suffering from vague pains, and the obstetric clerk on duty visited her, and reported her condition on his return. She was then seen by one of us. Her mental condition was quite good, and she gave a history of loss of appetite, sleeplessness, headache and spots before the eyes for two or three days. There had been no vomiting and no fits. She had noticed nothing abnormal about her urine, and considered that the amount passed had been as usual. There was œdema of the whole body, which was said to have been present for one week, but up to this time she had been able to do her ordinary household work. The uterus reached to the umbilicus and the fœtal heart was audible. The temperature was normal, the pulse-rate 84; the arterial tension was considerably raised. A catheter specimen of the urine was obtained, and was found to contain so much albumin that it became solid on boiling; there was no blood shown by the guaiacum test. The patient was ordered to keep her bed and was given a saline purge, and arrangements were made for her admission to the hospital on the following morning.

On March 24th, at 1.20 a.m. (*i.e.*, about six hours after she was last seen), the husband woke up and found the patient unconscious, and lying on the floor on her face and knees. He said that he had noticed her hand twitching before he had gone to sleep, and that evidently her falling on the floor had wakened him. As soon as he had got her back to bed he came up to the hospital for help. When the patient was seen by one of us about 2 a.m. she was cyanosed and quite unconscious; respiration was shallow and inclined to be of the Cheyne-Stokes type; pulse 84, tension very high; all reflexes were absent, no unilateral symptoms were noticed and no twitching; the pupils were equal and moderately dilated. An ambulance was procured at once, and the patient removed to hospital. On her arrival in hospital the pulse was found to be much weaker, and the respirations to be more markedly of the Cheyne-Stokes character. She was bled from a vein in the arm and 10 oz. withdrawn, and afterwards 4 pints of normal saline solution were infused, but without any improvement, her condition being extremely grave during the periods of apnœa. Rapid dilatation of the cervix was carried out by means of metal dilators, followed by de Seigneux's modification of Bossi's dilator, and a fœtus of about five months extracted by version. The child was living, and gasped for a few minutes after delivery. The patient's condition did not improve in any way, and she died at 7.15 a.m., without recovering consciousness. Unfortunately the specimen of urine obtained before the onset of coma was not kept, and as no other was available it is not possible to give any further details of the examination of the urine.

The following are the notes of the autopsy which was made on the following day by Dr. Powell White:—

There was some anasarca, especially of the lower limbs.

Brain.—There is an extensive hæmorrhage into the substance of the pons, which is greatly torn and disorganised. The hæmorrhage passes up for a short distance into the crura cerebri. The rest of the brain is normal. There is no evidence of disease of the cerebral arteries, nor was any sign of arterial disease found in any other arteries in the body.

Chest.—Both pleural cavities contain some excess of clear fluid. Lungs and heart normal.

Kidneys.—These organs are not much altered to the naked eye. The cortex is pale and fatty, and the pyramids are distinct. The capsule strips easily, leaving a smooth surface. Microscopically, under the low power, many of the glomeruli are seen to be sur-

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(a) Read before Obstetrical Section, Royal Medical Society, Jan. 9, 1908.

rounded by a ring of connective tissue. Many of the tubules are swollen, and in places the epithelium is swollen and necrotic. In one part of the section the tubules have been almost obliterated by a mass of recent white fibrous tissue. Under a high power the connective tissue which has infiltrated the glomeruli is seen to be rich in nuclei and of recent origin. Numerous young fibroblasts are present. There is extensive degeneration of the epithelium of the convoluted tubules. The cells are greatly swollen, and show evident granular degeneration. In places the nuclei have entirely failed to take up any stain. In a few tubules the cell outlines are no longer visible, and the lumen is obliterated by granular *débris*. The straight and collecting tubules have escaped change. Some fine fatty degeneration was found in a few scattered tubules after special staining. These changes suggest an acute degenerative process following on a slight chronic interstitial change.

Liver.—This organ weighed 50 oz. and was normal in size, shape, and consistence. On the surface and on section it presented some map-like irregular red patches, varying from the size of a crown piece to that of a sixpence, and having a fairly distinct margin. Microscopically, under a low power, numerous blood-containing spaces are seen scattered through the liver substance. The blood spaces are surrounded by fibrous tissue, and are arranged in groups. In the immediate neighbourhood of each group of blood channels the liver cells are flattened and elongated. With this exception the liver cells are normal in appearance. There is slight proliferation of the connective tissue cells along the portal canal and around the larger groups of blood spaces. These groups of blood spaces appear to have an interlobular arrangement, and to be developed in connection with a branch of the portal canal. Under a high power the blood spaces are seen to be bounded by a single layer of flattened endothelial cells surrounded by a definite ring of connective tissue. The contained blood appears normal. There is no evidence of fibrin formation or of the presence of an undue proportion of leucocytes. In places the septa have broken down and the adjacent channels have become confluent. The liver cells in the neighbourhood of the blood spaces are much flattened and compressed, and here and there islets of hepatic cells may be seen completely cut off from the liver substance. In places there has been definite extravasation of blood, and the corpuscles are seen lying free between the liver cells. There is a very large deposit of brown pigment in the immediate neighbourhood of the blood spaces, and for some distance from each group of spaces the cells contain an excess of pigment. The tumours appear to be cavernous angeiomata, and to have been developed by the dilatation of the existing blood capillaries.

Bladder and *ureters* appear normal.

Uterus rises to the brim of the pelvis There are some remains of the membranes in it. The cervix is slightly torn.

The post-mortem examination shows that death resulted from a cerebral hæmorrhage, causing extensive destruction of the substance of the pons varolii. But it also affords evidence in accordance with our view that the case was primarily one of eclampsia. The kidney changes were slight, but quite definitely those of degeneration in the shape of fatty change and necrosis, such as is usually found in eclampsia, and the amount of chronic renal disease is too trifling to admit of its being considered the primary factor in the case. Although the changes in the liver were not distinctive of those found in the toxæmia of pregnancy, the post-mortem evidence is on the whole quite consistent with our interpretation of the case.

The further evidence which we would bring forward on this question is, first, the occurrence of a definite pre-eclamptic stage. When the patient was first seen, she exhibited the signs of impending eclampsia—sleeplessness, spots before the eyes, headache, with general œdema and highly albuminous urine. That the symptoms came on as early as the fifth month is no valid argument against the disease being eclampsia, for during the last few years there have been three such cases treated in St. Thomas's Hospital in the fifth month of pregnancy—*i.e.*, the case under discussion and two others. Also, according to Clarence Webster (1), one has been observed as early as the fourth month by Willis, and Tarnier, out of 52 cases, noticed one at the fifth month. The earliest case we have come across in the literature is one before the fourth month recorded by Pratt (2).

The next point is that, although there is no definite evidence of a fit, there are points in the history very suggestive of their occurrence. There is the husband's statement of his having noticed the hands twitch before he fell asleep, and there is the fact that the patient was found out of bed on the floor. But the absence of fits is no evidence against the case being one of eclampsia, for, as Schmorl (3) says, convulsions are only a symptom of eclampsia, though a most important one, and they do not constitute the disease itself. Many cases have been recorded as eclampsia in which there were no fits. We may give references to a few we have come across. Schmorl (4) records three, including one of Wendt's (5); Labhart (6), Meyer-Wirz (7), Esch (8), Bouffe de St. Blaise (9), and Binder (10) one each.

Further, the cases of a similar nature we have been able to collect form very important evidence of our case being one of a definite group, in which hæmorrhage into the base of the brain is the immediate cause of death in eclampsia. These cases will be quoted later on, and form, perhaps, the strongest argument in favour of our contention.

Lastly, there is the question of an alternative explanation. It is certainly not easy to understand why a large hæmorrhage of this kind should occur in a previously healthy young woman of 24, without disease of the arteries. Three of the other cases we have collected occurred in young women, so that presumably the poison of eclampsia was the determining cause of the apoplexy in them also.

Assuming, then, on these grounds that the case was one of eclampsia, the next point we wish to consider is the occurrence of cerebral hæmorrhage in eclampsia. The changes in the brain in eclampsia are not definite, but it is very common to find small hæmorrhages, generally meningeal, which are usually ascribed to the rise of blood pressure due to the fits, and that this is the probable explanation is shown by the fact that they are generally found to be most marked in those cases where there have been a large number of convulsions. These small hæmorrhages are, however, quite different from extensive apoplexies, which are much more rare. A very brief review of the statistics will show this.

In a large number of cases from the Vienna Clinic analysed by Schauta (11), out of 90 post-mortem cases 10 cases were noted as showing evidences of cerebral hæmorrhage, and of these, in 4 it was termed "apoplexia gravis" and in the others "apoplexia capillaris." Schrieber (12), in 27 fatal cases, notes no large cerebral apoplexy, though there are 4 cases of capillary hæmorrhage. Glockner (13), out of 26 post-mortem examinations, mentions cerebral hæmorrhage as having occurred in three cases, and meningeal hæmorrhage in 1, though no details are given as to size. Schmorl (14), as the result of his examination of 73 fatal cases, says of the cerebral conditions found:—"Out of 65 cases, in 58 changes in the brain were noted in the shape of small, seldom large, hæmorrhages with areas of softening." For the most part he looks on these as thrombotic in origin and as secondary to the convulsions.

The cases to which we especially wish to draw attention are those of hæmorrhage into the pons varolii, or base of brain, as it is such cases which appear to be similar to our own. Occasionally such are found recorded in some of the statistics already quoted, but the details of the illness are not given fully enough to make them of use for our purpose. For instance, in Schauta's paper he records a case of hæmorrhage into the pons preceded by fits, and one of hæmorrhage into the corpus striatum, in which the history was incomplete. The case which appeals most to us in regard to our own experience is one recorded by Pfannenstiel (15), under the title "Apoplexy as the Cause of Death in Eclampsia." It is of special interest to us, as Pfannenstiel was evidently much impressed by his mistake in diagnosis. He says that the case appeared to be one of eclampsia or uræmia, as shown by the deep coma, the absolute insensibility and loss of movements, by the wide inactive pupils, and the high albuminosity of the urine. The possibility of apoplexy was not considered because there was no asymmetry of the face or any unilateral signs, though he states that these may have been present before the patient was seen.

His patient was a primipara, æt. 22, who was admitted to the clinic, in labour and unconscious, with the diagnosis of eclampsia, at 9 a.m. According to her sister, she had previously been quite well in this, her first pregnancy, but for a few days had had swollen feet and severe pain in the back and side. Some four hours before admission, while lying in bed, she had an attack of sickness and a short fit, after which consciousness had not returned. When seen after admission, she was lying on her back with her limbs quite limp; there was œdema up to the knees. The pulse-rate was 68, of medium strength; respirations 44, shallow and rattling. The pupils were widely dilated, equal, and the corneæ insensitive. The fundus was normal, and no change was noted in the small vessels. The face was symmetrical, and the sensibility over the whole body was lost. The urine withdrawn by catheter was barely 80 c.cm., and became solid on boiling, so that the test-tube could be turned upside down; it contained a few casts and some fatty epithelium, but no blood-cells. The fundus uteri was three finger-breadths below the xiphoid, and the fœtal heart was heard two finger-breadths below the navel. The os admitted two fingers, and the membranes were intact. A kolpeurynter was placed in the vagina; a hot bath (30° R.) for half an hour was given, and an icebag was placed on the head. At 11 a.m. there was marked tracheal rattling and the pulse was irregular, so 600 c.cm. of blood, very dark in colour, were abstracted from a vein, and an equal quantity of normal saline solution injected. After this the pulse improved, and the tracheal rattling became less. At noon the condition was again worse, with a small pulse and very shallow breathing; the os was found to be the size of a thaler, so dilatation with the fingers was adopted, followed by rupture of the membranes and version with the bringing down of a leg. Shortly afterwards a male child, well developed and recently dead, was delivered; ten minutes later the placenta was expressed. For a short time after delivery the respirations were deeper, and there was no tracheal rattling; the pulse was 96, regular and stronger than before; and there was no bleeding. The pupils remained widely dilated, and there was no corneal reflex. This improvement proved, however, to be very temporary, for the pulse became feebler and the breathing stertorous, and at 3.15 p.m. the patient died.

The post-mortem findings were briefly as follows:—In the kidneys there was little change to the naked eye; microscopically there was fine granular and cloudy swelling of the epithelium, with here and there necrosis; there were some fine granular coagula in some of the canals. The *liver* showed a map-like pattern, with deep red colouring of the parenchyma, both on the surface and on section. Microscopically there were areas of unstained or poorly stained cells; the liver cells were fatty, and contained blood pigment. In the *brain* there was complete destruction of the left optic thalamus and surrounding parts by a hæmorrhage which had broken through into the left lateral ventricle, with hæmorrhagic softening of the right optic eminence and filling of all the ventricles with dark blood. There were points of blood in the pons; the arteries were normal, except in the neighbourhood of the hæmorrhage. In the optic eminence was a varix the size of a cherrystone, with fresh thrombosis, and microscopically the position of the bursting of this thin-walled sac was recognised. No varices were noted elsewhere in the body.

In discussing the case Pfannenstiel considers that delivery improved matters for a time by lowering the abdominal pressure, and so relieving the blood-pressure. He thinks that the extensive nature of the cerebral hæmorrhage was the reason of the error in diag[illegible] it early compressed large areas of both cerebral tracts, and so no one-sided symptoms were noted, but only total paralysis and deep coma. Probably the thin-walled varix in the left optic eminence, which must be regarded as pre-existent, formed a *locus minoris resistentiæ*, and when the blood pressure was raised in consequence of the first eclamptic attack, it gave way. He considers that the case is shown to be one of true eclampsia by the highly albuminous urine, by the presence of œdema and the usual premonitory symptoms, and by the pathological findings in the liver and kidneys. Except that the area of the base of the brain involved in the hæmorrhage is not quite the same, this case is similar to ours, and bears out the interpretation which we have given of it.

The next case which we have come across is one recorded by Meyer-Wirz (16). The patient was a primipara of 38, with a considerable amount of albuminuria. Spontaneous delivery of a living child had taken place at 5 p.m., and the doctor, when called two hours later, found her unconscious, in deep coma and cyanosed, with a pulse of 100 and a temperature of 37.5° C. The pupils were of medium size and equal; respiration was of the Cheyne-Stokes type. The uterus was contracted, and there was no hæmorrhage. Two grams of chloral were given by the rectum, and oil of camphor hypodermically; an icebag was put to the head, and artificial respiration was tried, but the pulse rate and temperature rose until they reached 160 and 40.6° C. respectively just before the death of the patient. The post-mortem revealed the following condition:—

Brain.—Pia mater œdematous; sub-pial hæmorrhages in the parietal and temporal convolutions of the right side. In the posterior fossa were 30 c.c. of blood-stained fluid. At the base of the brain was a definite sub-pial hæmorrhage, and blood coagula were present on the under-surface of the medulla and round the origin of the vagus. The pons was markedly widened and bulged forward. On taking away the brain, the surface tore through on the left side, and thick blood flowed out. There were blood coagula in the Sylvian fossa, and the lateral ventricles were dilated and contained blood-stained fluid. There were blood coagula in the corpora quadrigemina. On the right side there was a circumscribed hæmorrhage between the corpora striata, almost in the middle line, and the surrounding tissue was softened. The hæmorrhage involved principally the lenticular nucleus and the internal capsule. The caudate nucleus and the cerebral peduncles were free. In the pons was an extensive hæmorrhage, the aqueduct of Sylvius and fourth ventricle being filled with coagula. There was nothing in the cerebellum.

Kidneys.—The capsule stripped easily; microscopically there was cloudy swelling and some parenchymatous change, but no fatty change.

Liver.—This organ was slightly enlarged, and on its surface were some slight hæmorrhages. On section many punctiform hæmorrhages were seen, and small miliary necrosis all over, especially under the capsule.

The next case is one recorded by Maygrier and Chavane (17). The patient was a primigravida of 25, pregnant 7½ months. When first seen everything was normal, and no trace of albumin was found in the urine. On the following day some difficulty in breathing was noticed, and this rapidly increased. The patient was pale, and there was sharp pain in the epigastrium. Nothing abnormal was found in the lungs or heart. Oxygen was given, and a hypodermic injection of ether. In a few hours vomiting and diarrhœa set in, followed by eclamptic convulsions at short intervals without coma. The urine was then examined and found to be solid with albumin. The convulsions continued, and three hours later the patient was semi-comatose, with a pale skin, but no œdema. The urine was dark, appearing to contain blood, and was solid with albumin. Respiration was normal, and the temperature 36.4° C. Labour had commenced, and the membranes were ruptured; the fœtal heart was heard beating strongly. Chloral, chloroform, and oxygen were administered, and later the patient was bled to the amount of 300 gm., and normal saline infused to a like amount. Rapid dilatation by hand was performed, and a dead child delivered by forceps. During this operation artificial respiration was done, but without relief of the cyanosis, although there was some attempt at respiration. There was considerable post-partum hæmorrhage, so the placenta was removed by hand, and an intra-uterine douche given. The patient died suddenly shortly afterwards.

Inquiry afterwards from the friends showed that the woman had come to the hospital about three months previously, when it was found that there was albuminuria, but she then refused admission. The placenta showed six foci of hæmorrhage, but no œdema. A post-mortem examination was made 24 hours after death. There was no œdema. There were signs of old tubercle in the lungs. The heart was enlarged and fatty, with pale muscle, and some old disease of the mitral valve.

Liver.—The liver was pale yellow, with red patches of irregular outline beneath the capsule, which extended into the substance of the organ. On section there were numerous red patches resembling blood extravasations. Microscopically there were hæmorrhagic points which in places invaded and destroyed the lobules. The liver cells were much deformed, but still stained. The protoplasm was slightly granular. The condition of the liver was hæmorrhagic rather than degenerative.

Kidneys.—The kidneys were pale, and the capsule stripped easily, but they appeared normal to the naked eye. The only microscopical change of importance was cloudy swelling of the epithelium with granular protoplasm which stained badly.

Brain.—There was a large hæmorrhage in the right hemisphere, destroying a large part of the cerebral peduncle, and extending as far as the anterior wall and posterior limb of the internal capsule, skirting the corpus striatum. The third ventricle was much dilated, and there was a clot the size of a pea in the head of the caudate nucleus. The left ventricle was entirely filled with a large clot, part of the hæmorrhage extending forwards.

Another case of a like nature is recorded by Esch (18), under the title of "Eclampsia without fits." The following is an abstract of this case: On January 20th, 1899, Esch was called to a primigravida of 25, who had had pains since 11 p.m. on January 19th. Her last period was on April 14th, 1898. The history showed that she had passed bloody urine on the evening of the 19th, had had dimness and spots before the eyes, and had been twice sick. There was no abdominal pain, but severe headache; at 9 a.m on the 20th there was twitching of the face and complete blindness, but the patient was still conscious. When first seen the fundus uteri was between the navel and the sternum, the fœtal heart was audible, and there were slight pains; the os admitted one finger, and the membranes were unruptured. After the amblyopia great excitability came on, but with clear intelligence. At 12 noon the mental acuteness began rapidly to diminish, and this so quickly that by 12.30 the patient had completely lost consciousness. The urine was highly albuminous. The patient was removed to the Clinic; nothing happened during removal. On admission at 3 p.m. she was comatose, with deep stertorous breathing, and twitching of the face; the pulse was 84 and irregular, the temperature 39.7° C. The pupils were narrow and reactionless. The face was livid, and there was slight œdema of legs; cardiac dulness was not increased, the sounds were clear, and rhonchi were heard over the lungs. Uterine pains were present. The urine was drawn off by catheter at 7.30, and 150 c.c. of dark brown urine obtained; it was acid, sp. gr. 1018, and contained a few casts and leucocytes, but no red cells and no bile. The pulse-rate increased, and, without the occurrence of any fits, death took place at 11.20.

Post-mortem Report.—Unfortunately the *kidneys* were removed for demonstration purposes, and there is no record of their condition.

Liver.—There were irregular hæmorrhages under the serosa, from the size of a lentil to larger confluent plaques. The organ was clay-coloured on section, and showed many punctiform hæmorrhages. Its structure was ill-defined, and the boundaries of the lobules were not easily recognised.

Brain.—On removal of the skull cap there were punctiform hæmorrhages over the posterior part of the right parietal lobe; on section through the brain further scattered punctiform hæmorrhages were seen. In the posterior part of the right corpus striatum there was a hæmorrhage the size of a hazel-nut, which had destroyed the brain substance; the lateral ventricles, especially the right, were distended with blood-stained fluid.

No doubt other cases might have been found by a more exhaustive search, but our own case and the four others we have quoted are sufficient to support our contention that basal hæmorrhages form a definite complication of eclampsia, and are one of the causes of death in this disease. Further, these cases of "apoplexia gravis" ought to be recognised as a definite group of cases in which the eclamptic poison has chiefly affected the cerebral vessels. No doubt many such go unrecognised, for it is only where a post-mortem examination of the brain is made that their recognition is possible. For instance, one of us has recently seen an eclamptic case presenting many points of resemblance to these cases of death from basal hæmorrhage. A young primipara, a few days after labour, had headache and dimness of vision, with slight twitching, but no definite fit, and shortly became comatose. When seen she exhibited the deep coma and inactive pupils, the cyanosis and the tracheal rattling and stertorous respiration gradually becoming of the Cheyne-Stokes type—the very features which characterise the cases under discussion. The absence of a post-mortem examination makes it impossible to speak definitely of the nature of the case, but it strongly suggested the earlier one, on which this paper is based. This also applies to the case brought before the Glasgow Obstetrical Society by Dr. A. J. Wilson (19), under the title "Apoplexy (?) in a young II.-para." The patient, a woman, æt. 22, six months pregnant, went to bed in her usual health, but was observed early in the morning to be unconscious, having vomited dark-coloured fluid like blood; urine was passed involuntarily. There was no œdema or paralysis. The cervix was dilated, and the fœtus extracted. Next day there was some return of consciousness, and twitching of the hands and face were noticed. There was suppression of urine and incontinence of fæces. On the evening of the second day the coma deepened, and later paralysis of the left arm and leg was observed, accompanied by Cheyne-Stokes breathing. The urine had been passed involuntarily up to the time of death, which occurred on the fourth day. No post-mortem examination was permitted, and, unfortunately, also, there was no examination of the urine. These two cases are mentioned (even though the want of an autopsy renders them unavailable for the present purpose) merely to show that the occurrence of apoplexy in the course of eclampsia may be suspected when the case presents some unusual symptoms.

Indeed, in none of the cases under review was cerebral hæmorrhage recognised before death. It may be worth while, therefore, to note the most characteristic features of these cases. For the most part they occurred in young women (the ages being 24, 22, 38, 25, 25), and all in primigravidæ. This, however, but reflects the great preponderance of eclampsia cases among primiparæ, but the occurrence of cerebral hæmorrhage in women of this age points in a very striking way to the effect of the eclamptic toxins on the arterial walls. In our case pregnancy had only advanced as far as the fifth month; in another case to the eighth month; and in the other three to term; in two of the latter the symptoms began when the patient was in labour, and in one within a few hours of the termination of labour.

After some premonitory symptoms in the shape of headache, ocular disturbance, twitching or respiratory difficulty, the serious nature of the case was generally first shown by the onset of coma, which was sometimes, but not always, preceded by a fit. There was no fit in Meyer-Wirz's case or in Esch's; there was a slight fit in Pfannenstiel's, and possibly in our own, and in one only, Maygrier and Chavane's, were there repeated convulsions. Albuminuria was marked in all, and in three cases the urine is described as boiling solid.

The next point is the onset of deep coma, with little in the way of preceding convulsions, and without those occasional movements of the limbs and body which in the ordinary eclamptic comatose patient represent the occurrence of further convulsions. The effect of the damage to the grey matter and afferent and efferent tracts, and the increased intracranial pressure, is shown by the marked respiratory disturbance. The breathing is stertorous, with tracheal rattling, and in the later stages is of the Cheyne-Stokes type. Consequently, cyanosis is a very marked feature in all the cases; in illustration of this, attention may be drawn to the frequency with which oxygen was given and artificial respiration tried, and also to the way in which the patient's appearance at once suggested the advisability of bleeding. The pupils are described as inactive, equal in size, and of various degrees of dilatation. Probably the most striking picture would be provided by a case like our own, where the patient, after showing some of the premonitory symptoms of eclampsia, and with little or nothing in the way of convulsions, suddenly becomes deeply comatose, and has marked respiratory stertor and Cheyne-Stokes breathing.

The post-mortem findings, except for the large cerebral hæmorrhages, are the same as those usually seen in eclampsia. The kidney changes are described as cloudy swelling and granular degeneration of the renal epithelium, in some cases amounting to necrosis. The liver is described as hæmorrhagic and degenerate, and it is interesting to note that irregular red patches as noted in our case were seen also in Pfannenstiel's and in Maygrier and Chavane's case. This, however, we did not think had any part in the pathology of our case.

It will be noted that though in the majority of cases there was hæmorrhage into the pons, we have included any case where there was definite damage to the brain substance by hæmorrhage—in fact, we have excluded only the small meningeal hæmorrhages.

In bringing this case before the Section, and in commenting on it, we may hope that our error in diagnosis and our experience may be of assistance to the Fellows, and also that, by drawing attention to the occurrence of apoplexy in eclampsia, we may have helped to show that this is but another expression of the damage effected by the poison which is the cause of this disease.

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(1) Clarence Webster. "A Text-book of Obstetrics," W. B. Saunders, 1903, p. 372.

(2) Pratt, Wm. "Convulsions with Something like Missed Abortion," *Lancet*, 1881, ii., p. 498. (A very interesting account of recovery from eclamptic convulsions in a patient four months pregnant. The patient recovered, but the ovum was not expelled for another two months, when a dead fœtus of about four months development was passed.)

(3) Schmorl. ("Zur Lehre von der Eklampsie," *Archiv. für Gynäk*, 1902, lxv., p. 519.

(4) Schmorl. *Loc. cit.*, p. 506.

(5) Wendt. *Archiv f. Gynäk.*, 1898, lvi., p. 104, and Schmorl's paper above, p. 506.

(6) Labhart. *Zeitschr. f. Geburts. und Gynäk.*, 1905, liv., p. 264.

(7) Meyer-Wirz. *Archiv. f. Gynäk.*, 1904, lxxi., p. 24.

(8) Esch. "Eklampsie ohne Anfalle." *Zentralb. f. Gynäk.*, 1006, xxx., p. 295.

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(12) Schrieber. *Archiv. f. Gynäk.*, 1896, li., p. 335.

(13) Glockner. *Archiv. f. Gynäk.*, 1901, lxiii., p. 166.

(14) Schmorl. *Loc. cit.*, p. 516, and *Zentralb. f. Gynäk.*. 1901, p. 700.

(15) Pfannenstiel. "Apoplexie als tödlicher Ausgang von Eclampsie," *Zentralb. f. Gynäk.*, 1897, p. 601.

(16) Meyer-Wirz. *Loc. cit.*, p. 24.

(17) Maygrier et Chavane. "Eclampsie—Mort par hémorrhage bulbaire," *Bull. de la Soc. d'obstét. de Paris*, 1899, ii., p. 410.

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(19) Wilson. *Journ. of Obstet. and Gyn. of Brit. Emp.*, 1906, x., p. 80.

THE TREATMENT OF LATERAL SCLEROSIS.

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I am desirous of calling attention to a case which presents many points of interest. The man is 30 years of age, and was originally in the Royal Navy. Subsequently he specialised, and became a deep-sea diver. He is not suffering from caisson disease, and his occupation has nothing to do with the symptoms of which he now complains. He was admitted on April 8th, 1907, suffering from lateral, or spastic, spinal paralysis, the exact form being that technically known as Erb No. 2. I need hardly remind you that William Erb is Professor of Clinical Medicine at Heidelberg, and that he was a pupil of Nicolaus Frederick, whose name was conferred on a particular form of hereditary ataxy. Erb first described spastic spinal paralysis, or primary spastic paraplegia, in 1875. Only three symptoms were enumerated by him:—

1. A certain amount of feebleness of the lower extremities.
2. More or less muscular rigidity in the same region.
3. A marked increase of tendon reflexes.

No other symptoms were present, no anæsthesia or disturbance of sensation, no involvement of the bladder or of the functions of the organs of generation, no loss of nutrition of the structures of the muscles of the skin, and no anomaly of the brain, cerebral nerves or organs of special sense.

The three signs stood alone and by themselves. To this symptom-triad was subsequently added Babinski reflex.

Erb, on the basis of clinical and anatomical facts, and reasoning from analogy, arrived at the conclusion that the pathological condition underlying this syndrome, or collection of symptoms, was a chronic, slowly-ascending sclerosis of the lateral columns of the cord. Charcot a year or two later published a series of similar cases and arrived at a similar conclusion. Up to that time there was no post-mortem confirmation of the correctness of the pathological diagnosis. This came later, but not until after an interval of nine years, when Minkowski, in 1884, published a case in which there was the pure picture of spastic spinal paralysis with, as shown at the autopsy, sclerosis of the crossed pyramidal tracts. In rapid succession, Von Strümpell in Germany, Déjerine in Paris, and many other observers, published cases with autopsies, and the disease we now call "Erb No. 1." was placed on a firm pathological basis.

Erb, however, not content to rest on his laurels, in 1892 differentiated a second clinical form of disease, which, although presenting a strong resemblance to spastic spinal paralysis, differed from it in the fact that it was post- or para-syphilitic, and that there was always some disturbance of bladder function with a slight subjective and objective disturbance of sensation. This disease Erb described as "syphilitic spinal paralysis," and we usually speak of it as "Erb No. 2."

Our patient is suffering from this form of the disease. He gets tired on the slightest exertion, and his gait is distinctly spastic in character, as you observe when he attempts to walk the length of the ward. His reflexes are much exaggerated, and Babinski is distinctly in evidence. The difficulty in walking, he tells us, was first noticed about six months ago. Six weeks before admission there was dragging of both feet, with a constant tendency to catch the toes on the ground. About this time he noticed that the front part of the soles of his boots wore out much more quickly than the heels. You will observe that there is nothing indicative of involvement of the posterior columns, and that the pupils react both to light and accommodation. He says that for some months he has had incontinence of urine, with dribbling, especially at night. The urine, which has frequently been examined, is of sp. gr. 1012-16, acid, and contains neither sugar nor albumin. Sometimes, however, a little pus has been detected. There is no anæsthesia, and there has never been incontinence of fæces. With regard to a history of syphilis there is some doubt; at all events, there is no conclusive evidence. He has not always been a temperate man, and admits that for some years he took many glasses of brandy and water a day. In spite of the absence of any history of direct infection, there is very little doubt that the disease is of syphilitic origin, but whether it is a specific infiltration, an infection of the blood-vessels, or a degenerative change, it is difficult to say.

On admission, it was decided to give him the benefit of a course of antisyphilitic treatment. As a rule we give iodide of potassium in fairly large doses three times a day, and order calomel ointment to be rubbed into the abdomen night and morning. This answers well, but as it is not desirable to fall into routine methods, we decided in this case to give hypodermic injections of calomel. The dose selected was half a grain dissolved in vasinol, a 10 per cent. solution. This was injected with the usual antiseptic precautions deep into the muscles of the gluteal region in series of three spread over a week, and with weekly intervals. After the second week the patient was slightly salivated, but this was easily controlled. He had fifteen injections in all, and there was some improvement, especially with regard to spasticity.

From time to time we have used, in various forms of fibrous contraction thiosinamin, the allyl-sulpho-carbamide, prepared by warming oil of mustard with alcoholic solution of ammonia. The surgeons have made observations with it in Dupuytren's contraction, and have injected it hypodermically for removal of scar tissue with fairly satisfactory results. On the medical side it has been tried in cases of pyloric obstruction and in locomotor ataxy. It seemed to be indicated in our patient, for the sclerosis was probably the result of the deposit of fibrous tissue. Just as we were considering the matter our attention was called to a preparation known as tiodine, or thiosinamin-ethyl-iodide. It is an iodo compound, having a definite chemical composition, and is a combination of thiosinamin and iodine. The dose for hypodermic injection is 1 c.c., containing 3½ grains of the drug.

The first injection was given on June 25th, and was followed by a reaction. The febrile disturbance subsided on the fifth day by lysis. There was nothing pointing to pneumonia, pleuritic effusion, or ulcerative endocarditis.

In August the patient went home for a holiday, so that treatment had to be suspended. In October I gave the drug hypodermically to a man suffering from locomotor ataxy. It produced no reaction, and after six injections he left to return to work. The duration of the treatment was too short to give any definite result.

There are very few medical agents which have the property of raising the temperature. Thyroid will send it up to 101 or 102 degrees, especially in cases of myxœdema or cretinism. Strychnine may have some influence in this direction, but it is certainly not very marked. The only drug I know which really sends up the temperature is B.-tetrahydronaphthamine, and that is in rabbits and dogs. What may be its action on man I do not know. In rabbits the rectal temperature rapidly rises from 4.5 deg. to 5.5 deg. C. In these experiments the respiration was quickened, being about doubled in dogs and rabbits, and in cats reaching a rapidity of about ten times the usual rate. The heart beats much more forcibly, and the effect is purely cardiac and not vaso-motor. The drug is distinctly active, and doses of 0.01 to 0.05 exert a stimulant action on the heart, on respiration, and on metabolism.

On October 2nd our original patient returned to the Hospital, and he had not improved, in spite of the fact that his holiday had been spent in his native town, and under the most favourable hygienic conditions. His walking powers were very limited, and he was unable to stand without support. Babinski's sign was more pronounced, and ankle clonus was marked. The urinary trouble had increased, and there was such a degree of incontinence that the porringer had to be left in his bed. The urine had a sp. gr. 1015 and contained some albumin. He complained of spasmodic pains in the legs, for which he was give hypodermic injections, first of stovain and then of novocain, without benefit.

Finding that he was steadily getting worse, and that there was but little hope of improvement, I determined to continue the tiodine. After a few preliminary injections of stovain to eliminate the effects of suggestion, we gave two injections at intervals of three days of ten minims of tiodine. These gave rise to no elevation of temperature. On October 25th, at noon, the temperature then being normal, the patient was given fifteen minims subcutaneously. At 4 and 8 p.m. there was no rise in the temperature, but at midnight it was 100.2 deg., falling to 96.6 deg. at 4 a.m. At noon on the 28th the same quantity was administered, and at midnight the temperature was 100.2 deg., falling to 98 deg. at 8 a.m. On the 1st, 8th, and 10th of November the same dose was given, and was not followed by any rise of temperature. From November 14th until December 24th a dose of seventeen minims was given every alternate day.

The improvement in the condition of the patient was very marked, and this was especially noticeable with respect to locomotion. In October, on readmission, he was unable to stand without support, but by the middle of December he could walk with the aid of a stick. He could ascend a long flight of stairs to the convalescent room at the top of the hospital without assistance. In October he was disturbed twelve to fifteen times every night to pass water, but in December the nightly call was once or twice, and sometimes not at all. Another point which especially attracted his attention was that he could freely work the toes of his right foot, which before had been impossible. There is no alteration in the condition of his reflexes.

He has had twenty-six injections since October 25th. He has continued steadily to improve, and in a few days he is leaving us to take up active physical work on a poultry farm. The drug is undoubtedly useful, but its administration must be attended with caution.

DEDUCTIONS FROM ONE HUNDRED CONSECUTIVE OPERATIONS FOR APPENDICITIS.

BY J. W. DOWDEN, F.R.C.S.,
Surgeon, Edinburgh Royal Infirmary.

THE following remarks bear chiefly on acute appendicitis, and though illustrative cases are incidentally quoted, the author purposely abstained from entering upon details of operative procedure. Among the causes of appendicitis he could not but think that we must place an unhealthy condition of the mouth. He had been struck by the large proportion of cases suffering from sepsis of the buccal cavity, carious teeth, etc. Clinically he divided cases into two varieties—acute fulminant and mild. The symptoms were well known and usually distinctive: what were known as the "cardinal symptoms" scarcely required mention. In regard to the question of diagnosis, all cases of acute or subacute inflammation should be examined locally, as well as by the rectum. In some attacks of appendicitis, or when complications are present, any abdominal catastrophe may be simulated. He insisted strongly that no amount of skill or experience enabled one to diagnose the exact morbid condition of the appendix or the degree of complication in an acute attack; it was equally impossible to foretell what was going to occur; the symptoms only pointed to what had actually taken place, not to future complications. As regards the sex in his series, 66 were males, 34 females. The acute cases showed 52 males and 30 females, with a mortality of 16; the interval cases, that is, those who had survived an acute attack, gave 14 males and 4 females, with no deaths. Second attacks had occurred in 37 of all his patients. Of the 82 acute cases, the age distribution was as follows: Under 16, 16, with 6 deaths; 16 to 30, 50 cases, with 9 deaths; over 30, 16, with 1 death. Of these, 19 had had previous attacks, and 3 died. Suppuration was present in 58, and 14 died. Coming to the date of operation, in relation to the death rate, his figures were as follows: Operation on first day, 11, with no deaths; on second day, 16, with 2 deaths; on third day, 18, with 7 deaths; on fourth day, 10, with 1 death; on fifth day, 5, with 2 deaths; on sixth day, 1, with 1 death; on seventh day, 7, with 2 deaths; after seven days, 14, with 1 death. He regarded the prognosis in acute appendicitis always serious, because it was absolutely impossible to foretell what course the disease would take. It was essentially a surgical affection, and the logical treatment was removal of the appendix as early as possible. This was really the chief deduction made—that as soon as appendicitis was diagnosed the appendix should immediately be removed.

THE WOMAN OF THE FUTURE, FROM A GYNÆCOLOGIST'S POINT OF VIEW (*a*).

BY ED. OCTAVIUS CROFT, M.D.,
President of the North of England Obstetrical and Gynæcological Society; Senor Surgeon to the Leeds Hospital for Women and Children.

AT the commencement of his address the author referred to the frequency with which members of the profession looked back at the work of their predecessors, and in doing so were apt to congratulate themselves on the brilliant achievements of the present day, without considering whether the progress of our knowledge was having a clear run, and whether it was being diverted into side issues or hindered by developments which might be of immense immediate value, but which might obscure the main issue. He suggested picturing in mind a typical healthy woman in the more or less distant future, and estimating the probability of her enjoying an immunity from many of the physical and mental disaffections as known to the present-day gynæcologist. She would require the command of a much higher knowledge of prophylaxis and of the conditions of normal health, and such knowledge would have to become an integral part of her own mental equipment and the laws of health to be obeyed in an almost automatic manner. The indications of such a development were referred to and exemplified. Rapid advances were liable to be associated with the development of exuberances of rapid growth and feeble vitality. These exuberances were temporary hindrance, and were more liable to form in the process of mental than physical development. They chiefly appeared in the form of eccentricities of various kinds. The general advance of bodily soundness in women was thought to be checked rather than aided by the exuberance of many quack proceedings in connection with physical culture which existed to-day.

The various classes of gynæcological disease were reviewed in the light of their ultimate avoidance. The large class of inflammatory affections which were mainly associated with microbial infection of varying degrees were to be looked upon as avoidable, as also were manv of the disorders of pregnancy and abnormalities of labour. The eradication of venereal infectious diseases was not being dealt with at all at the present day; it was to be hoped that a more common-sense view would be taken of this matter in a more enlightened future. The prevention of puerperal infection seemed a difficult lesson to learn, in spite of its simplicity. It was suggested that the ultimate solution of the question would be in the hands of the suffering womenkind. When they themselves fully realised the position they would demand the remedy, and the demand would be more quickly met.

With regard to the possibility of dealing with the apparently hopeless conditions of maldevelopment, the suggestion of Dr. Balantyne and the subject of eugenesis were referred to. There is no clue, he contended, to the prophylaxis of the new growths of the female organs, such as cystic disease, fibroids, and cancer. Referring to fibroids, the brilliant results of a curative kind obtained by operation during recent years, while of enormous immediate value, has practically paralysed all research into the ætiology and nature of these growths. More work is being done regarding cancer, but the high degree of technical skill required of the operator and the pathologist has rather tended to create a chasm between the two which is difficult to bridge. Both are liable to be lacking in the opportunity for the observation of the living habits and phenomena of the disease as it progresses in the patient. It would be interesting to revisit the earth at some future time to ascertain the extent to which the future woman had succeeded in avoiding the ills to which she is now liable.

(*a*) Abstract of Presidential Address delivered before the North of England Obstetrical and Gynæcological Society, January 17, 1908.

THE REV. C. H. YATMAN, of New York, who is staying at the Langham Hotel, has come to London as the representative of Mr. Nathan Straus, of New York, to look over the ground with a view to extending Mr. Straus' pasterised milk campaign to London. Mr. Straus has been giving away and selling at cost, in New York, millions of bottles of pasteurised milk for feeding infants, and the great reduction in infantile mortality in that city is attributed by the public health authorities almost solely to his efforts.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

CASE OF ENLARGED GALL-BLADDER.—**MR. H. BETHAM ROBINSON** operated on a man, æt. 59, who had been admitted with the following history:—For eight months there had been tenderness in the right hypochondriac region, and there was also some pain on bending. He had had lumbago at times, but he was a rheumatic subject. He had no digestive troubles, but had more or less constipation. He had no special symptoms referable to the liver, and no loss of weight. On examination, the abdomen was normal, except for a very definite oval lump of a sausage shape extending down from the right costal margin under the right rectus as low as one inch below the umbilicus; its lower edge was distinctly rounded; it moved downwards on inspiration; there was some impaired resonance over it which merged into the normal liver dulness. Nothing else abnormal was to be found on general examination; the temperature and urine were normal. It was obvious, Mr. Robinson said, from the examination that the case was one of distended gall-bladder, and the absence of any jaundice, white stools, dark urine, or enlarged liver made him confident that the obstruction to the gall-bladder was in the region of the cystic duct. At the operation the liver cushion was used. A vertical incision was made in the line of the outer third of the rectus, splitting the muscle. A very distended gall-bladder was brought out of the wound adherent to a thinned-out portion of a small liver; the gall-bladder had a pale, translucent appearance, and its body was about six inches long and two inches in diameter. After packing off the abdomen with gauze, the fundus of the gall-bladder was tapped and a clear fluid, like dilute glycerine, drawn off. An incision was now made into the gall-bladder, and nine stones, facetted, were removed. On examining the neck of the gall-bladder, another hard mass was felt lodged in the beginning of the duct; this lump could not be displaced backwards in the gall-bladder, so an incision was made down on it through the walls of the duct, and two stones, facetted like the previous ones, were removed. A probe passed through this opening down the cystic duct and down the common duct gave no evidence of there being other stones present. The wound in the duct was stitched up with interrupted fine silk sutures, the mucous coat being avoided. A rubber drain was fixed in the fundus of the gall-bladder, the rest of the incision being stitched up with some fine silk. The fundus of the gall-bladder at the sides of the rubber drain was fixed to the peritoneum and posterior sheath of the rectus. A "cigarette" drain was passed down to the region of the neck of the gall-bladder, coming out of the abdominal wall just below the attached fundus. The abdominal wound was then closed in layers. Mr. Robinson remarked that the operation had confirmed the diagnosis of distension of the gall-bladder from obstruction about the cystic duct, this obstruction proving to be impacted calculi, causing gradual backward distension of the gall-bladder by its own mucous secretion. The condition of the gall-bladder was that designated hydrops or mucocele. He pointed out that impacted calculi or new growth were the most likely causes of the enlargement, but the absence of any marked wasting and cachexia or general symptoms seemed to put the idea of malignant disease out of court. As for the treatment adopted it was seen, he said, that the gall-bladder was drained and afterwards fixed to the abdominal wall; it might be urged that after removing the obstruction and suturing up the wounds in the neck of the gall-bladder and its fundus the viscus could have been dropped back into the abdomen; this, however, was a risky procedure as subsequent distension of the gall-bladder might be followed by extravasation. On the other hand draining the gall-bladder was perfectly safe and had distinct advantages; leakage was unlikely to occur from want of tension, the character of the fluid entering the gall-bladder is satisfactorily determined, and the drainage itself lessens or prevents any subsequent infection of the walls of the gall-bladder. It might be urged by some, he suggested, that this was just the case in which a cholecystectomy might have been done at this time. The propriety of doing this, however, depends very much on the surgeon's individual opinion, and there were advantages in determining what is the condition of affairs after the removal of the obstruction, in other words it is a perfectly safe procedure even if there should be an overlooked stone in the common duct low down, whereas if such should be the case considerable risk may be run after removing the gall-bladder.

The next day the "cigarette" drain was removed, and bile was coming from the gall-bladder, showing the restored patency of the cystic duct. There was a slight rise of temperature to 101.2 on the second night after the operation, but this disappeared in the morning, and was the only occasion on which the temperature was above normal. The stitches from the abdominal wound were removed on the seventh day; the tube in the gall-bladder came out on the tenth day, and was not replaced; the escaping bile from the fistula rapidly lessened, and all drainage had ceased by the fourteenth day.

The fluid from the gall-bladder at the operation proved to be bacteriologically sterile, and no cells were seen. The facetted stones were highly polished, of lightish brown colour, and in the main were composed of cholesterine.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, JANUARY 17TH, 1908.

MR. SETON PRINGLE in the Chair.

GRAFTING OF FIBULA TO TIBIA.

MR. R. ATKINSON STONEY read the notes of a case in which he had grafted the fibula to the tibia. Patient, a boy, æt. 7, was admitted to the Royal City of Dublin Hospital, November 26th, 1905, suffering from acute osteomyelitis of tibia; he had been ill for ten days, and a huge abscess had formed involving the whole of leg from knee to ankle. The abscess was opened immediately, and the diaphysis of the tibia was found completely stripped of its periosteum. The necrosed tibia was removed by two operations, in January and April. By April, 1906, the sinuses had closed, and an involucrum had formed in the lower and upper parts of the leg, but there was a gap of about one and a half inches between the two ends, due to destruction of the periosteum, as the result of the virulence of the original infection. An operation was performed in which the neck of the fibula was cut across and the upper end of the lower fragment implanted into the upper end of the involucrum of the tibia. Firm union has now occurred, and the boy is able to run about without the aid of a stick, though there is considerable shortening, as the result of over a year's loss of growth while the illness lasted, and the ends of the tibia were not in contact. The operation is a modification of one described by Hahn in 1885, and was suggested by a case reported by Professor E. E. Goldmann, of Freiburg, in the *Lancet* of January 13th, 1906.

The **CHAIRMAN** said the case was, so far as he knew, the first of the kind reported in Ireland, or at any rate shown at the Academy. He believed it was the only line of treatment which was likely in such a case to leave a useful limb.

Mr. **Taylor** congratulated Mr. Stoney on the success of his operative procedure.

Dr. **Stokes** asked if there was any tendency of the ankle to turn outwards.

Mr. **Stoney**, in reply, said there was no tendency of the ankle to turn outwards. If anything, there might be a tendency to turn inwards, but such was hardly likely in the present case.

POST-ANÆSTHETIC VOMITING.

Dr. **Gunn** read a paper on the above subject. He first drew attention to the fact that, as the anæsthetists had not the after-treatment of operative cases, they only to a slight extent realised what a troublesome complaint post-operative vomiting might be. He believed it was the duty of the surgeons to use every means in their power to prevent this vomiting. Dr. Gunn himself had been using a method, suggested by MacArthur, of giving the patient frequent drinks of pure cold water right up to the administration of the anæsthetic, and this method had been entirely successful in nine cases, partially successful in 19 cases, and had had no result in 12 cases, out of the 40 patients who had been treated in this way.

The **Chairman** said he had, some years ago, carried out a series of observations on the action of the kidneys during anæsthesia. He found that the amount of nitrogenous material and water excreted during the anæsthesia was very small; but as soon as the patient came out of the anæsthetic the kidneys began to act, and there was a hyper-excretion of water and an increased excretion of nitrogenous material for some hours. It was possible that in this lay the explanation of the pain across the loin. He had noticed when administering anæsthetics that the less the patient was cyanosed during the administration the less vomiting there was afterwards, so that it was important to let the patient breathe a certain amount of fresh air.

Dr. **Kirkpatrick** said anæsthetists had not seen enough of their patient, either before or after the administration, to have had the importance of the question of post-anæsthetic vomiting impressed upon them. For some years he had considered the question, and disagreed with Mr. Gunn on some points. He (Dr. Kirkpatrick) thought the preparation of a patient had a good deal to say to the condition of the patient afterwards, provided the preparation was satisfactory. He did not look on abstinence from food as of such importance as thorough purgation some time before the anæsthetic was administered. Various writers pointed out that the patients who usually gave most trouble with post-operative vomiting were those who suffered from more or less chronic constipation. He did not agree that the nature of the drug used had no very great effect on the post-operative condition. Occasionally after chloroform anæsthesia vomiting became so serious as sometimes to threaten the patient's life; such was exceedingly rare after ether. He was inclined to believe that the *method* of administering the anæsthetic—the nature of the anæsthesia obtained—was of far more importance than any other factor. The Chairman had pointed out the importance of avoiding cyanosis, and of giving fresh air; when patients were treated by that method they soon recovered, and vomiting was exceedingly uncommon. He would add that anæsthetists had been in the habit of maintaining a depth of anæsthesia which was quite unnecessary in most operations. He had carried out experiments, as the Chairman had, which showed a great diminution in the function of the kidneys, and he could not but think that in a patient who was profoundly anæsthetised there must result a very profound toxæmia. The activity of the renal epithelium in certain animals was not at all as much diminished as it was in the human being during anæsthesia, and it was very probable that that inactivity was associated with a fall in blood pressure.

Mr. W. I. **de Courcy Wheeler** said he had tried the open method of administering ether, and had found it very simple and the anæsthesia perfect. The patients never became cyanosed, but he had not had enough experience of the method to say whether the vomiting was less frequent. It was particularly suitable for old or fragile persons. Alcoholics, who were difficult to get under ether, vomited less than other patients; if the anæsthesia was begun with choloroform and continued with ether, the vomiting was far worse. Local anæsthesia was, he thought, the ideal method. It was perfectly safe to give if the proper drug was used.

Dr. **Pugin Meldon** said he found it useful to keep patients under the anæsthetic until they were back in bed. In that way the vomiting was not started; they went off into a sleep, and got rid of a good deal of the anæsthetic.

Sir **Thomas Myles** thought that very little was known as to the cause of post-anæsthetic vomiting. He had known a lady, prior to the introduction of aseptic technique, to vomit incessantly for twelve days. Every drug, except one, that they could think of, was administered; finally she was given half a grain of morphia hypodermically, and the vomiting ceased. He himself had been under every anæsthetic known. He had always insisted on having a cup of tea before the operation, and he was well purged out. He had never vomited or had a fit of sickness. He was inclined to think that the sickness was due to something inherent in the patient. In the majority of cases he thought they would be found to have some kidney trouble. He thought the experience from which Mr. Gunn made his deductions was too limited. If a careful analysis of the 20,000 cases administered annually in Dublin were made, as regards the urine and the vomiting, then they might be justified in making deductions; but merely to say that in 20 per cent. of cases albumen was present was not sufficient evidence on which to base a generalisation. If a patient was kept on a table in a cold room they could not help giving them a renal chill.

Mr. **Taylor** felt that cyanosis had something to do with the vomiting. In most cases of abdominal sections which he had done it had been his habit to give morphia either immediately before the anæsthetic or before leaving the table; less anæsthetic was then required, and there was less vomiting. He thought the vomiting was less the result of swallowing the anæsthetic than of nervousness.

EXOPHTHALMIC GOITRE.

Sir **Thomas Myles** read a short paper on a case of exophthalmic goître which he believes to have been cured by a diet of milk obtained from a thyroidectomised goat. The patient was a married lady, 25 years old, and the symptoms had been developing for more than a year. All the well-marked features of the disease were present, and there had been a progressive loss of strength and colour. The goats were operated on by Professor Mettam, of the Veterinary College, whose co-operation was gratefully acknowledged by the speaker, and when, two days later, the little wound in the neck had healed, the goats were sent to the patient, who resided in the country, and the treatment was begun and steadily persisted in. At the end of a month the improvement was very marked, and at the present moment the enlargement of the thyroid is barely perceptible and the exophthalmos has disappeared. For the last few months the milk diet has been supplemented by the use of Merck's tabloids, and in the administration of small doses of iron and arsenic. Sir T. Myles in bringing the case under the notice of the section did so with the hope of inducing other practitioners to give the method, which is simple but not costly, a fair trial.

Mr. **Taylor** said the method had been tried on the Continent some years ago, and a powder made from the milk of thyroidectomised goats could be bought, but the professors on the Continent had not spoken much in its favour.

Mr. W. I. **de Courcy Wheeler** said the main danger was that, even if the symptoms apparently abated, the patient might at any time drop dead. He had seen astonishingly good results of operative treatment abroad, but he thought the operation must be an extremely difficult and anxious one to perform.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, JANUARY 15TH.

The President, Dr. JAMES RITCHIE, in the Chair.

MR. F. M. CAIRD showed a specimen of carcinoma of the stomach removed by Billroth's second method.

Dr. R. A. **FLEMING** showed a man suffering from defect of articulation, spastic diplegia, and marked intention tremor, all dating from infancy. As regards the nature of the lesion, he had no doubt that it was cortical. There was no history of birth injury, nor any mental defect; the diagnosis lay between a meningeal hæmorrhage and a meningo-encephalitis. There was no family history of any similar disease. The father of the patient had a stammer resembling that of the case in question.

Mr. J. W. **DOWDEN** showed a patient after operation for perforated gastric ulcer. The perforation had been found close to the duodenum, on the lesser curvature, and he had removed the whole ulcer by a lozenge-shaped incision in parallel with the long axis of the lumen of the stomach and intestine. The duodenal sphincter had been cut into by the incision, and subsequently a pyloroplasty had been performed so as to obviate the possibility of any stricture. He had performed a similar pyloroplasty in perforated gastric ulcer in this situation on three other cases, with favourable results.

Mr. F. M. **CAIRD** showed a patient who had been operated on for cancer of the tongue. There was no glandular involvement. The operation had been done under local anæsthesia, cocaine being used. The right half of the tongue was excised. It was noticeable that a few hours after the operation there was very little interference with articulation. Healing was very rapid, as was usual in cases of excision of the tongue under local anæsthesia. Ten days later, as a precautionary measure, all the glands on the right side of the neck were dissected out. Subsequent microscopic examination had failed to reveal any carcinoma. The operation had been performed several years ago, and now the patient had returned because of a lump under the jaw. This was, Mr. Caird thought, almost certainly a cirrhotic condition of the submaxillary gland, and not malignant. He had observed such a state of matters in several previous cases. The gland could not, however, be distinguished from a malignant growth by the touch; the fact that the size of the tumour varied was in favour of the theory of cirrhosis. He proposed to remove the gland. (2) A patient with recurrence four years after enterectomy for malignant stricture of the colon. At the original operation, the patient at the time suffering from acute obstruction, a simple artificial anus had been made. A few days later the tumour was removed. There had been no recurrence until quite lately, when the patient had become jaundiced and lost weight. Tumours could now be felt near the original wound and in the region of the liver. The point which the case illustrated was that when a malignant tumour of the alimentary tract was thoroughly removed, local recurrence was less to be feared than a diffusion of the cancer by way of the lymphatics.

Dr. EDWIN **BRAMWELL** showed a boy who, after an acute onset, with some vomiting, had inability to move the head. On further examination the following symptoms were found. The movement of the head in all directions was feeble. The sterno-mastoids were weak, and gave slight reaction of degeneration. The right side of the tongue was atrophied, and the right pupil was contracted, and the right palpebral fissure narrower than the left. At first the case was thought possibly to be one of caries of the cervical vertebræ, but this had now been discounted, as the X-ray examination and Calmette's reaction were negative. The lesion appeared to be restricted to the sympathetic, and the nuclei of the spinal accessory and right hypoglossal. The diagnosis was polio-encephalo-myelitis.

Mr. ALEXIS **THOMSON** showed (1) a case after osteoplastic amputation through the middle of the leg, in which a portion of the tibia was retained in the anterior flap and brought into contact with the sawn section. Though the amputation was a recent one, the stump was so firm that it could be used as a bearing point for an artificial limb. (2) A boy of 17, with deformity of the lower limbs, consisting of contracture at the knee, and crossing of the legs, from spastic paralysis, following Pott's disease, in whom an attempt had been made to restore the weight-bearing capacity of the limb by osteotomy of the femur and transplantation of the tendons of the semi-membranosus and biceps into the patella. As a result the limb was now straight. It was proposed to perform arthrodesis of the ankle, and subsequently to treat the other leg in the same fashion.

Dr. CHALMERS **WATSON** showed two cases of chronic pancreatitis, one illustrating the form associated with, the other without, calculus in the pancreatic duct. It was a feature of the calculus cases that recurrent ague-like attacks took place at more or less regular intervals. Both patients gave Cammidge's pancreatic reaction, which Dr. Watson also demonstrated. It depends on the presence in the urine of a substance which on hydrolysis yields a pentose, and can be detected by the phenyl-hydrazin test. The different stages of the reaction were illustrated, and photographs showing the characteristic ozazone crystals, as compared with those of phenyl-glucosazone, were thrown on the screen.

Mr. W. J. **STUART** demonstrated the pneumatic sigmoidoscope, which had these advantages over the ordinary instrument:—It is not necessary to place the patient in the knee-elbow position; the speculum is introduced by the aid of sight, hence there is no risk of damaging an ulcer, etc., as when touch alone is relied on for a guide; the interior is always properly illuminated, and appearances can readily be demonstrated to students. The sigmoidoscope consists of a tube graduated in centimetres. It is provided with an obturator for use in passing through the external and internal sphincters, but which is then removed. A small electric lamp is then inserted and thereafter an air-tight window is screwed on. Then, by means of a small bellows, the air is pumped into the sigmoidscope, so as to distend the bowel in front of it, and as this is done it is gently pushed further in. The air prevents its edge from coming into contact with, and damaging the wall of, the gut. When an ulcer or tumour is detected, it can be allowed to fall against the orifice of the sigmoidoscope by letting the air escape; it is then an easy matter to remove a portion for examination by the aid of a special pair of forceps.

Mr. J. W. **DOWDEN** read a paper entitled

DEDUCTIONS FROM 100 CONSECUTIVE OPERATIONS FOR APPENDICITIS,

which will be found in abstract on page 122.

The paper gave rise to a full discussion centreing entirely round the question of when cases should be operated upon.

Mr. **COTTERILL** said he supposed that everyone was agreed that when one attack of appendicitis had occurred the appendix ought to be removed. The "interval cases," therefore, called for no special remark. The crux of the whole question hung round the acute cases. He did not quite agree that one could never foretell what was going to happen; he thought that careful, frequent observation settled one main point—namely, whether the patient was improving or getting worse. It was perfectly true that if one operated, say, within 24 hours, the risk was small. It was very much greater, however, from the second or third up to the tenth day. His experience, therefore, was that, provided the symptoms were subsiding, it was better to postpone operation until the acute attack had subsided. He made the reservation, however, that if the case was in the country, and not within easy reach, it ought to be operated on at once, to avoid the risks of delay.

Mr. **MCGILLIVRAY** agreed generally with Mr. Cotterill's opinion, and thought that it was advisable to postpone operation until the acute stage was over, provided that the patient's symptoms were abating. With regard to the propriety of insisting on the removal of the appendix after a single attack of appendicitis, he was not prepared to go so far as the previous speakers. In cases where, after a mild attack, all the symptoms subsided, and in a fortnight or three weeks there was not the slightest trace of pain or tenderness about the abdomen, he had never felt justified in urging the patient very strongly that he must undergo an operation.

Dr. **Affleck**, speaking from the physician's standpoint, strongly dissented from the opinion that, once an attack of appendicitis had occurred, the appendix never became normal again. He was convinced that in many cases Nature worked a cure. He was in no way against operation, and had derived great help in treating the disease from his surgical colleagues, but he was strongly opposed to laying down any such hard and fast rule as that every case of appendicitis required immediate treatment by operation. In this connection he alluded to the difficulties which often arose in diagnosis. Sometimes it was extremely hard to say whether or not a patient was actually suffering from appendicitis. His position was that, without unduly deprecating surgical intervention, it was most important to individualise, and to judge every case on its own merits.

Mr. **Caird** said that the first point he might allude to was the fact that most of the surgeons present could bring forward long series of operations for appendicitis; yet it did not seem so very many years since he had shown what was, he believed, the first appendix demonstrated to the Society as having been removed by operation. He wished to discuss the question of the mortality in the two sets of cases—acute and interval cases. He had recently been looking over his results, and found that his last 170 interval cases had included no deaths. Looking at statistics over all, the mortality in this class of case worked out at a fraction of 1 per cent., and probably that death-rate was unavoidable. They had to remember that in these cases they were operating on an already infected region, and that every now and then, despite all these cases, bad results would be got. He instanced a case of interval operation to illustrate this point. The patient three years before had had an acute attack of appendicitis treated in the country by the incision and drainage of a large abscess. A ventral hernia had ensued, and Mr. Caird had had to operate for the relief of this. At the operation the appendix was found quite free from adhesion, and lying free in the peritoneal cavity. The only sign of old disease was a little exudate lying on its peritoneal aspect near the root. This was carefully removed, and on inoculation into culture tubes gave a growth of b. coli and cocci. Now here we had, as the result of old appendicitis, an infective focus lying inside the peritoneal cavity. He could only suppose that the reason it did no harm was because the peritoneum had such resisting power, but that such a state of matters existed showed that every now and then the interval operation was likely to be attended with serious results. Turning to his operations in acute cases, ever since Beesly's paper on "Delayed Chloroform Poisoning" had appeared, he had habitually substituted ether as the anæsthetic; he was bound to say that his mortality was just the same as before. He could look back, however, on two or three early cases in which he believed now that death had been due to delayed chlorform poisoning. Mr. Stiles was less pessimistic than Mr. Dowden as to the possibility of forecasting the course of a case of acute appendicitis. He thought one could always recognise the fulminant type, and if this were seen within 48 hours he always advised operation at once. Indeed, he thought that when one saw such a case at night it should never be postponed until next day, but sent off to a nursing home and operated on straightway. The difficulty, of course, was in patients seen after the second day. Here he thought each man's individual experience must be the best guide. If the surgeon was in doubt he ought to operate. It should also be remembered that if one delayed operation in an acute case it might be six or eight weeks before the patient was fit for the interval operation, and then the removal of the appendix added several weeks to his convalescence. On the other hand, early operation meant that the patient was well in two or three weeks. He thought that as time went on the mortality of operations during the acute stage would fall. When appendicectomy was first practised, surgeons, on the whole, were surprised if patients recovered; now they were surprised if patients died. He thought the diminished mortality he now had was due to four things:—(1) To the fact that he had given up disturbing peritoneal adhesions, and did not attempt thoroughly to cleanse the peritoneum; (2) to using free drainage; (3) to sitting the patient up after operation so as to favour drainage into the pouch of Douglas; and (4) to the use of rectal salines, which he thought were better than intravenous injections. He also believed that the substitution of ether for chloroform in operations on all infective abdominal conditions had lowered the mortality, particularly in children. Another point he wished to refer to was the presence of fine crepitation due to minute bubbles of gas under the skin in cases of deep-seated abscess. This had sometimes helped him to recognise a deeply-seated retro-cæcal abscess.

Dr. **McAllum**, speaking as an anæsthetist, urged that surgeons should give ether a fair trial in septic abdominal operations. He was convinced that by doing so they would lessen the number of cases of post-anæsthetic acetonuria.

Dr. W. T. **Ritchie** said that he had seen several cases said to be of delayed chloroform poisoning which had proved to be septicæmia.

Dr. **Gulland** thought it was out of the question to assert that every patient with appendicitis should be operated on. Every physician knew great numbers of people who had had an attack of appendicitis, recovered completely, and were never thereafter troubled again.

Dr. **James Ritchie** spoke of appendicitis in relation to life assurance, saying that whereas he would load a life if an attack of appendicitis had occurred, he would pass it as first-class if the appendix had been removed. In practice, he said, it was impossible to insist on the removal of the appendix of every patient who had had an attack. If it was mild, and if recovery was complete, he shrank from putting the patient to the risk and expense of an operation. If, however, a second attack developed, then the appendix should at once be removed.

Mr. **Dowden** replied to the discussion.

Dr. R. A. **Fleming** gave a lantern demonstration of the

CHANGES IN THE OPTIC NERVE IN A SERIES OF CASES OF INTRA-CRANIAL TUMOUR.

He first showed the neuroglia in the normal optic nerve, and then the hypertrophied neuroglial cells in disease. In optic neuritis the change consisted in an hypertrophy of the neuroglia, and this hypertrophy was much greater in the neuritis consequent upon intra-cranial tumour than on that due to simple local irritation. In cases of brain tumour there was a similar hypertrophy of the neuroglial cells of the brain substance. Similar changes were found in albuminuric optic neuritis. Only the neuroglial cells, not the mesoglial, were affected. The exact pathogenesis of optic neuritis in intra-cranial tumour was not known. Of the two hypotheses as to its cause—increased intra-cranial pressure and a toxic action—the latter was probably correct.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held January 17th, 1908.

Dr. A. J. **Wallace** (Liverpool) was elected President for 1908, and office-bearers for the ensuing year were elected.

Dr. E. **Octavius Croft**, the retiring President, delivered a valedictory address on

THE WOMAN OF THE FUTURE, FROM A GYNÆCOLOGIST'S POINT OF VIEW,

a full abstract of which will be found on page 122.

Professor Chantemesse, of the French Academy of Medicine, has announced the possibility of a cholera epidemic along the Mediterranean seaboard next spring. If the cholera got to the Mediterranean ports the outlook would be grave, and it has broken out at Mecca already.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Jan. 26th, 1908.

Ophthalmo-Diagnosis of Consumption.

Dr. Calmette read a paper last week at the meeting of the Académie de Médecine on the ophthalmo-diagnosis of tuberculosis.

Since I made known, he said, by a communication to the Académie des Sciences last June, the first results of what I termed the ophthalmo-diagnosis of tuberculosis, a large number of doctors were able, by repeating the experiment, to affirm that this method permitted to diagnose, with almost absolute exactitude, the existence of tuberculous lesions in process of development in the absence of any apparent clinical sign.

It is only right to state that before me Wolff-Eisner had announced to the Medical Society of Berlin that tuberculous subjects presented a charcteristic reaction when a drop of a solution of the old tuberculin of Koch and glycerine (1—10) was introduced into the eye. However, I had no knowledge of this communication.

After my first experiment, I found that this glycerine solution irritated considerably the conjunctiva, and consequently abandoned it, preferring a formula of my own. I precipitated the tuberculin three times in proof spirit, removing thus all impurities, when it was re-dissolved in physiological salt water at the dose of one per cent. One drop of this solution introduced into the internal angle of the eye is sufficient to produce, if the patient is tuberculous, a characteristic reaction. In children it should be of half the strength (1—200) on account of their sensitiveness being naturally more exaggerated.

Already hundreds of thousands of patients of all ages have been submitted to this test, both in France and abroad, and it seems now firmly established that ophthalmo-diagnosis, employed with the precautions suggested, furnishes indications as exact as those given by subcutaneous injections of tuberculin, presenting, on the other hand, an advantage over the latter in the fact of it being inoffensive.

Although this test has been employed more or less inconsiderably, and proper precautions have not always been taken to avoid, by antiseptic lotions, the introduction of infectious germs into the eye during the reaction, very few cases of persistent conjunctivitis or of keratitis have been observed. These complications are not in reality due to the tuberculin, but to pre-existing or imported infectious germs (bacilli of Weeks, staphylococci, gonococci). In many cases such accidents could have been avoided if, instead of using the solution which is rapidly spoiled by exposure to the air, tubes of sterilized tuberculin were used. According to M. de Lapessonne, the ophthalmo-reaction presents no danger to the healthy eye, and with the usual precaution of cleanliness, its employment is inoffensive, except, perhaps, in aged persons.

The interpretation of the results of ophthalmo-diagnosis is certainly sometimes a very delicate point. First, the reaction takes place with very variable intensity. Sometimes it shows itself four or five hours after instillation, and disappears at the end of 12 or 16 hours. The conjunctiva is only slightly injected, especially in the neighbourhood of the caruncculus, accompanied by lacrymal secretion. At others the vascular redness becomes perceptible only after 24 or even 48 hours, and persists five or six days. The patients complain of no pain, only of a smarting sensation in the eye, and some trouble of the vision provoked by the abundance of the secretion. Chemosis is never observed, nor is the temperature affected; the reaction is purely local.

It is good practice to examine the patient at three successive periods—6 or 8 hours, 24 and 48 hours after instillation of the tuberculin. If the test was made on the left eye, for instance, the colour of the caruncculus should be compared with that of the right eye. If the reaction has commenced, and although there may be no redness of the conjunctiva nor lacrymal secretion, the caruncculus of the tested eye will be seen to present a dark red colour which is characteristic. When the reaction is negative, the colour of both caruncculi remains the same.

The intensity of the reaction does not appear to be in direct ratio to the extent or gravity of the tuberculous injection. However, it is more intense and more rapid in children and adults who present incipient lesions barely discernible clinically.

In pronounced tuberculous patients, the reaction is slow to appear, and is less marked. In cachectic persons and those suffering from tuberculous peritonitis, no reaction takes place, but here also the subcutaneous injection of tuberculin is negative.

As regards infants born of tuberculous mothers, the ophthalmo-diagnosis does not react in the first months of their existence. On the other hand, children of one or two years react in the proportion of 3.5 per cent., and this proportion increases rapidly with the age, so that at between 10 and 19 years it attains 15 per cent.

These facts would seem to confirm the idea now in vogue that the child is not born tuberculous except in very exceptional cases; they become tuberculous from contagion or from being fed with milk from tuberculous cows.

In any case, the ophthalmo-diagnosis applied to each member of a family when tuberculosis is suspected, warns the physician of the impending danger before any clinical signs are apparent, and as the malady, treated at its very outset, is generally curable, the attendant is armed for the struggle with the maximum of chances towards success.

The utility of the ophthalmo-diagnosis can extend over a much larger field. It could be used for eliminating candidates for the Army, Navy, public schools, etc., who from a previous medical examination are more or less suspected of tuberculosis.

GERMANY.

Berlin, Jan. 26th, 1908.

At the Medizinische Gesellschaft, Hr. L Hirsch showed a young child that had been brought to him a year before with

Tuberculosis of the Supra-orbital Margin.

He then thought that success could be obtained with conservative treatment, and recommended this, and then lost sight of the child. When it was brought to him again, however, he found that it had suffered a great deal from pain, and that the eye was completely mummified. If he had carried out a radical course of treatment a year before, a great deal of pain at least would have been saved.

A second patient shown was a man of 42, who, after two day's headache and giddiness, became afflicted with complete amaurosis, bilateral pupillary rigidity, and paralysis of the abducens. Although the man denied syphilis, he was at once put upon an energetic course of inunction treatment. The result followed. His sight recovered so far that, in spite of bilateral atrophy of the terminals of the optic nerves, the vision on left was V = 6/20, on the right V = 6/12.

Hr. O. Pielicke then spoke on

Tuberculin in Tuberculosis of the Kidney.

The speaker recognised the brilliant achievements of surgery in renal tuberculosis, but he claimed that treatment by tuberculin could also do good service. As an example of this he related the case of a woman, æt. 42, whose right kidney was distinctly tuberculous, and in whom a cystoscopic examination showed that tuberculous disease was commencing in the bladder round the orifices of the ureters. The left kidney, even, was not quite intact, but the urine from it was clear and was free from albumen. The patient's bladder was washed out with silver solution and tuberculin injected, at first 1/20 mg. in pauses of from four to eight days, increasing up to 0.5 mg. Larger doses than these at once set up active fever. The patient's general condition improved, she increased in weight, the cystoscopic condition improved, the bladder finally healed, the urine cleared, but still contained a few bacilli. This condition continued for about a year, during which the patient made a journey abroad, and during this time all treatment was suspended. The treatment was therefore broken off prematurely.

He would specially plead for a trial of treatment by tuberculin in cases in which the second kidney was not quite sound, where the renal affection was complicated by lung disease, and for employment in the after-treatment after operation, or as a preliminary course for the object of obtaining better results from operation. Sometimes patients declined operation, and then a trial should be made of it.

Hr. J. Israel was all for operation. The immediate results of operation were very good. Out of 112 nephrotomies for tuberculosis, the deaths in connection with the operation had been only 2 per cent., and the permanent results had been quite surprising. Even without tuberculin treatment there were remarkable ups and downs in the course of the disease, and sometimes even considerable improvements. No harm had generally been observed by the use of tuberculin when the dose of it had been increased gradually; but some observations had given him matter for thought. He had once seen a patient with renal tuberculosis who was undergoing a course of tuberculin treatment suddenly develop tuberculous peritonitis, a rare complication in tuberculous affections of the kidney, although the tuberculin treatment had been carried out by an expert. The patient died from her peritonitis in a short time. He had also seen another case get worse very rapidly. If used as a preliminary to operative treatment, valuable time was lost which might well be fateful.

Hr. Karo agreed with Israel's views, but he was of opinion that tuberculin was useful in after-treatment after an operation; at least, the wound appeared to heal better, and the bladder symptoms subsided more quickly.

Hr. Rosenthal spoke on the

Treatment of Syphilis by Arsenic.

He had treated 60 cases with it. The treatment was not reliable, and its early use did not prevent the outbreak of secondaries. The results obtained were not unlike those obtained from atoxyl, but the dose of the latter could be much increased. There was danger, however, in its slow elimination. Koch and others had seen blindness follow the use of large doses.

Arsenic had no specific action on the disease. It might be used where there was any idiosyncrasy as regarded mercury, or where a relapse had occurred shortly after a mercurial course in malignant syphilis, in combinations of syphilis with tuberculosis or carcinoma, and, generally speaking, wherever there was any contra-indication as regarded the employment of mercury. The danger of poisoning by arsenic was not to be neglected. A combination of arsenic and potash iodide might be serviceable.

AUSTRIA.

Vienna, Jan. 26th, 1908.

Chorea and Melanosis.

At the Pediatric meeting Grüner showed a girl, æt. 9, with arseno-melanosis after using about 40 grams, over 600 grs., in 16 weeks, with excellent results on the chorea. The form of administering this large quantity was Fowler's solution. His prognosis of the melanosis was favourable, as the colour was rapidly disappearing since the drug was withdrawn. Morbus Addisoni was the disease to be confounded with this, but the patches on the mucous membrane was absent in arsenio-melanosis and present in Addisoni.

Noorden thought the melanosis was a dangerous symptom of arsenical intoxication, and portended some troublesome sequelæ.

Eisenschitz thought propylamine a safer and more effectual drug for chorea.

Galatti said Simonini, of Modena, obtained excellent results from the use of paraganglin in this disease.

Artresia of Œsophagus.

Mathilde next showed specimens of narrow œsophagus from a child that lived three days. At the lower part of the channel the œsophagus communicated with the trachea, but at the pharynx end the œsophagus was quite occluded, the trachea lying back against the pharangeal wall. This occlusion extended down to the vocal cords, below which a sac was formed. When the sound was passed from the stomach it entered the trachea about the bifurcation, so that the œsophagus was along the trachea to the mouth.

Tandler said he had met with different forms of atresia. There was another more common form where fistulæ communicated at different points between the trachea and œsophagus.

Struma Stenosis.

Lieber presented a child, aged 14 days, who, after the first bath, was seized with contractions of the thyroid glands. After applying a pad and bandage to the neck the struma disappeared, but reappeared on its removal. After four days constant application the swelling has quite disappeared, leaving no symptom of stenosis.

Escherich said congenital struma after a warm bath was a common occurrence, as the moist head induced a great blood flux. He found the application of a piece of ice wrapped in cotton wool soon corrected this morbid condition.

Orthostatic Albuminuria.

Jehle read an exhaustive paper on the albuminuria of childhood, expressing a belief that this subject was far from satisfactory at the present time. He considered this form of albuminuria to be nothing more than an accentuated form of physiological albuminuria, and differing from pathological albuminuria depending upon a lesion of the kidney. Noorden characterises this form of albuminuria as diabetes albuminosus, while others have names attributing the changes to a variable blood pressure in the organ. Tubercle, syphilis, and other blood diseases are credited with the greatest share of blame, but all are yet shrouded in mystery. He presented six children with albuminuria, who passed albumen only when in the standing posture. When walking, running or sitting, no albumen was eliminated. The greatest amount was passed when the child stood up on its knees, but when it sat down on its ankles the albumen disappeared. The altered position of the spine also affected the constituents, as kyphosis of the lumbar region produced while lordosis suppressed it. If it stood with a slight bend, no albumen appeared, but when erect the albumen was present. If any of the patients were fixed in a bent posture with a belt round the groin and a cravat on, walking or standing were both alike—no albumen present; but immediately these bands were released the albumen appeared on standing. If the child be put up in plaster, albumen will be eliminated either standing or lying; if the lordosis in the lumbar region be reduced, the albumen disappears. It appears from these experiments that the lordosis is the primary cause of the albumen in these orthostatic cases. The natural lordosis in the third and fourth vertebræ is not so productive of albumen as the lordosis in the first and second lumbar vertebræ, hence any weakness in the lumbar muscles is likely to produce albumen. From this it is evident that pressure on the kidneys which interferes with the circulation of the blood is the proximate cause, and may thus be reduced to an anatomical lesion of the kidney. The proper treatment of orthostatic albuminuria, therefore, lies in correcting the anatomical lesion.

Noorden said the paper was a very interesting and instructive lesson on an equally obscure subject that had engaged many investigators during the last few years. This mechanical elucidation of orthostatic albuminuria was the best explanation he had got on the subject, but it did not explain all. Why, for instance, have we albumen in many cases only at particular hours of the day, such as the morning, and none in the afternoon? And why does acetic acid bring down such quantities? Strasser agreed with Noorden, and affirmed the albuminuria was cyclical.

Tandler showed a child with more than normal lordosis that agreed with Jehle's theory. He had no doubt that many adults suffered from this orthostatic albuminuria.

Escherich thought Jehle had progressed another step forward in orthostatic albuminuria which, according to theory, should be designated lordotic albuminuria.

Munnaberg was not satisfied with Jehle's explanation as orthostatic albuminuria soon corrected itself without considering the anatomical factor. Muscular strain, mental exertion, cold baths, shock, etc., all produce orthostatic albuminuria without lordosis.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

CHAIR OF CLINICAL SURGERY, UNIVERSITY OF EDINBURGH.—Pending the appointment of a new occupant of this chair, the University Court have arranged to ask Mr. J. W. Dowden to carry on the work of the class, as he had already been entrusted by the managers of the infirmary with the charge of the wards lately under Professor Annandale's care. Mr. Dowden has been in close touch with Mr. Annandale for a great many years, and the appointment as interim holder of the chair is regarded with satisfaction on all hands. Mr. Dowden is not a candidate for the vacant chair, though the majority of the other surgeons whose position renders them eligible are so. The future Professor, whoever he may be, will labour under the disability (if it ought to be called so) of holding the chair, not for life, but until he attains the age of 65. The reason for this is the age limit recently enacted by the managers of the infirmary. Whoever is appointed will have to give up his hospital wards at that age, and a Professor of Clinical Surgery who held no hospital appointment would be rather a contradiction in terms. No doubt this will influence the Crown in their choice, though, of course, two opposite views may reasonably be held on the matter—viz., that it is best to appoint a comparatively young man, who will hold the chair for a number of years, or that it might be better to have an older man who would energetically throw himself into the work, though for a less period. In any case, it may honestly be said that surgery in Edinburgh was never so well represented as it now is. The idea that surgery is the weak point in the school, however true in the past, is quite erroneous nowadays, and three names at least will suggest themselves to Edinburgh men as those of surgeons who would not only fill the chair to the satisfaction of everyone, but would lend it fresh distinction.

LORD LISTER AND THE FREEDOM OF THE CITY OF GLASGOW.—On Wednesday last, the 22nd inst., the freedom of the City of Glasgow was conferred on Lord Lister, who was unable to be present from advanced age and enfeebled health. The Lord Provost, Sir William Bilsland, alluded to Lord Lister's former connection with Glasgow, as Professor of Surgery in the University, and Surgeon to the Royal Infirmary, where he developed the antiseptic treatment of wounds He said it was exactly a century ago since Dr. Edward Jenner, the discoverer of vaccination, had a similar honour conferred on him.

Sir Hector Cameron represented Lord Lister, and read the following letter from his illustrious teacher:—"My Lord Provost,—The freedom of the city of Glasgow is an honour justly held in the highest estimation. I greatly regret that the state of my health prevents me from expressing in person my gratitude for this great distinction, and I appreciate very highly the kindness of yourself and your fellow-magistrates in offering to confer it on me *in absentia*. This is far from being the first occasion on which I have had reason to be grateful to Glasgow. Arriving there on my appointment by the Crown to the Chair of Surgery with only one personal acquaintance in the city, the late Professor Allan Thomson, I was welcomed with the utmost cordiality by my colleagues in the University, and received abundant kindness from the genial citizens of the Western Metropolis. Having been in due time elected by the managers of the Royal Infirmary as surgeon to that institution. I experienced uniform consideration at their hands when applying to the treatment of wounds the great truth which had been recently revealed by the illustrious Pasteur regarding the nature of fermentative changes in organic substances. That truth, though it seemed to me to shine clear as daylight from Pasteur's writings, was for many years not generally recognised; and thus it was my privilege to witness in my own practice, as the application of the principle became greatly improved, the revelation of pathological truths of fundamental importance and a revolution in practical surgery; and I look upon the years spent in your city as the best period of my life. The old infirmary is now giving place to more commodious buildings, and, great as must necessarily be the expense of this undertaking, I do not doubt that the proverbial liberality of Glasgow will prove fully equal to the occasion." The reading of the letter was received with applause.

INFECTIOUS DISEASES IN SCOTLAND.—A few fresh cases of small-pox have cropped up in Edinburgh and Leith; the total number of cases is now about 24. One or two patients have been notified as suffering from cerebro-spinal meningitis. In Glasgow the epidemic of enteric fever has not yet spent its force, cases still being reported though not in great numbers. There have been between 70 and 80 cases altogether. The outbreak has been traced to an infected milk supply.

RESIGNATION OF THE MEDICAL OFFICER FOR FIFE AND KINROSS.—Dr. Nasmyth's resignation has led to some discussion in the County Council as to the terms on which his office is to be filled. One section of the Council is desirous of appointing four medical officers, one for each section of the county; another section wish to have two medical officers. The total salary available being from £500 to £600 it is difficult to see how by multiplying the officials adequate remuneration could be given to each, and this view is evidently that taken by the Local Government Board, which is strongly against any return to subdivision of the county into areas and the employment of part-time medical officers.

MALADMINISTRATION OF THE FALKIRK FEVER HOSPITAL.—The charges of inefficiency and extravagance brought against the Falkirk Fever Hospital by Mr. Miskimmin were the subject of a public inquiry by the Sheriff of Dumfries and Galloway and Sir Henry Littlejohn. The inquiry has not yet been completed, and the report is not yet made public. A great deal of evidence of a very disquieting nature was however given. Convalescent scarlet fever and enteric patients deposed to having been allowed out of the hospital while still under treatment. Dr. Clarkson, one of the leading practitioners in the town, animadverted strongly on the carelessness of the nursing, and instanced the case of a diphtheria patient who contracted typhoid while in hospital. There was no night staff, and the matron and nurses were sometimes out at the same time. Accounts were given of concerts and card parties held in the hospital at unseemly hours, and there were numerous complaints as to lack of nursing, the quality of the food, irregularities in carrying out the medical treatment ordered; the bright spots in the lives of the patients apparently being the absence of any irksome restrictions based on ideas about isolation, and the abundance of tobacco at their disposal. Perhaps the most serious irregularities were those alleged of allowing a case of small-pox to walk to the hospital, and a convalescent typhoid case to have a substantial meal containing such dainties as roast beef, cabbage, new potatoes, and stewed rhubarb. This was said to have been done in defiance of the medical officer's order, and it is lamentable to state that the patient died on the following day. No doubt the upshot will be that the hospital will now be put on a thoroughly satisfactory footing, but only those who know how long it takes to restore the confidence of the public in an institution after such allegations, can estimate the harm done.

THE LATE PROFESSOR SIR THOMAS MCCALL ANDERSON.—We regret to announce the unexpected death, on the 25th inst., of the distinguished Regius Professor of Medicine in the University of Glasgow, representative of the University on the General Medical Council, and the holder of many other important public appointments.

BELFAST.

VISIT OF SIR VICTOR HORSLEY.—On Thursday last a fine example of the strenuous life was set by Sir Victor Horsley. During a visit extending to just twelve hours he delivered three addresses. The occasion of his visit was the Jubilee celebrations of the Irish Temperance League, and when invited to attend these meetings he consented on condition that the chief meeting should be largely a medical one, the chair being taken by the President of the Ulster Branch of the British Medical Temperance Association, Dr. Calwell. This was arranged, and the chair was so filled. At this meeting Sir Victor dealt with the drink problem from the national standpoint, advocating high licenses and local option, and showing how these two agents promoted temperance in other countries. A vote of thanks was moved by Dr. McMurtry (a pioneer of the temperance movement in Belfast), seconded by Sir John Byers, and conveyed to the lecturer by Professor Sinclair, who took the chair when Dr. Calwell was obliged to leave. At an afternoon meeting for ladies, Sir Victor gave an address on "The Use of Alcohol in Health and Disease," advocating the view that it is a narcotic drug, and specially harmful to young people. He would abolish it entirely from the table, and did not consider it indispensable as a drug, its place being easy to fill. The Ulster Branch of the British Medical Association took advantage of Sir Victor Horsley's visit to invite him to address their winter meeting, which was held in the Medical Institute in the forenoon. To a large meeting, presided over by Dr. Warnock, of Donegal, he delivered a most thoughtful and stimulating address on "The Early Diagnosis of Intracranial Conditions Requiring Surgical Interference." He dealt specially with the very early disturbance of tactile sensation, the means of discovering it, and the lessons to be learned from it. The address was a model of lucidity, and beautifully illustrated with lantern photographs and diagrams. At its close a vote of thanks was moved by Professor Sinclair, seconded by Dr. St. George, of Lisburn, and passed by acclamation.

DEATH OF DR. TAGGART, OF ANTRIM.—The death of Dr. Taggart in his seventy-fifth year removes a well-known medical man from Antrim. He was born at Randalstown, Co. Antrim, in 1833, and entered the ministry of the Presbyterian Church in 1855. After some years' ministry in Australia, he returned to Ireland, studied medicine, and graduated M.D. in 1864. He settled in Antrim, only a few miles from his native place, and there he practised till his death. He was for many years the Medical Officer of the dispensary district. Though he had retired from the ministry of his church, he continued to take the warmest interest in it, acting as an elder, teaching in the Sunday School, and helping generously in all good works. He had travelled and read much, and was a keen observer, so that his mind was highly cultured. He was held in high esteem by all classes and creeds, and he will be much missed.

LETTERS TO THE EDITOR.

INHERITED SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have been much interested in the address by Mr. R. Clement Lucas on the above in THE MEDICAL PRESS AND CIRCULAR of January 1st, 1908, and the subsequent letters by Dr. Walsh and another. I observe that Mr. Clement Lucas speaks of Colles' law. In this respect the clinical observation that a diseased child born of a mother who is without any obvious venereal symptoms may infect the most healthy nurse, but is rarely known to infect its own mother, is usually associated with the name of Colles, and is universally referred to as "Colles' law."

But some time ago, in the columns of the *Lancet*, February 25th, 1899 ("Colles' Law" or "Wallace's Law"?), I drew attention to the facts in support of the claims of another distinguished surgeon, W. Wallace, whose oral lectures in Dublin had appeared and were appearing in the *Lancet* of 1833-7, in which later observations of Colles occur independently. Some of these observations—*e.g.*, the acquisition of disease by the "dry" nurse and in "wet" nursing appeared in the *Lancet* of February 13th, 1836; others, viz., the contagious nature of the two forms of disease (hereditary and acquired) in the infant; the acquisition of disease from a strange child "not her own child," and apparent freedom from disease in the mother of a diseased infant appeared in the *Lancet* of May 7th, 1836, which was before the publication of Colles' work, dated January 20th, 1837.

A review of Colles' book appeared in the *Lancet* of March 25th, 1837.

"What could have induced the worthy gentleman, who considers himself—sad mistake—to be the 'author' of its contents, to put forth such a *cruda indigestaque moles* in 1837? Is the practice going down in Dublin, and are the Irish public in want of the reminiscence? It must be so . . .; not a fact is contained in the whole volume which has not either long since been published or been preceded in print by a similar fact as appositely told . . . we would undertake to prove that all the facts contained in a chapter on 'Syphilis in Infants,' which occupies more than forty pages, and certainly is the best chapter in the book, will be found in almost as many lines in the lectures and remarks delivered by Dr. Wallace on this subject, and recorded in the *Lancet*. In short, we regret, for the credit of English medical literature, to say that the whole volume is a crude jumble of facts with which, and with many more, all intelligent practitioners are already acquainted. . . Unless, in short, the conjecture already expressed affords some explanation of the birth of this volume, we must abandon the task of guessing at the object of its publication; but we are the more disposed to believe our opinion to be well founded from the fact that Dr. Colles has taken especial care to keep from the public eye in his pages the names both of Carmichael and Wallace, brethren residing in the same city, highly appreciated there, and well known wherever British medical literature has reached."

In the *Lancet* of May 20th, 1837, Wallace deals more especially with the freedom of the suckling mother from the disease of her own child. He states that by means of many cases he had been led to the discovery of an important law—viz., that, as soon as the constitution of any individual becomes contaminated with this poison, all parts of his body are rendered insensible to inoculation with the matter of his own sores or of analogous sores of another individual, as an example of which he alludes to the fact that he had never seen a mother injured by her own disordered child. "You may say she was sound. I admit she was so to external appearance, but you have, in my opinion, a proof in her having given birth to an unsound child that she was unsound. . . . In the present state of pathological science few will refuse to admit the originality of these views; but they will surely attach to their author an epithet, in their opinion opprobrious. They will describe him as a speculatist. So they may. My speculations are only the general expressions of the facts I have witnessed. Half a dozen of years will not, I am convinced, pass by until they shall be generally admitted as immutable truths, as laws of Nature; and then, most probably, if I am not beyond the din of this sublunary planet, they will find a father in some other quarter."

In 1838 Wallace was beyond the "din," but his work remains, if universally unaccredited.

In my article, however, I stated that "the question of priority was of minor importance in comparison with the observations and interpretations of Wallace," which I maintained therein and independently elsewhere (*a*) on behalf of the primarily contaminated and untreated mother. And now, to my great pleasure, in confirmation of Wallace, as I conceive it to be, Mr. Clement Lucas independently holds that "inheritance from the father alone is put now entirely out of court,

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(*a*) **"On Maternal Syphilis, including the Presence and Recognition of Syphilitic Pelvic Disease in Women." By J. A. Shaw-Mackenzie, M.D.Lond., 1898. J. and A. Churchill.**

that it follows that infection of a mother by her syphilitic fœtus can never occur, that inheritance is invariably through the syphilised mother."

Yours faithfully,

J. A. Shaw-Mackenzie, M.D. (Lond.).

TRYPSIN AND CANCER—THE QUESTION OF PRIORITY.

To the Editor of The Medical Press and Circular.

Sir,—May I apologise to you, your readers, and especially Dr. Shaw-Mackenzie, for my delay, through an oversight, in answering your article of December 4th regarding this question?

The question of priority is of very minor interest to me personally; and this not for the obvious reason that certainly I have made no discovery, but because my ruling desire now, as for nearly two years past, is simply to get trypsin used, as I think it should be used, in every case of malignant disease, at whatever stage, and whatever other treatment be or be not employed. As regards priority of idea, I think Dr. Beard has it, as I try to show in my book; but that is his personal affair, and I shall make no attempt to urge the point now. As regards priority of act or practice, there has never been any question as to Dr. Shaw-Mackenzie's claim, surely! On page 68 of my book I say that "to him, undoubtedly, must be awarded the credit of being the first physician to employ the new treatment." The word physician had better been "person," perhaps, since I might have conceivably meant some reservation as to a surgeon—or Dr. Beard, as now occurs to me; but, of course, I did not. I take it for granted that trypsin was never injected into a human being (except unknowingly, I suppose, in injections of blood) until Dr. Shaw-Mackenzie did so, as he tells us, in January, 1905. Dr. Beard, of course, is "not even a medical man," as some king of thought, who must surely have heard the name of Pasteur, said somewhere in the attempt to decry the new treatment; and, having no patients of his own—nor ever having had any—he has no conceivable claim to priority of practice.

Dr. Shaw-Mackenzie's practice I believe to be based upon an erroneous theory (that trypsin digests glycogen), but that is neither here nor there. Neither my book, nor anything I have ever written anywhere, contains the smallest vestige of personal abuse, or anything remotely resembling it, of Dr. Shaw-Mackenzie, who is unknown to me, but, of course, has my best wishes on general principles.

And now a word, which I am sure you will allow me, as to myself. There is obviously no altering the fact that I have had a medical education, have taken a medical degree, and was registered on the same day, as usual. I have also practised medicine in hospitals and—to the extent of, I think, three patients—privately. Two of these paid me—about the usual percentage, I am given to understand. But I do not practice medicine, and have not done so for some four years. You mention my "professional brethren," but my professional brethren are authors in general and also lecturers. If I owe professional allegiance to anybody, I suppose it is to the Authors' Club, to which I belong. My case surely cannot be so peculiar; there must be other men, holding medical qualifications, who are yet not members of the medical profession. You say I am "generally understood not to be engaged in actual practice." (I don't know whether the adjective is meant to weaken or strengthen the noun, but, at any rate, I do not practice in any shape or form.) True, I have paid scores of visits to cancer patients during the last two years, and have seen any number of injections made, but always with the practitioner in charge, and always, of course, without fee. There has been some paying, but it has been the other way; nor can I imagine that anyone who has seen the beneficent results I have seen would hesitate to do what he could to enable poor people to participate in them, even though almost the whole medical profession was loading him with personal abuse meanwhile.

However, I fear your statement as to the general understanding is scarcely correct, even though I must have stated in twenty articles and from scores and scores of platforms that I don't practice. Yet one of the burdens of my existence is to deal with the correspondents who, rarely enclosing stamps, want to consult me—foolishly enough, no doubt, but one is bound to answer them, nevertheless.

I have even drafted an advertisement for the *Daily Telegraph* and *Daily Mail* to state that I don't practice, and cannot earn my living for this nuisance of correspondence and telegrams, and even people calling; but such advertisements would have been too ridiculous, and would have endeared me to few.

Here, however, let it be publicly said, for what feels like the ten-thousandth time, that I don't practice, won't practice, have lost any capacity I ever might have had to practice; yet, also that any medical man whom I can serve in any way as regards the ferment treatment of cancer has me freely at his service until such time as I can leave for ever the most expensive and sleep-destroying business I have ever had anything to do with, and can proceed with my own literary interests, which are in the main sociological.

There is still on the bookstalls a little volume of mine which seems to sell, though I have no interest in it, and which you were good enough to praise some years ago. Its chapters were written anonymously, when I was a literary beginner, for the *Pall Mall Gazette*; and, picking it up the other day for a reference, I was horrified to find the phrase "my patients" on the first page I opened. Whether these were the dauntless three, or hospital patients, I don't remember; but, at any rate, I had ceased to practice before the booklet appeared with my name.

Any of your readers is welcome to interrupt my work any morning by calling at my house, and if he can find a stethoscope or a clinical thermometer on the premises he may have it as a present, and I will never write another line.

I am, Sir, yours truly,

C. W. Saleeby.

13, Greville Place, N.W., January 20th, 1908.

[Our further criticism of Dr. Saleeby's attitude is a graver one—namely, that he has appealed to the public through the lay Press in sensational articles to judge of the value of a method of treatment which is still *sub judice* among medical men who have the opportunity of forming an opinion. We regard it as more than cruel to lead patients suffering from so terrible a disease as cancer to have recourse to any treatment other than thorough surgical means, except in inoperable cases. The effect of placarding the newspapers with praise of a medical treatment cannot but be to lead nervous and anxious people to dally with it till the golden hour has passed. Our columns are open to any record of scientific evidence in favour of any rational method of treatment, and no one would rejoice more than ourselves if the ferment treatment of cancer proves of substantial value to humanity.

Two-thirds of Dr. Saleeby's letter is devoted to a personal issue, and would have been quite as effective if couched in a single sentence. He admits Dr. Shaw-Mackenzie's priority in practice, but denies his priority in theory, because he, Dr. S., does not agree with that theory. It is to be hoped that Dr. Beard will be able to furnish a more satisfactory answer to our challenge of December 4th, 1907, as to the priority of the trypsin method in cancer.—Ed.]

MALIGNANT ANTI-VIVISECTION FANATICISM.

To the Editor of The Medical Press and Circular.

Sir,—As a dog returns to its vomit and a fool to his folly so the fanatical victim of a fixed idea iterates and reiterates the lies his morbid imagination has evolved, or emits and repeats his own version of the falsehoods he has taken in from the utterances of his brethren. The psychology of the anti-vivisection fanatic has afforded an interesting study. The letters I have evoked confirm the opinion generally formed of the mental calibre and the moral state of these poor creatures. They are really more to be pitied than many inmates of our asylums, the victims of delusions much less painful to themselves than those of these wild fanatics. An anti-vivisectionist who really believes in the lies he utters, and, sensitive as he professes to be, realises mentally the scenes of torture he depicts, must live himself in continual torment. He is, indeed, very often on the way to the lunatic asylum; he has, at any rate, the mind and the temperament which lead thither. Could anyone but a hopeless fanatic write in cold blood that it is impossible for a humane man to become a vivisector, and that vivisection is in the last degree demoralising? A mad libel on the illustrious dead and living; upon the elect class who in a money-grubbing and selfish age have devoted themselves, and are still giving up their lives, with complete self-sacrifice, to the service of humanity. In conferring the freedom of Glasgow upon Lord Lister and other distinguished men on Tuesday last, the Lord Provost said that "Lord Lister's name would have an imperishable place among the greatest and noblest benefactors of humanity." Lord Lister we have happily with us; many of us know him, or even claim him as a personal friend. We are able to appreciate the foul aspersions which malignant anti-vivisection fanaticism flings at him and the great band of noble figures, living and dead, who have wrought in the same field, and helped not only to lessen enormously the mass of human pain, but also to advance the knowledge of nature upon which the progress of mankind depends. The injury arising from the rabid propaganda of these fanatics is falling, as usual in such cases, on the ignorant crowd, upon the masses, too dull to reason and incapable of receiving any mental impression save from the repetition of a crude, coarse statement. They do not know—they cannot understand—the meaning of science; but, if the statements are sufficiently and continuously forced upon their attention, especially by those they look upon as educated gentlemen, they will believe that experimental physiologists are all anti-human wretches, and the medical profession, their pupils, a crew of heartless tricksters. Now comes the opportunity of the cynical quack. We are witnessing now the apotheosis of the quack—a whole army of impostors amassing wealth by the deception and plunder of suffering humanity. Tens of thousands of the poor and ignorant, wrought upon by anti-vivisectionists, are refusing the help that scientific medicine and surgery can so often surely afford, and are going to death through prolonged anguish, which might have been prevented, or mitigated, by science. For this mental and physical suffering—a million times greater than the terror and pain inflicted by physiological experiment, even if these were as great as the fanatics declare—the mad leaders of the innocent, ignorant crowd are alone responsible.

I am, Sir, yours truly,
A SURREY DOCTOR.

January 23rd, 1908.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent "A Surrey Doctor" evidently knows little of vivisection. He should study the medical journals (especially the *Journal of Physiology*), the Report of the Royal Commission of 1876, the "Confessions of a Physician" by "Veresaeff," and other works on vivisection, in which he will find ample evidence of the cruelty and the demoralising effects of the practice of experimenting upon living creatures. His own letter supplies additional evidence of this. It is full of prejudice and passion, and shows how he would like to silence his opponents if he could. But the British people (especially the working classes) are finding out what vivisection really is, and I believe the time is not far distant when this immoral and dangerous practice will be strictly prohibited and suppressed by law. I enclose my card, and remain,

Yours faithfully,
Hove, January 23rd, 1908. A. V.

THE *STAR* AND THE MEDICAL PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I understand from the sentence which you have allowed your correspondent to include in his letter ("it is [illegible] unnecessary to continue a controversy in your pages") that you do not desire the controversy he commenced to be continued. For, of course, the decision rests with you, and not with him. But I hope you will permit me to say that my reference to the vaccination of one-day-old infants "before the reduced fees came into operation" was not, as he says, an innuendo but an admitted fact. The evidence is to be found in the report of the proceedings of the Aston (Birmingham) Guardians on December 17th, before whom two medical officers, charged with this offence against humanity, appeared and allowed the charge to go without defence.

The other statements of "A Surrey Doctor" also confirm my previous suggestion that the profession err in ignorance, for he puts forth as truth what a greater knowledge of the subject would show him to be the very matter in controversy. It may be that Prof. Crookshank's work was "discredited years ago." It was never answered. The misfortune is that like "A Surrey Doctor," so many are willing to discredit rather than to investigate or disprove.

And my point as to compulsion remains untouched.

Yours, etc.,
THE EDITOR OF THE "STAR."

[We are sorry that the sentence quoted from "A Surrey Doctor's" letter should be thought by our correspondent to mean that we do not wish the controversy to continue. "A Surrey Doctor" was expressing his own view, not ours. Anything within reasonable limits of space (and to the point) we shall be most happy to publish.—ED.]

THE PROPOSED INQUIRY INTO THE ACTION OF ALCOHOL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If you will be good enough to read the communication which you received on the proposed inquiry as to the action of alcohol in pneumonia, I think you will see that you have done the International Union of Medical Abstainers an injustice. This inquiry is proposed by those who doubt the value of alcohol, but the whole profession are asked to conduct it and to furnish the results. I presume you do not wish to imply that the results will be tampered with.

As to the scheme which you deprecate, it seems clear that if a sufficiently large series of consecutive cases are treated, odd cases with and even cases without alcohol, the comparison would be as fair and thorough as could be arranged. But I agree with you that this plan verges on the immoral, and, though certain Continental physicians see no objection to it I urged that an alternative plan might be allowed (Plan B.), which you do not mention, a plan more suited to English ideas, and my colleagues agreed to this. In this alternative plan the physician administers alcohol, or withholds it, as he thinks proper, and tabulates the result. This is not so crucial as Plan A., as possibly the severer cases are more likely to get alcohol, but it is scarcely fair to us that you should ignore it. I trust you will do us the favour of inserting this letter in your next issue.

I am, Sir, yours truly,
J. J. RIDGE.

[We publish Dr. Ridge's letter with pleasure. We do not think anyone reading our note would gather that we suggested *dishonest* tampering with results; we meant simply the unconscious bias which the leaders of a partisan movement necessarily possess in favour of their cause, and which is fatal to the serene dispassionateness that should pervade a scientific inquiry. Plan A. fully illustrates our point. We did not mention Plan B., first, because it was not possible in a short note to deal with every point; secondly, because it was subsidiary and not the main plan; thirdly, because in so far as it was in point, it did not seem open to any particular criticism. Our readers will not suspect us of wishing to do any injustice to the cause of temperance, which we have championed so frequently.—ED.]

CHRISTIAN SCIENCE AGAIN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read the note, "Christian Science Again," in your issue of the 15th inst., and I feel sure that the very strength of your antagonism to Christian Science will gain admission to your columns for this letter, because I believe that that antagonism is not divorced from a wish to be absolutely fair. May I say at once that the only thing that could seriously affect the growth of the Christian Science movement would be dishonesty on the part of Christian Scientists, and that it is therefore of paramount importance to Christian Scientists that there should be nothing to hide in the working of Christian Science. Mrs. Davidson called in a doctor, in perfect good faith, as the full report of the case shows, after the death of the patient. It is possible that she made a technical mistake in not reporting the death to the Coroner instead, but it cannot be pretended that she attempted to "unload" her patient.

There is a law, and a very necessary law, that inquests should follow deaths, under certain conditions. I am not aware that Christian Scientists have ever attempted to "burke" this law. I could, on the contrary, produce cases where nothing would have been easier than for those concerned to do so, but where they have deliberately elected to go into the coroner's court rather than hide anything.

I believe I may claim as wide a knowledge of the Christian Science movement in this country as anybody connected with it, and, so far from making "a wonderful amount of money out of it," I hardly know anybody who has succeeded in getting a bare livelihood out of it. Christian Science workers are nearly all either in possession of private resources or working hard by day for the means to support themselves, so as to be able to devote their spare time to the sick and sorrowful.

As to Christian Science being unscientific and blasphemous, that is a colossal generalisation which the world, as it learns more and more what Christian Science is, is less and less moved by. If it is unscientific to make absolute truth your aim, to endeavour to demonstrate your premises in the most practical manner, it may be the first; if it is blasphemy to accept Christ as the Way, and to strive to walk in that way, it may be the latter.

I am, Sir, yours truly,

FREDERICK DIXON.

London, January 24th.

THE SOCIETY OF MEDICAL PHONOGRAPHERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is many years since the Society of Medical Phonographers was last mentioned in your columns, and we shall be glad if you will allow us to direct attention to the fact that it still exists and still issues its medical periodical in lithographed phonetic shorthand. We believe that many members of the profession are ignorant of the Society and its efforts to promote the effective use of shorthand in medicine, both in practical work and in research.

The Hon. Secretary will be glad to furnish particulars of the Society to any members of the profession or students who may desire to join it.

We are, Sir, yours truly,
WILLIAM R. GOWERS, President.
G. SIMS WOODHEAD, }
C. W. CATHCART, } Vice-Presidents.
ASKAR C. GRUNER, Hon. Secretary.
Pathological Department, General Infirmary,
Leeds, January, 1908.

MOTOR-CARS FOR MEDICAL MEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the interesting account which you give of the recent exhibition of motor-cars in Dublin, you say rightly that the most important part of the show for the majority of the medical profession was the "small cars." You, however, omit to go a step further, and say what is the best "small car" for a country practitioner. Of course, I can understand the difficulties which lie in the way of a medical journal definitely recommending one car to the disadvantage of its rivals, as it might be accused of favouritism, and therefore, I do not ask you to make a selection. Perhaps, however, some of your many motorist readers would do so, and would inform a brother practitioner as to what car they consider most suitable for everyday use in a country district where roads are bad. The car may be a two or a four-seater, as is thought best, but it must be of moderate price, economical in its up-keep, and reliable.

I fully share—what is evidently your belief—that the time is near at hand when the country practitioner can definitely abandon horses in favour of a more speedy, more reliable, and, for its mileage, more economical means of locomotion. But, even if the time has already come, much depends upon the car, and if, in addition to giving the name of the most desirable car, my charitable informant will also add some particulars as to the cost which he has personally incurred in its up-keep, he will place me still further in his debt. Perhaps I should simplify his task if I ask a definite question. Is there any make of small car which could be run at an average of, say, 15 miles a day, or 5,000 in the year, at a cost of £50 a year, not counting the wages and keep of a man for looking after it, should such be employed?

I am, Sir, yours truly,

M. D.

ADMISSION OF WOMEN TO THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your editorial note on this subject in your last issue states that "under existing circumstances the licence (of the College of Physicians) cannot be given apart from the membership of the Royal College of Surgeons of England, as the two qualifications are now conjoint and indivisible." Is this really so? Or, has not the College the power to grant its licence to any registered medical practitioner? Such a power is possessed by the Irish College, and it seems strange that it should not also be possessed by the sister College in London.

I am, Sir, yours truly,

L.R.C.S.I.

OBITUARY.

SIR THOMAS McCALL ANDERSON, M.D.GLASG., F.F.P.S.GLASG.

WE regret to record that Sir Thomas McCall Anderson, Regius Professor of Medicine in the University of Glasgow, and an Honorary Physician to the King in Scotland, died suddenly on Saturday while attending a dinner of the Glasgow Ayrshire Society in St. Enoch's Hotel. He had proposed the last toast of the evening, and the company was dispersing. He had only descended a few steps of the hotel stairs when he was seized with heart failure, and expired in a few minutes. Born in 1836, Sir Thomas studied in Edinburgh and Glasgow, graduating with honours in medicine at Glasgow University in 1858. He afterwards continued his studies in many of the celebrated schools and hospitals on the Continent of Europe. His first appointment was that of Lecturer on the Practice of Medicine in Anderson's College. When the Chair of Clinical Medicine was founded in Glasgow University in 1874, Sir Thomas was its first occupant, and he held the office for 26 years. In 1900 he succeeded Sir William Gairdner in the Chair of Practice of Medicine. His success as a teacher was due to his systematic mode of expression and to his powers of organisation. As a physician he was a good practical and sagacious adviser. His powers lay perhaps more in the direction of therapeutics and treatment rather than in the direction of pathology and the more intricate problems of diagnosis. As a dermatologist Sir Thomas was widely known, not only in this country, but in America and in Europe generally, and his writings upon the subject have enjoyed a large circulation. As a consultant for a great many years he enjoyed a very extensive practice. The clearness with which he expressed his views as to diagnosis, and the thoroughly practical manner in which he initiated treatment, commended him to a large circle of his professional brethren. Some two years ago he received the honour of knighthood.

ST. GEORGE C. REID, M.R.C.S.

WE regret to announce the sudden death, at his residence at Thornton Heath, of Dr. St. George C. Reid, at the age of 48 years. Dr. Reid, who was bacteriologist to the Central London Throat and Ear Hospital, besides having an extensive local practice, was Consulting Surgeon for Diseases of the Throat and Ear to the Croydon Infirmary, and Secretary to the British Laryngological Association. In early life he had served as Surgeon in the Russo-Turkish War, for which he held the medal.

SPECIAL ARTICLES.

THE NOTIFICATION OF BIRTHS ACT IN SCOTLAND.

THE Aberdeen Town Council met in the Town Hall on the 20th inst., the Lord Provost, Sir Alexander Lyon, presiding, and received a deputation of medical men consisting of Dr. Williamson, president of the society; Dr. Marnoch, secretary; Dr. Lister, treasurer; Dr. Edmond, Dr. John Gordon, and Dr. M'Kerron.

THE SOCIETY'S MEMORANDUM.

Dr. Williamson read the society's memorandum as follows:—The Aberdeen Medico-Chirurgical Society, having on various occasions considered the terms of the Notification of Births Act, unanimously resolved at a meeting held on the 9th inst. to ask the Aberdeen Town Council to receive a deputation from the society, who should lay before the Council the special points in the Act which appear to the members of the medical profession to be objectionable, and to ask the Council's consideration of those points before deciding on the adoption of the Act. While desirous of submitting the following objections, the society desire it to be clearly understood that its objections are not directed against the principle underlying the Act, which they consider a good one, calculated as it is to reduce infant mortality; but they most strongly object to the method of working the Act, in so far as it lays on medical men the burden of notifying births at which they have been present, and that under a penalty if they fail to do so.

1. Medical men feel that it is not necessary that the burden of notification should be laid upon them, but that the proper person to be charged with such a duty is the father, whom failing the nearest relative or person in attendance on the mother. The argument has been used that it is the duty of medical men to notify infectious disease, but the society wishes to point out that the two Acts are not analogous. In the case of the Infectious Diseases Act (1889) a skilled opinion is given, and can be given only by a medical man; whereas in this Act it is merely a statement of fact which is asked for, and which can be intimated by any person in the house; further, in the case of infectious disease there is a serious risk to the public health, and to prevent this risk the case is notified. There is no risk to the public health in a case of child-birth.

2. Further, there is nothing to be gained by compelling medical men to notify. The main idea underlying the Act is that the Public Health Department would come into touch with children shortly after birth, and give instructions as to the proper rearing of the child; presumably such instructions would not be given where there was a medical attendant, consequently there can be no advantage in getting notification from medical men.

3. It is altogether contrary to the usage and best traditions of the medical profession for a medical attendant to give any information whatever regarding his patient, except in cases where the law requires an expert report in the interests of the public welfare, and, therefore, should a parent dissent from the notification of a child's birth, the medical man is professionally bound by these traditions to respect his wishes. Already a large number of births occur where no medical man is present, and should the Act be adopted, this number is likely to be increased, inasmuch as parents who desire secrecy as to the birth of a child would attain their object best by procuring unprofessional services, thus exposing both mother and child to needless risk. The chief purpose of the Act would in such cases be defeated.

4. The society would further draw the attention of the Town Council to the fact that, though the Act, as it stands, makes it compulsory for medical men to notify, there is no provision for any remuneration for giving such information, while the neglect of notification is a punishable offence. Medical men voluntarily do much of their work gratis, but to make the neglect of gratis work an offence punishable by law appears to the society to be scarcely within the bounds of common justice.

Should the Town Council of the City of Aberdeen decline to adopt the Notification of Births Act in its present form, as some other important corporations have done, the Aberdeen Medico-Chirurgical Society believes that such an action may draw the attention of the Government to certain anomalies in the Act, and thus lead to such revision as would make the Act of real service to the public health and acceptable to the medical profession, whose co-operation is essential for the successful attainment of the object—namely, a reduction of the present excessive mortality of infants.

LABORATORY NOTES.

MOSTELLE GRAPE JUICE.

WE have submitted to a chemical analysis a sample of the Red Mostelle Grape Juice, as supplied by the Grape Juice Company, Limited, of 7, Great Tower Street, London. This Grape Juice is the pure juice of sun-ripened Spanish grapes, prepared in Spain in such a manner as to leave all the constituents of the ripe grapes unaltered by fermentation or boiling. Our analysis of the red variety of Mostelle shows it to contain the following constituents:—

Extractives	21.40 per cent.
Mineral matter	0.28 ,,
Acidity as tartaric acid ..	0.69 ,,
Salicylic acid	absent.
Foreign colouring matter	absent.
Alcohol	absent.

There is present in the extractives a large percentage of the sugar derived from the grape, and our analysis shows that this juice is free from adulteration, being, as represented, the pure juice of the grape, free from alcohol, and preserved by sterilisation. We think that this juice forms an admirable temperance beverage, being delicious when taken either plain or with the addition of aerated water, and, quickly assimilated, it should form a valuable tonic drink in many cases.

Two other varieties of Mostelle are made—White and Golden Muscat.

METCHIKOFF'S "SANERIN."

THE latest product of Messrs. Allen and Hanbury's ingenuity is of more than ordinary interest. It is a tablet called "Sanerin," which is derived from a pure culture of bacillus acidi lactici. "Sanerin" is confessedly the outcome of Metchnikoff's work on old age, and if his theories be well grounded, it may prove the very elixir of life. The tablets may either be taken after meals in the usual way, but the more useful way, it is suggested, is for them to be employed to curdle milk, and for the soured milk to be drunk. The idea is that the lactic acid bacillus lives in and produces an acid medium, and its presence in hardy growth, therefore, is inimical to the presence of nearly all other organisms. Besides producing longevity, it is claimed for "Sanerin" that it is beneficial in diarrhœa, intestinal indigestion, and many similar cases.

"TABLOID" QUININE COMPOUND.

MESSRS. BURROUGHS AND WELLCOME have sent us samples of the above product. Each contains:—Cinchona alkaloids, 1 gr.; antifebrin (acetanilide), 1 1-5 gr.; camphor monobromate, 1-5 gr.; powdered ipecacuanha, ⅛ gr.; cascara sagrada extract, ¼ gr. This combination, it is suggested, is especially valuable at the present season, when changes of weather involve the risk of rheums and catarrhs. The antiseptic, anti-pyretic, expectorant and laxative principles of the compound quinine tabloid should help the patient to combat the infection and cut short the febrile process.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Epidemic Pneumonia.—Fabyan (*Bull. Johns Hopkins Hosp.*, Dec., 1907) reports an epidemic of acute pneumonia in a family of ten within ten days. Six of the ten had definite signs of lobar pneumonia. Two others, including the father, who was the first one sick, gave a typical enough history of pneumonia, but had recovered before they were examined. Only one case was fatal. Pneumococci were recovered in this case, both from the blood during life, and from the blood and consolidated lung at autopsy. On careful examination of the home surroundings, no special etiological factors were found to account for this unusual contagiousness of pneumonia. D.

Motor, Sensory and Vaso-Motor Symptoms Arising from Coronary Sclerosis.—(*Mun. Med. Woch.*, Oct., 1907.)—In the observation of a large number of cases of angina pectoris, Schmoll has found that the symptoms may be divided into sensory, motor, and vaso-motor manifestations. These are:—(*a*) Sensory pain, a feeling of impending death, numbness of arm, or arm and leg, etc.; (*b*) motor—irritative or paretic; contraction of the intercostal, pectoral, or abdominal muscles on the one hand, weakness of the left hand and arm on the other; (*c*) vaso-motor—the left arm or the left half of the body may be blanched during the attack, owing to a contraction of the vessels of the part. Between the attacks these manifestations are less marked, but they are still present, if sought for carefully. Hyperæsthesia of the skin over the area of pain during the attack, slight weakness of the part, blanching or cyanosis between the attacks, are almost the rule. These symptoms can be traced to one or more spinal segments, usually between the eighth cervical and second dorsal. Schmoll accepts Mackenzie's theory that the irritation proceeding from the heart along the sympathetic to the spinal cord sets up an irritation there, which in turn is referred to the periphery. D.

Treatment of Whooping-Cough.—Kilmer (*Jour. Am. Assoc.*, Dec., 1907) reports a series of 550 cases of whooping-cough treated by the abdominal belt. Thse cases represent the observations of some thirty pediatricians. Most of the observers testified to the almost constant benefit noticed regarding the cessation of vomiting and moderation of cough It is in no sense a curative procedure. The belt is made of linen, with a strip of silk elastic webbing two inches wide inserted in either side. The belt laces in the back, and is worn over the undershirt. The width is four to eight inches, depending on the size of the child. The length is about three inches less than the circumference of the child's abdomen at the navel. At first only slight constriction is used, which is increased until the vomiting is controlled. D.

Paroxysmal Tachycardia.—Schmoll's article (*Am. Jour. Med. Sciences*, Dec., 1907) is an attempt to show that in paroxysmal tachycardia we have to deal, not with a single pathological entity, but with at least four groups as follows:—(1) Cases in previously damaged hearts; (2) cases from dysthyreosis; (3) cases with lesions of the central nervous system; and (4) cases of apparently functional character. The condition is characterised by attacks of suddenly appearing tachycardia, lasting ten or fifteen minutes up to five days, ceasing as suddenly as they began. In the attack the heart rate is either double or four times the normal. Cases are described showing how these features may occur in connection with each of the etiological factors mentioned. Most attention is directed toward the so-called idiopathic or functional cases. These were carefully studied by means of tracings in the attempt to explain the occurrence of the increased heart rate upon physiologial grounds. Through these tracings it is made evident that the tachycardia is the result of extra systoles, in some instances apparently originating in the bundle of His and involving only the ventricle, and in other instances by the presence of an auricular wave, more probably originating in the venous sinus. D.

Pathological Tissue Changes after Injection of Alcohol.—Baumgarten (*Berlin Klin. Woch.*, 1907) has made a large number of observations on animals after subcutaneous injections of alcohol. No local necrosis or abscess formation was found at the point of injection. Further, no formation of new connective tissue in the liver or elsewhere was noted. He did find, in many cases, erosions of the mucous membrane of the stomach and intestines. From these experiments the author suggests that alcohol is not a causal, but a predisposing factor, in cirrhosis of the liver in man. D.

Ætiology and Treatment of Lupus Erythematosus.—Macleod (*Practitioner*, Jan., 1908) reviews our knowledge of this disease about which so much has been written since Cazenave first described and named it in 1851. The most generally accepted explanation of its causation attributes it to the action of some local irritant or to the presence of some toxin either generated *in loco* or reaching the skin from some distant focus of disease, and attacking that part of the skin where from anatomical reasons the circulation is naturally weak. The French school of dermatologists, following Boeck of Christiania, believe that this toxin is tubercular, and have classified the disease as a "toxi-tuberculide." There are strong reasons against this teaching, and the evidence in support of it is by no means conclusive. Histologically the lesions differ markedly from those of tuberculosis, and every effort to demonstrate the presence of the tubercle bacillus in the lesions has failed. Attempts to produce the disease by the injection of tubercular toxin have likewise failed, and in several fatal cases careful postmortem examination has failed to detect any evidence of tubercular foci elsewhere. Macleod draws attention to the relation which exists between lupus erythematosus and various circulatory disturbances, such as chilblains and Raynaud's disease, on the one hand, and the toxic erythema of the type of erythema multiforme on the other. Macleod then suggests that lupus erythematosus is not a specific disease, but one which may be brought about by a number of causes in a predisposed individual. It is conceivable that the same toxin acting under different circumstances might produce the lesions of both lupus erythematosus and erythema multiforme. With regard to the treatment by radiotherapy, Macleod has found the Finsen-Reyn lamp much more efficacious than either the X-rays or high frequency. In using this treatment he follows the procedure suggested by Norman Walker, and exposes the skin at a distance of about ten inches from the lamp for half an hour every second day without employing a compressor. K.

Rheumatic Hyperpyrexia in a Child of Six.—Lock (*Brit. Journ. of Children's Diseases*, December, 1907) believes that this is the first recorded case of this complication of rheumatic fever in so young a child. About a year ago the child had an attack of chorea, which, however, got quite well, but left her with a rough systolic murmur which was audible at the apex beat. In September last she had an attack of acute pneumonia, which terminated by crisis on the fifth day. Two days later she had a return of the chorea, followed in three days more by well marked symptoms of rheumatic fever. She was then given five grains of sodium salicylate in an alkaline mixture every four hours, but next day the temperature was higher and further joints were involved. The chorea still persisted, and the dose of the salicylate was doubled. On the following day the temperature rose to 105° F., and ten grains of the salicylate were administered every hour. In the evening of the same day the temperature had risen to 107° F., and an ice pack was ordered, but though the temperature fell two degrees the cold was not well borne, and cyanosis and embarrassment of respiration followed. On the following morning the temperature rose to 108° F., and an hour later to 110° F., when the child died suddenly. The temperatures were taken in the rectum by a trained nurse, and verified by Mr. Lock. During the progress of the case there did not appear to be any fresh development of endo- or peri-carditis, and the swelling of the joints was not very marked. The pulse, though feeble, was never greatly hurried, but the respirations were very frequent and noisily panting in character. The most marked feature was the complete suppression of sweating. There was a plentiful crop of sudamina vesicles from former sweats, but the skin was quite dry and pungently hot throughout.

K.

Calcium Salts in Functional Albuminuria.—Wroughton (*R.A.M.C. Journ.*, January, 1908) records the case of a soldier who was admitted to hospital passing a small quantity of urine containing a considerable quantity of albumin. The patient was kept in bed for several days, and though the quantity of urine gradually increased there was no diminution in the amount of albumin. The patient presented no signs of nephritis, and the urine was quite clear and contained no tube casts. The patient, after four days in hospital, was put on five-grain doses of calcium chloride three times a day. The next day there was a large increase in the urinary water, and a considerable diminution in the quantity of albumin. Two days later the albumin had completely disappeared. This case would appear to corroborate the contention of Wright and Ross (*Lancet*, October 21st, 1905) that the effect of the administration of calcium salts may aid in the differentiation between functional and organic albuminuria. K.

Relationship Between Avian and Human Tuberculosis.—Shattock and others contribute an article on this subject to the *Lancet* for November 23rd, 1907. As a result of their experiments they have come to the following conclusions:—(1) The human tubercle bacillus is pathogenic to the pigeon in a very limited degree only. It sets up no disease of the intestine or of the abdominal viscera when introduced with food into the alimentary canal, and sets up a local, or local and glandular infection only, when injected into the muscles or subcutaneous tissue. (2) The avian tubercle bacillus, as tested from various kinds of birds, is pathogenic to the guinea-pig in a very limited degree. (3) The human bacillus is not convertible into the avian by inoculation into the bird—*i.e.*, the bacilli are not identical. (4) They maintain that, though either bacillus will exhaust the opsonin from tuberculous serum, this is no proof of their identity, as amongst other things the opsonin may be extracted from tuberculous serum by saturation with a thick suspension of melanin. M.

Empyema of the Antrum of Highmore.—Swirschkowsky reports the results of investigations made in 100 cases of empyema of the antrum of Highmore (*Russ. Med. Rundschau.*, Heft. 10, 1907), and formulates them as follows:—(1) Purulent inflammation of the antrum may be set up by a large number of micro-organisms. (2) Empyema is very often primarily due to a pathological condition of the teeth, and in consequence for diagnostic purposes a careful examination of the teeth is essential. (3) The so-called classical symptoms of an empyema, though present in simple cases, are seldom to be found in complicated ones. (4) In diagnosis the greatest weight is to be placed on the finding of a drop of pus under the middle turbinal bone. This is of more value than transillumination, although this last-named method of examination should also be employed. (5) Aspiration is only to be used as a diagnostic aid when all other means have failed. (6) Opening of the antrum is best carried out through the alveolar process, the second set of election being through the socket of the second molar tooth. (7) In carrying out operations for radical cure, the technique of Caldwell is to be chiefly recommended. M.

Treatment of Scarlatina by Rectal Injections of Moser's Serum.—Slatogocour (*Russ. Med. Rundschau.*, Heft. XI., 1907), finding that subcutaneous injections of serum for scarlatina were unpleasant and painful to the patient, has been experimenting with the serum to ascertain whether its beneficial effects were retained when it is given per rectum, and has come to the following conclusions:—(1) The value of the serum is just as great when given per rectum as when injected subcutaneously. (2) The dose required should be the same as when given subcutaneously—that is, from 200 to 300 c.c. (3) Complications are much rarer when the rectal method is practised, and especially the local irritation and swelling of the skin is avoided. (4) The rectal method is specially suitable for children on account of the above-mentioned advantages.

M.

Reflexes in Scarlet Fever.—Rolleston has made a systematic study of certain reflexes in 175 cases of scarlet fever, and has arrived at the following interesting conclusions (*Quarterly Journal of Medicine*, January, 1908):—(1) In many case of scarlet fever the normal plantar response of flexion is temporarily replaced by extension. (2) The severer the case and the younger the patient the more likely is this change to occur, and as a rule the severer the case the longer the duration of this phenomenon. (3) In a few cases all forms of plantar response are abolished. (4) In a large number of cases, whatever the types of response first obtained, there was an interval of varying duration, in which the plantar reflexes were absent. In some cases there was complete absence of this reflex, the muscles of the hip normally concerned in this response being as inactive as those of the foot. In others the hip reaction was brisk, while the muscles of the foot failed to respond. (5) The epigastric and abdominal reflexes are also affected, and the more severe the attacks the greater is the liability of their being affected. They are, however, less frequently affected than the plantar reflexes. (6) The cremasteric response is the briskest reflex of early youth, and is the least likely of all reflexes to be abolished. (7) The knee-jerks were found to be absent in three cases only, all of which were severe. (8) Knee joints attacked at the period of the endo-carditis showed more derangement of their reflexes than when afflicted during other complications of scarlet fever. M.

MEDICAL NEWS IN BRIEF.

Catholic University School of Medicine, Dublin.—Annual Dinner.

On Saturday evening the seventh annual dinner of the Past and Present Students of the Catholic University School of Medicine was given in the Dolphin Hotel. Professor Coffey presided. The dinner was very largely attended, and afterwards various awards were distributed to the students. Dr. Cox then proposed the toast of "The Medical School," to which Professor Coffey replied. In the course of his speech Professor Coffey said, referring to Irish University Education, that the outlook was now more hopeful. The Minister who had taken up this question had taken it up when disheartening circumstances might have excused his interference in it. No one would more readily recognise than they would the courage with which Mr. Birrell faced the problem, and they believed he would do his best to settle this scandal to the government of the country. As to the form of settlement, they had no definite knowledge, but he thought they might say that unless the settlement was to be academic, free, and generous, trusting the people, providing the opportunities which will enable the intellect of Ireland without sacrifice of principle to derive the highest benefits from education in Ireland; to raise the respect for Irish intellect among the civilised peoples of Europe—unless it was possible under the scheme that that should be brought home to the people, he thought he might say that the Catholics of Ireland would not be satisfied with the Bill. Again, in the settlement of the question, unless Mr. Birrell approached it in that generous spirit which would enable him to put himself in the place of the Irish Catholic, and recognise that there was no difference in sentiment or principle between the views of the Irish priest and the Irish layman, the Bill would not secure the support of the Irish people. Having expressed the belief that an educational settlement in the form of the Queen's College system would not give satisfaction, the Chairman concluded by saying that whether a settlement of the University system came or not, the work of their school would go on guided by the same principles, and be carried on with the same enthusiasm as that which had brought it to its present success. (Applause.) Dr. J. J. Fitzgerald (Cork), Dr. O'Farrell, and Mr. Barniville responded. Amongst the remaining toasts were "The Catholic College and Schools," proposed by Dr. A. J. Smith, and "The Guests," proposed by Mr. McArdle, F.R.C.S.

An International Congress of Ophthalmology.

The following gentlemen have constituted themselves into a Committee of Organisation for the XI. International Ophthalmological Congress, which meets at Naples in the spring of 1909:—President, Professor Angelucci; members, Professors Addario, Albertotti, Alessandro, Bajardi, Baquis, Bardelli, Basso, Bietti, Bocchi, Bossalino, Ceraso, Cirincione, de Berardinis, de Lieto Vollaro, Desogus, Falchi, Fortunati, Francaviglia, Frugiuele, Gallenga, Gatti, Gaudenzi, Gonella, Guaita, Lodato, Manfredi, Mazza, Monesi, Orlandini, Ovio, Parisotti, Pes, Petella, Puccioni, Rava, Reymond, Roselli, Santucci, Sbordone, Scalinci, Scellingo, Scimemi, Simi, Sgrosso, Tartuferi, Trombetta, and Valenti.

Following an old-established custom, and as some slight appreciation of their merit, they have conferred the honorary presidency on Professor Marc Dufour, president effective of the Congress of Lucerne, and the honorary vice-presidency on Dr. Landolt, member of the Organising Committee of that Congress.

From the programme elaborated by the preceding Congress, and unanimously adopted by the members thereof, they have compiled the regulations for the XI. International Meeting, a copy of which may be had on application to the English corresponding members. As soon as the final preparations for the Congress are made all other necessary notices and circulars, also particulars with regard to the journey, will be sent to inquirers, and the means by which it is hoped to render pleasant the short stay of the members of the Congress among us.

Intending visitors should inform the English corresponding member (Mr. Walter Jessop, 73, Harley Street, W.) of their desire to be present at the Congress.

Study of Tropic Disease.

At a gathering of Liverpool medical men on Saturday last, Sir Alfred Jones said the work accomplished by the Liverpool School of Tropical Medicine had set the world studying that subject. Liverpool had spent £80,000 in that investment, and there had been no better investment in the world, for it had saved thousands of people, and had brought the death rate in Africa down from 30 per cent. to 2 per cent. That was marvellous, and it would be more marvellous in future. It had enabled Europeans to live in Africa in safety, and enabled that country to get a better class of Europeans. The school was now engaged in investigating the "sleeping sickness." Unless they could check that disease there would soon be no population in Africa.

The Bristol Royal Infirmary Training School for Nurses.

The Committee of the Bristol Royal Infirmary have arranged to establish a preliminary training school for their nurses. Suitable premises have been secured for the purpose, which will be placed under the control of a sister, who will instruct candidates for admission to the nursing staff of the Bristol Royal Infirmary in the various matters pertaining to the profession prior to their being received into the wards. The curriculum is to be a very comprehensive one, and the time spent in this training school should prove of very great advantage to the probationers. The Bristol Royal Infirmary was one of the first three provincial hospitals started about 1735, and the authorities are again showing their progressive spirit by making this the first residential preliminary training school for nurses out of London. Indeed, there are only two such schools attached to London hospitals, the original one at the London Hospital and a more recent one at Guy's Hospital. The Bristol Royal Infirmary is to be congratulated on the step which has been taken.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on the 24th inst., with the following results:—

First Examination Five Years' Course.—Of 36 candidates entered, the following 18 passed the examination:—Michael Joseph Ahern, Probhat Chandra Mukherji, Nripendra Nath Chandra, Anath Nath Palit, William J. M. White, Edward E. W. Shiels, Walter S. Durward, Mrs. Dwarkabai Kamalakar, John N. N. Atkinson, Solomon D. Bridge, Singcha Hoashoo, Krishnarao G. Dhairyawan, Chandiprasad Trivedi, Marcel F. A. L'Hoste, Bhola Nath, Kaithail Koshi Jocab, Charles L. W. Fleming, and Lionel L. Coghlan, and 6 passed in Physics, 2 in Biology, and 1 in Chemistry.

Second Examination, Four Years' Course.—Mr. William Alexander Irwin passed the examination.

Second Examination, Five Years' Course.—Of 27 candidates entered, the following 11 passed the examination:—William Browne (with distinction), Maurice C. Anderson, E. R. Jones, Bikramajit Sahni, Cesar J. Lacayo, Kathleen Reed, Howard V. A. Gatchell, James Blackburn, Charles G. Timms, Chandiprasad Trivedi (with distinction), and Bhola Nath, and 1 passed in Physiology.

Third Examination Five Years' Course.—Of 35 candidates entered, the following 18 passed the examination:—William J. Cogan, Robert W. Pickup, Charles W. Gee, Hugh Millar, Cornelius O'Herlihy, Syed Abdul Karim, Harold Gordon Chouler, Robert Massie, Patrick Reid, Llewellyn E. Davies, MacWilliams Henry, Thomas B. McKendrick, John P. Synnott, Harold H. Field-Martell, Krishnarao G. Dhairyawan, William R. Griffith, and Sidney Sharples, and 3 passed in Materia Medica.

Final Examination.—Of 76 candidates entered, the following 26 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—Robert Dick Orok, John H. C. Hicks, Charles A. Page, Meade L. Ford, Matthew H. Fleming, William C. Doughty, Edmund C. Kinkead, Ethel Adelaide Orchard, Mathew E. Grimshaw, William F. McKenna, Framroz Maneckji Vajifdar, Herbert W. Kerrigan, John Macdonald, Clement H. Heppenstall, Mundkur Shiva Rau, William S. Scheck, William W. McKinley, David Welsh, Alexander H. M. Maxwell, Satischandra Das, Caroline L. Kohlhoff, Zerk D. Lotter, Walter H. Wijenayake, Joseph L. Pinto, Sakharam R. Bhagwat, and George Lindsay Irwin, and 9 passed in Medicine and Therapeutics, 7 in Surgery and Surgical Anatomy, 15 in Midwifery, and 13 in Medical Jurisprudence.

Society of Apothecaries of London.

The following candidates having passed the necessary examinations, have been granted the L.S.A. Diploma of the Society, entitling them to practise Medicine, Surgery, and Midwifery:—A. R. Hardy and W. P. Pinder.

H.M. the King has sent a present of old linen to the Chelsea Hospital for Women.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

AN ANCIENT QUACK.

THE medical libel case, which has set us all thinking about patent medicines, would suggest a pilgrimage to the tomb of Lionel Lockyer, the famous empiric of Charles II.'s time, whose epitaph in St. Saviour's, Southwark, boasts that—

> This verse is lost—his Pill embalms him safe
> To future times without an epitaph.

A pamphlet, issued in 1670, advertises these "Pilulæ Radiis Solis Extractæ," as if they were any modern specific. Seventy-four cases are given, including ingenuously the man who thought ill of them after one box—"All such may keep their money and their diseases, too!"—and the man who "was left incurable, but was cured of a Regiment of diseases, and only by these pills." It is rather sad to see that such enterprise ended on one occasion in the White Lion prison; but the quack was no more loved by the authorities then than now.—*Daily Chronicle.*

LUPUS.—We believe we are correct in ascribing the plan to Professor Senator, of Berlin. He uses gelatine as the only "drug" in the treatment of gastric ulcer. His formula is:—

White Gelatine	50 grammes.
Sugar and Oil of Fennel...	āā q.s.
Water	450 grammes.

A tablespoonful every three hours or more frequently.

VITAL STATISTICS.

LONGEVITY IN EUROPE.—Longevity in Europe, says the American "Medical Record," is distributed as follows:—

Germany, with a population of 55,000,000, counts only 78 centenarians; France has 313 centenarians in 40,000,000 inhabitants; England, 146 in 45,000,000; Scotland, 46 in 4,000,000; Spain, 410 in 18,000,000; Norway, 23 in 3,000,000: Switzerland, 1 in 3,300,000; Denmark, 2 in 2,465,000; Belgium, 5 in 6,670,000; Sweden, 10 in 5,300,000. In the Balkan States the proportion of centenarians is considerable: Servia counts 573 in 2,625,000 inhabitants; Roumania, 1,084 in about 6,000,000; Bulgaria, with 3,300,000 inhabitants, has 3,883 centenarians. It will be noted that Bulgaria has the greatest number of centenarians of all the countries in the world. It is stated that there is about one centenarian to every hundred inhabitants. In 1892 350 centenarians died in Bulgaria.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 29TH.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20, Hanover Square, W.).—5.30 p.m.: Adjourned Discussion on Dr. Edgecombe's paper on Blood Pressure in Spa Practice (introduced by Dr. F. Fox). Mr. T. Hawksley: Exhibition of Blood Pressure Instruments.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. P. J. Freyer: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. W. Langdon Brown: Some Intestinal Intoxications.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

THURSDAY, JANUARY 30TH.

ROYAL SOCIETY OF MEDICINE (NEUROLOGICAL SECTION) (20, Hanover Square, W.).—8 p.m.: Cases. 8.30 p.m.: Discussion on "Tics."

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m.: Card Cases. 8.30 p.m.: Mr. S. Snell: (1) Carcinoma of Orbit; (2) Colobroma of Iris in each Eye occurring in Five Generations. Mr. S. Mayou: Microphthalmia resembling Glioma, with Lenticonus and Hypertrophy of the Ciliary Body. Mr. L. Paton: Optic Neuritis in Cerebral Tumours. Dr. A. J. G. Barker: A Case of Suppurative Tenonitis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. L. Williams: The Bogey of Albuminuria.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture-Demonstration:—Dr. A. J. Whiting: Cases of Aneurysm of the Thoracic Aorta (at the Mount Vernon Hospital Out-patient Department, 7, Fitzroy Square, W.).

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Syphilis: History and Primary Invasion (Constitutional and Local). Eruptions, Erythematous (I., Macular; and II., Maculo-Papular).

FRIDAY, JANUARY 31ST.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. S. Stephenson: Clinique. (Eye.)

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. C. Lockyer: Cancer of the Womb.

Appointments.

BURY, REGINALD FREDERICK, M.R.C.S., L.R.C.P.Lond., Honorary Surgeon to the Warneford Hospital, Leamington Spa.

GLOVER, J. A., M.D.Cantab., L.P.H., Deputy Medical Officer of Health to the Islington Borough Council.

HULBERT, J. G., Major, I.M.S., M.B., B.C.Cantab., Clinical Assistant to the Samaritan Free Hospital for Women.

MACMILLAN, EVAN, M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Strathmiglo District of the county of Fife.

MANNERS, W. F., M.R.C.S.Eng., Clinical Assistant to the Samaritan Free Hospital for Women.

PURNELL, R., M.D.St. And., M.R.C.S., L.S.A., J.P., Member of the Visiting Committee for Shepton Mallet and Bristol Prisons.

SHIRVELL, EDGAR A., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer at the Royal Albert Hospital, Devonport.

SMITH, G. F. DARWALL, B.M., B.Ch.Oxon., F.R.C.S.Eng., Surgeon to Out-patients at the Samaritan Free Hospital for Women.

STUART, FREDERICK, M.B., B.S.Durh., Clinical Assistant to the Samaritan Free Hospital for Women.

SUGDEN, W. A., L.S.A., Clinical Assistant to the Samaritan Free Hospital for Women.

Vacancies.

County Borough of Croydon.—Female Assistant to the Medical Officer of Health. Salary, £250 per annum. Applications to F. C. Lloyd, Town Clerk, Town Hall, Croydon.

Lurgan Union (Ireland).—Resident Medical Officer. Salary, £80 per annum, with apartments, laundry, and first-class rations. Applications to James Calvert, Clerk of Union, Workhouse, Lurgan. (See Advert.)

Leeds Tuberculosis Association.—Resident Medical Officer for the Sanatorium at Gateforth, near Selby. Salary, £100 per annum, with board, lodging, and washing. Applications to Chas. H. Sedgwick, Secretary, 37, Great George Street, Leeds.

County Borough of Salford.—Fever Hospital.—Assistant Medical Officer at the Ladywell Sanatorium, Salford. Salary, £150 per annum, with apartments and board. Applications to L. C. Evans, Town Clerk, Town Hall, Salford.

Borough of Bootle.—Hospital for Infectious Diseases.—Resident Medical Officer. Salary, £100 per annum, with board, washing, and apartments at the Hospital. Applications to the Chairman of the Health Committee, Town Hall, Bootle.

Northampton County Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent, Berry Wood, Northampton.

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors.

County Borough of Great Yarmouth.—Assistant Medical Officer of Health. Salary, £200 per annum. Applications to W. Edgar Stephens, Town Clerk, Town Hall, Great Yarmouth.

Births.

BISS.—On Jan. 24th, at 75, Prince of Wales' Mansions, S.W., to Dr. and Mrs. Hubert Biss—a son.

JACKSON.—On Jan. 22nd, at Woodhouse, Bakewell, the wife of R. Houlton Jackson, M.R.C.S., L.R.C.P., of a daughter.

BARBER.—On Jan. 24th, at 45, Friar-gate, Derby, the wife of Hugh Barber, M.D., of a daughter.

Marriages.

ADAMS—SMITH.—On Jan. 20th, at St. Michael's Church, Oxford, Philip E. H. Adams, F.R.C.S., of Oxford, son of Dr. G. D'Arcy Adams, of London, to Marjorie, second daughter of Rev. A. C. Smith, M.A., of Banbury Road, Oxford.

Deaths.

ANDERSON.—On Jan. 25th, suddenly, Sir Thomas McCall Anderson, M.D.Glasg., F.F.P.S., Hon. Phys. to H.M. the King in Scotland, Regius Professor of Medicine, University of Glasgow.

BIRCH.—On Jan. 24th, at Newbury, Robert Birch, M.R.C.S., L.R.C.P., L.S.A., aged 57 years.

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As a digestive tonic, therefore, 'BYNIN' AMARA is not only safer to take than Easton's Syrup, but is of greater value both in aiding and strengthening the powers of assimilation.

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Nux Vomica Alkaloids equal to Strychnine	$\frac{1}{16}$,,
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DOSE FOR ADULTS—One dessert to one table-spoonful, suitably diluted.

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R. B. Watson, M. D., *Surgeon Pennsylvania Co. and Lockhaven Hospital, Lockhaven, Pa.:* "The results obtained from the use of Valentine's Meat-Juice establish all that is claimed for it. In a case of Phthisis it alone kept the patient alive for weeks, as it was the only nourishment she was able to take."

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, FEB. 5, 1908. No. 6.

NOTES AND COMMENTS.

A Regrettable Error.

WE feel that we owe, and we hereby unreservedly tender, an apology to the *Lancet* and to some of our readers. In our comments last week on the libel case which our contemporary fought so fearlessly, we were made to say in the first line, "We need hardly say that the *Lancet* has *no* sympathetic condolences in the issue of the libel action brought against it by Mr. A. Q. Tucker." What was actually written was "*our* sympathetic condolences," and the proof was so passed for press. Owing to an accident to the type, the sentence had to be set up again at the last moment, and the word "no" was substituted for "our" without reference to ourselves. Unfortunately, a number of copies containing this almost grotesque error were sent out before it was discovered, but immediately we recognised it the issue was stopped, and the whole journal reprinted. Mistakes of course will occur in the best regulated families, but this was a particularly unfortunate one, and the sole consolation we have is that the misprinted copies only reached medical men, who must have observed that there was something wrong. The *Lancet* has our *most* sympathetic condolences on the result of the action, and we trust that the rest of our remarks last week made it sufficiently plain that we have nothing but admiration for the public spirit that actuated it all through the Tucker case.

Free Studentships in Midwifery.

THE modern midwife finds herself, thanks to her enthusiastic but injudicious supporters, in the anomalous position of being "neither fish, flesh, fowl, nor tasty kipper." She has been pitch-forked into the community under a farcical system of "inspection," the inspector often living twenty or thirty miles away from those whom he is supposed to have under his eye, and, as a salve to medical opinion, she is enjoined to call in a medical practitioner when she gets into a tight corner, the medical man giving his services for the love of humanity and in the teeth of his convictions. The most shocking cases of ignorance and neglect come before the Central Midwives Board, and probably many a mother's life is lost through sheer ignorance. Far from recognising that midwifery is a skilled art involving an intimate knowledge of medicine and surgery and one that should only be practised by medical men or trained midwives under the immediate personal supervision of medical men, the supporters of the present system seem bent on raising the midwife, not only to the point of being an independent practitioner, but of an independent authority on her art. At Cardiff, last week, a sub-committee of the Technical Instruction Committee decided to request the medical officer to report on the qualifications of any midwife who, in his opinion, would be capable of training pupils! It appears that the Committee is so "flush" that they wish to found twelve free studentships in midwifery, although a medical member informed them that there are already a sufficient number practising in Cardiff, "and 50 per cent too many." However, in the blessed name of education, the studentships are to be founded, and the holders, we gather, are to be trained by the present ladies in their practice. If such training is to be accepted as qualifying them to be placed on the *Register*, we can only say that we are excessively sorry for the poor mothers of Cardiff.

Free School Certificates.

WE should, we hope, not be suspected of any want of sympathy with elementary education if we express the opinion that the compulsory character of the Act of 1871 is leading the community to many strange positions which it little dreamed of when the Bill was before it. The provision of meals necessarily follows from forced attendance at school, as it is obvious that it is mere folly to attempt to teach hungry children. Equally obvious is it that the State could not indefinitely shut its eyes to the physical defects of children whom it drove to seek knowledge at its school, but who could not acquire it, because of physical disability. Medical inspection has been duly inaugurated, and to ourselves it seems logically to follow that if the system be eventually popular and successful, the State will sooner or later be forced to provide not only medical inspection, but medical treatment for those suffering from defects which idle or careless parents neglect in spite of due warning. Then, too, there is at present the pressing difficulty of school certificates for children absent through sickness. It certainly is not the duty of hospital officials to give such certificates, and when a child is absent from school and not under a private practitioner, no one else can. The attendance officer is in the dilemma of being bamboozled by crafty parents on the one hand, and bringing into the police-court those with a genuine reason for the child's absence on the other. A batch of summonses came last week before Mr. Paul Taylor, who lately earned the eternal gratitude of the medical student, and one woman pleaded that her child was ill, but that she was unable to pay a doctor for his certificate. Mr. Taylor opined that the parish doctor or some official ought to be paid out of the public funds to give such certificates free to the poor, and the attendance officer promised to bring the matter to the notice of the education authorities. There would be no difficulty of any kind if the education authorities would consent to pay a sufficient fee for such certificates. If the information is worth having it is worth paying for, and there is no need for salaried officials to be created *ad hoc*, when there are plenty of private practitioners to do the work. But doubtless, as in all other cases where medical service is required, educational bodies do not see why the certificates should not be given free.

Free Ambulance Lectures.

INDEED, the amount of freedom which is supposed to characterise medical service in every line of life would be ludicrous if it did not have its pathetic side. At the annual meeting of the Middlesborough and Cleveland Centre of the St. John's Ambulance Association last week, the local paper says that it was not "of a very inspiring character, and the report presented was not as encouraging as could be wished." It describes the good work that has been done by the students, but says that finances are not as flourishing as the supporters wish. It adds naïvely that the "prospects are not improved by the possibility of the medical men demanding fees for the instruction of classes." It is only in human nature that the supporters of an institution should become a little lukewarm when there is a prospect of being called upon to pay a little more, but we sincerely hope that the medical men will make the "possibility" of demanding a fee into an undeniable certainty. The work of the St. John's Ambulance Association is undoubtedly useful, but that is all the more reason why it should be paid for at an appropriate rate by those who devote their time, professional knowledge, and skill to its execution. Continuing its report, the newspaper says: "One noticeable feature of the meeting was the fact that it consisted entirely of employers or their representatives." We are left in no doubt, then, as to who the gentlemen are who support the Association's work, and who presumably think it worth while to encourage their employees to learn. It is hard to believe that employers, who are men of business, seriously expect medical men who live entirely by their own personal effort to give up their time for nothing in order to teach their employees a useful art. The medical men, at least, will find the lectures none the less appreciated if the lecturer receives his proper remuneration for his work.

Free Reports on Compensation Cases.

ANOTHER Northern journal, the *Manchester Dispatch*, is grumbling apparently because hospital surgical officers do not furnish free reports on accident compensation cases, and because "it is also alleged that claims for compensation are not too warmly espoused by hospital doctors, and that it is only reluctantly that they give evidence on behalf of sufferers." We admit freely the difficulty which the poor are placed in by being poor. The law is a luxury which society has decided to make as inaccessible to those who work for their daily bread as champagne suppers and trips to Monte Carlo are. It is a cruel grievance that the poor cannot enjoy the same access to the processes of justice as the rich do, but the fault is with society and not with the medical profession. The highest legal skill is not placed freely at the disposal of the poor, even in the case of murder trials, but the highest medical skill is available free for the most trivial ailment. Because medical men have, out of compassion, laid themselves out to serve the poor in time of sickness, it by no means necessarily follows that they should also give up their time and employ their skill to remedy the wrong which society inflicts on the poor in their temporal circumstances. The Government were asked, when the Workmen's Compensation Bill was before the House of Commons, to provide salaried medical practitioners to adjudicate on all claims made under the Act, and they refused. The workman was left to work out his own salvation, and if it is made sufficiently plain that medical men have not the time to spare to examine, report, and give evidence in compensation cases "on spec," it may be that a satisfactory solution will be provided. At present it seems to us that the only feasible plan is for the trades unions to employ their own doctors for their members who meet with accidents and whose claims are disputed. But the matter is not one for private medical charity.

LEADING ARTICLES.

FERGUSSON V. THE MALVERN COUNCIL.

LAST week an important case was settled in the King's Bench Division by a judge and jury. The action was brought by Dr. John Campbell Fergusson against the Malvern Urban District Council to recover damages under somewhat peculiar circumstances. The plaintiff owned a hydropathic establishment in Malvern. In May, 1905, an outbreak of enteric fever took place in this establishment, involving no less than fourteen persons, several of whom died. As the result of subsequent litigation Dr. Fergusson was called upon to pay £7,000 in compensation and damages on account of the infection incurred at his institution. He thereupon entered an action to recover damages from the Urban District Council, on the ground that the outbreak was caused by the pollution of the water supply by sewage under the control of the Council, which thereby became responsible. The drinking water came from the Tudor Well, and the jury, when asked the specific question by Mr. Justice Lawrence, found that the plaintiff had no property in the water flowing from that source into his tank. The point is of much technical importance, as an appeal against the subsequent verdict fixing responsibility on the Council may be based thereon. The plaintiff's allegation was that the drinking water at his establishment had been polluted by sewage negligently allowed by the Council to escape from their sewers. The defendants denied that they had negligently allowed sewage to escape from the sewer, and pleaded that even if such escape took place it was not the actual cause of the outbreak, which was rather due to the bad sanitary appointments of the hydro. They further said that in law the plaintiff had no cause for action, as he had no proprietary right in the water which was said to have been polluted by sewage, nor had he obtained any licence to take it. After a long and patient trial the jury found that the Council were guilty of negligence in permitting sewage to escape from their sewer, but that the plaintiff was not guilty of contributory negligence. They further found that the escape of sewage was the only cause of the outbreak, and that the state of the drainage of the house was not concerned, while the infection could not have been avoided by any reasonable care on the part of the plaintiff. Damages they assessed at £7,500. Although the responsibility of local authorities for polluting water has been established in various trials, there do not appear to be any cases in which responsibility has been fixed upon them for polluting a private supply of drinking water, as in the present instance. That is of course a different circumstance from the pollution of streams or watercourses, which, by the Public Health Act of 1875, local authorities are expressly forbidden to pollute with sewage. Indeed, the recognition of the absolute necessity of the preservation intact of our drinking water supplies lies at the root of any sound national system of public health administration. The work of the sanitarian, however, is far from complete in this direction. A vast deal of sewage is poured into our streams and rivers, and the metropolis of the kingdom, with its vast population, is for the most part supplied with water that has been grossly contaminated. The whole country, in short, is urgently in need of a new and stringent Act for the prevention of pollution of streams and rivers. The main difference between the United Kingdom and a country like India, that is ravaged by pestilences of various kinds, lies in the relative purity of the home drinking water supplies. Jamaica, formerly one of the most deadly of tropical stations, has now become a healthy island, with good water supplies. In advancing this general statement it should be added that a better system of sewage disposal is connected with improved drinking water supply. So far as the Malvern trial is concerned, it will be of inestimable value in attracting the attention of local authorities throughout the kingdom to a due sense of their responsibilities in the control of sewage. Should the Malvern decision be upset on appeal it is reassuring to note that the only ground of appeal is on an issue of proprietary right in a particular supply of water, and not the question of the responsibility of a local sanitary authority to keep its drains watertight.

THE DIMINISHING BIRTH-RATE.

The chief point about the national birth-rate is that it still diminishes, and the vexed questions raised by philosophers, sages, and moralists remain unsolved. The annual report of Sir William Dunbar, Registrar-General of Births, Marriages and Deaths, has been issued for the year 1906. In the years 1900-1902 the rate of fertility amongst married women in England and Wales was, with the exception of France, lower than that recorded in any European country. That this diminution is in some part due to the modern inclination of mothers to limit the production of offspring appears to be borne out by the official figures. While on the one hand the number of births decrease, there is no evidence that marriage is becoming unpopular. So far from that, the marriage-rate in 1906 was 15.6 per 1,000 of the population, a point that compares favourably with its predecessors for the past two decades. The exception occurred in the year 1899, when the rate was 16.5 per 1,000, and the years 1896 to 1902, when the matrimonial market appears to have been remarkably brisk. Compare with these figures the number of marriages in 1886, which was only 14.3, or that of 1893, when it was 14.7. The diminution of births, therefore, is clearly not due to fewer marriages. Of other explanations that have been advanced, one that has been repeatedly advanced is that marriage is being postponed to a later age. The tendency exists, it is true, but figures seem to show that it is nothing like so important a factor in the situation as its advocates would have us imagine. From the Registrar-General's figures we learn that in ten years there has been a rise of 0.44 per cent. in the age of bachelors marrying, and of 0.34 in the corresponding age of spinsters entering into the marriage state. Translated into terms of everyday life, these percentages simply mean that the average bridegroom going to the altar for the first time is five months older than he was ten years ago, and the average bride four months older. The mean age of brides who have not been married before is 25½, while that of bridegrooms under a similar condition is rather over 27. One remarkable fact is the steady decrease which has been going on for years past in re-marriages. This circumstance may perhaps be partly accounted for by the decline in the death-rate and the consequent longer duration of first marriages. As regards the central feature in the position disclosed by the Registrar-General, there can be little question as to the vital import to the nation of the diminishing birth-rate. In spite of the attention that has been bestowed upon this point by many competent observers during the past few years, it cannot be said that any satisfactory solution has hitherto been advanced. If the diminution in the increase of population be a sign of decadence, then we, in common with other civilised countries, have arrived at a stage of lessened collective prosperity. On the other hand, it might possibly be conjectured that mankind is acquiring a sounder view of the scientific aspects of his duties in the reproduction of his species. His sense of responsibility to his offspring may be undergoing some profound, if unrecognised, change whereby he is growing more cautious in the discharge of his marital relations. The morality of parents procreating children whom they are unable to bring up under decent conditions as to food, clothing, and education, is surely open to question. Yet it is the principle, differing only in degree, which has, in all probability, determined the decreased birth-rate which has for years past produced so remarkable a result among the middle classes of the United Kingdom. The whole subject is of a complex nature. It bristles with fallacies and involves a host of considerations, moral, social, physical, and economic, some of them of a most obscure and controversial kind. In view of the vital importance of the matter to the community, it is to be hoped that competent scientific authorities will take up its consideration in a calm and scientific spirit. In various ways the question is intimately concerned with that other great national problem, excessive infantile mortality. It may be that the diminishing number of births on the one hand will be more than amply compensated on the other by the better preservation of the young of our population who are now so ruthlessly sacrificed to the imperfections of their environment.

CURRENT TOPICS.

"Printers' Errors."

It is understandable that the average man should tear his hair and run the gamut of wild emotions when he finds his choicest copy "disfigured"—as he terms it—by fantastic printers' errors. Possibly if he were more closely acquainted with the inwardness of the situation, his soul would be moved to pity rather than to anger. The occupation of printers' readers, operators on linotype machines, and of compositors is conducted in quarters that are often crowded, noisy, malodorous, and ill-ventilated, and where the hours of labour are often necessarily prolonged by overtime. There is the additional risk of lead-poisoning from handling the type, an acquired condition that leads to anæmia and ill-health of a mild but chronic nature. Then, again, the glare of some modern types is extremely fatiguing and, we believe, injurious to the eyesight of all concerned. Under these circumstances of physical drawback it is a marvel that so comparatively few errors occur in the unceasing torrents of printed matter that daily flood the world. The printer is undoubtedly in many instances the scapegoat for bad handwriting or worse composition. We would suggest that a Royal Commission might possibly discover some method whereby the path of a future generation of printers might be made smoother, and the pillow of many an editor and journalist cleared of its crumpled rose leaves.

A Bath-room Tragedy.

THE Coroner for South-West London, Mr. Troutbeck, last week inquired into the circumstances attending the death of a late inmate of Chelsea Workhouse Infirmary. By an oversight of the bathman the deceased had been left alone in the bathroom for about two hours, an exposure which, in the opinion of the jury, accelerated death from "natural causes," There are several points worthy of attention arising from this inquest, which, by the way, took place some time after the death, and the body was actually exhumed. The Coroner, distrustful for some reason or other of the powers of the local medical practitioners, called in the services of his "expert" pathologist, Dr. Freyberger. His report was that the cause of death was heart failure, while the deceased was suffering from acute inflammation of the lungs, and acute relapse of chronic inflammation of the kidneys. In view of the history of the case he was further of opinion that the treatment in the bath-room would accelerate the man's death. Facts and inferences of this nature would surely have been attested to by medical practitioners of the district, who have discharged their duties with efficiency and credit from time immemorial. In summing up the Corner remarked :—"This man's death has been accelerated by an inexcusable mistake. The infirmary has been allowed to get into a state where there is carelessness and loose working on the part of many people, from the highest to the lowest. I hope that what has come out in evidence will be sufficient to cause a serious inquiry as to whether there can be a great amendment in the working of the infirmary." So strong an expression of opinion must clearly have been founded on previous experiences of the working of the institution. We are of opinion that the Local Government Board would do well to make a searching inquiry into the administration of the whole of the Metropolitan Poor-law Infirmaries.

The Trade in Tuberculous Meat.

THE potential cost of the bad butcher to the State by way of the disease he scatters broadcast is simply incalculable. It is impossible to say that the tubercle bacillus is effectually killed by any ordinary process of cooking, and it follows, therefore, that the flesh of tuberculous cattle, if used for the food of man, carries with it the active germs of infection. These propositions being granted, it remains for sanitary authorities to exercise to the utmost whatever powers they may possess to stamp out the trade in tuberculous meat. It is to be feared that in many districts the new gospel has not penetrated, and farmers and butchers place their pernicious wares on the market without fear of punishment. On the other hand, it is reassuring to find that vigorous steps are being taken to repress the traffic. Last week, for instance, the Mitcham Medical Officer of Health, Dr. Fegan, instituted a successful prosecution against a local butcher who had a badly diseased tuberculous cow in his possession. Previous offences were proved against the defendant, who was sent to prison without the option of a fine. As a matter of fact, public opinion has not yet been educated to the proper attitude on this important subject of the identity of bovine with human tuberculosis. Many educated persons are found ready to advocate in public the opposite theory, and the former difference of opinion amongst medical authorities on the point is still grasped at eagerly by those interested in maintaining the present order of things.

Teething Powders.

IT appears to be somewhat the fashion nowadays to make light of the warnings of the medical profession against patent and proprietary nostrums, and to announce off-hand that their motives are those of self-interest. If there be any directly selfish motives in the matter, the average man in the street would assign them with little difficulty to the newspapers and the patent medicine proprietors who reap so golden a harvest out of this questionable traffic. Take the one point of so-called teething powders. As a matter of fact, no such specific medicament exists, or can exist, in the nature of things as known to scientific medicine. Many of these nostrums contain morphia and many others calomel, and there need be little hesitation in agreeing to the general proposition that a great many children are killed every year by the use of "teething powders." As all medical men know, morphia is a peculiarly deadly drug when administered to infants and children. Why should an ignorant drug vendor be permitted to distribute his perilous morphia-laden wares wholesale when the practice is condemned utterly by medical science? The City of London Coroner was not far off the mark the other day when he remarked that if he had the power, he would make it a criminal offence to put morphia into teething powders. Another frequent source of danger in these catchpenny remedies is the slow conversion of a portion of the contained calomel into corrosive sublimate. To the presence of the latter irritant, rightly or wrongly, is attributed many of the convulsions in babies associated with the adminstration of popular teething powders.

The Origin of Cancer.

ANYTHING that may possibly throw any light on the origin or the cure of cancer deserves to be regarded seriously, for the true light may eventually come from the least expected quarter. At the same time, it may be admitted that there is hardly any malady around which has gathered from time to time a more plentiful crop of theories that have not withstood the tests of time and experience. The parasitic nature of cancer is a fascinating conception to many minds, and some of our most experienced scientific investigators have published observations that led to the hope of a solution of the problem of the etiology of this most baffling disease. A further contribution in a similar direction has been made by Dr. Ford Robertson, pathologist to the Scottish asylums. The rod-shaped bodies he describes in malignant growths are revealed on microscopic examination only after staining by a special method. Should these observations be confirmed, the door will be opened into a new area of investigation. Whatever the final solution may be, all believers in the progress of science will retain an unshaken conviction that the full knowledge of cancer will one day be delivered into the hands of man. Meanwhile, the day of complete illumination would be immeasurably hastened were the State to endow scientific research with ample funds, so that all theories of *primâ facie* value could be subjected to absolutely rigid and unbiassed investigation.

University Education in Ireland.

The announcement in the King's Speech that Parliament will this Session be asked to consider a measure "to extend and improve University education in Ireland" will be received with satisfaction by most of those who are interested in educational questions in Ireland. There are, of course, some who will be opposed to any change, but most people will agree that the present unrest is almost worse than any fixed system, however faulty. As no contradiction has appeared, we may presume that the Bill, when it appears, will be something on the lines recently laid down by the Provost of Trinity College. That is to say, Dublin University will be left untouched, and the Royal University will be re-constituted, and will consist of four colleges—the three existing Queen's Colleges and a new college to be established in Dublin. Whatever be the faults of the scheme—and doubtless many will be discovered—it at least has the advantage over previous schemes, that it will not arouse a fierce opposition. It provides for a development of existing institutions along the line of least resistance. If, consequent on the establishment of the new college, the present hostility of a large proportion of the population toward Trinity College and the Queen's Colleges may disappear, the gain to the cause of Irish education will be enormous. We hope that the low position of the Bill in the list of measures in the King's Speech does not mean that it is in danger of postponement to another session.

The Place of Public Health in Municipal Government.

Judging the matter from an entirely detached standpoint, one would think that there was nothing more important in municipal concerns than the health of the citizens. In consequence, one might conclude that there were few matters of greater moment in municipal management than the care of the public health, but we fear that this view does not commend itself to many of the members of our municipal boards. An instance, in itself quite unimportant, but well illustrating the attitude of the community toward public health questions, occurred the other day in one of the suburban townships of Dublin. A gentleman, elected for the first time to the Council, after a few days wrote to the papers complaining of the treatment given him by his colleagues. He had expected, he said, to be put on some of the important committees of the Council, but instead he found a place on one committee only, and that an unimportant one—the Public Health Committee. It is difficult to imagine any sentiment more completely unfitting a man for such a position as this gentleman holds, but we fear that he does not stand alone in his contempt for the most important asset of any community. In a few places a more enlightened spirit prevails, but in matters of public health we fear that Ireland still lags far behind the rest of the Kingdom.

PERSONAL.

Mr. Charters Symonds delivered the Lettsomian lecture of the Medical Society on February 3rd, on "Tuberculosis of the Kidney"; and on February 17th and March 2nd he will lecture on "Malignant Disease of the Cæcum."

Professor R. Tanner Hewlett has been appointed Milroy Lecturer for 1909 at the College of Physicians of London.

At the same College, Dr. J. A. Ormerod has been appointed to deliver the Harveian Oration on October 19th of this year.

Dr. William Carter, who, on his retirement, was entertained at dinner by his professional and other friends on January 18th, was presented with his portrait in oils on that occasion.

The Bradshaw Lecture will be given in November this year by Dr. William Pasteur.

A special meeting of the Sunderland Health Committee was held on January 28th, to meet Dr. Manby, inspector of the Local Government Board, who is making a systematic survey on behalf of the Local Government Board of the ports of the Kingdom.

Dr. Leonard Guthrie will deliver the FitzPatrick Lectures of the Royal College of Physicians of London.

Dr. T. S. Edwards, of Edinburgh, has been awarded the Murchison Scholarship, founded to perpetuate the memory of Dr. Charles Murchison, and awarded alternately by Edinburgh University and the Royal College of Physicians of London.

Professor William Osler, M.D., F.R.S., Regius Professor of Medicine at Oxford, and Dr. Arthur Latham, Physician to St. George's Hospital, have been chosen to fill vacancies on the council of the National Association for the Prevention of Consumption.

The following Fellows of the Royal College of Physicians of London have been elected members of the Council of that body:—Dr. E. E. Herman, Dr. D. W. Finlay, Dr. N. I. C. Tirard, and Dr. W. P. Herringham.

At the 25th annual dinner of the Sanitary Inspectors' Association, held on Saturday night at the Hotel Cecil, Sir James Crichton-Browne, the President, occupied the chair.

At the thirteenth annual dinner of the Mirfield and District Medical-Chirurgical Society, held at Batley Town Hall on January 20th, Dr. J. D. Doherty, of Batley, this year's President of the Society, occupied the chair.

The Somerset Education Committee have appointed Dr. Stevenson, of Walthamstow, as Medical Inspector for the county, at a salary of £500.

A CLINICAL LECTURE
ON
GENERAL SURGICAL TECHNIQUE.

By W. I. de COURCY WHEELER, M.D., F.R.C.S.I.,

Surgeon to Mercer's Hospital, Dublin.

GENTLEMEN,—In recent years surgeons have not thought it necessary to write or lecture extensively on the subject of general surgical technique, regarding it as a question already settled in principle, though varying in detail with individual workers. Yet I venture to think that, by adopting such an attitude, the profession may fall into the same error as Ambrose Paré in the year 1597, who claimed that he had so far perfected the art of chirurgery that there was nothing left for posterity "but a certain small hope to add some things."

To-day I intend to elaborate the principles and practices you have seen for some years adopted in this hospital, touching on many points, rather than labouring the various theories on the question of asepsis *versus* antisepsis, or to discuss in detail any of the matters bearing on surgical technique. Many volumes have been published on each of the subjects to which I intend to refer, and extensive details would be of no advantage to you, even if time permitted, in such a lecture as this. When you commence to operate you will be puzzled at first by the different pathways surgeons follow in order to gain the same end, and when you have imitated many methods which appear scientifically sound, you will gradually adopt a technique of your own, by following which the best results will be obtained. It is a mistake to adopt slavishly any single method of operating, for in the hands of one it will bring forth ideal results, but will bring discredit on the work of others. Whatever routine you follow, let it be based on scientific principles sufficiently weighty at least to satisfy your own mind, distinguishing such scientific principles from "fads" with which surgical literature abounds.

Asepsis and Antisepsis.—The indications for the use of antiseptics in modern surgery are becoming less, and if you have followed the various surgical cases to the theatre, you will have noticed that the use of them is conspicuous by its absence. Even in septic cases, such as compound fractures, the liberal use of normal saline solution has completely replaced the old reliance on antiseptics. Mechanical rather than chemical principles underlie the purification of the skin, surgical cleanliness being accomplished by thorough scrubbing of the hands with soap and running sterilised water, followed by the application of ether and alcohol. Neither of these latter are used as germicides, though alcohol when diluted has an undoubted antiseptic effect. This treatment of the skin is in keeping with true aseptic principles, the ether and alcohol acting mechanically by removing the fat and hardening and dehydrating the skin. Whatever preparation is preferred for the hands of the operator must be as rigorously carried out in the case of the skin of the patient, though in the latter it is well to dispense with the use of the nail-brush lest the skin be irritated and the healing of the wound delayed. It is absurd to lay down any definite time required for cleansing the hands; it depends entirely on the condition of the skin and the vigour with which each individual proceeds to wash.

The watery solution of bin-iodide of mercury has been replaced by an alcoholic solution, and with this the hands are often treated when the commercial alcohol is not available. Anyone who uses alcohol in the preparation of the hands gets a sense of cleanliness which no other chemical imparts. Other more complicated methods are also scientifically effective in the preparation of the hands; for example, Harrington's solution of alcohol, hydrochloric acid, and corrosive sublimate used for some months, but was abandoned owing to the injury done to the floor of our theatre when it was splashed, and to its irritating effect on the hands. It must not be supposed that antiseptics of an unirritating kind are in any way harmful to the uncut skin, but they can be dispensed with, and once the incision is made, it is hardly necessary for me to remind you that no antiseptic will kill pathogenic organisms in the tissues. Any inhibition which they produce is counterbalanced by a proportionate inhibition of the vitality of the leucocytes and of the karyokinesis which precedes cell division. "Antiseptic washing and douching can, therefore, only be occasionally justifiable when the chemical injury caused by it is more than counterbalanced by the infective material destroyed." For these reasons the instruments (after being sterilised dry in the steam steriliser with the dressings) are lifted out, wrapped in a towel, and arranged on a table covered with sheets for the operation. They are not allowed to stand in carbolic or other lotions lest the tissues should be impregnated with an irritant every time an instrument is used. Furthermore, it is a contradiction to keep polished sterile instruments in an antiseptic solution when the wound and the hands of the operator can be safely exposed to air infection. In a modern theatre air infection has been proved to be negligible; but lest an air infection be converted into a contact infection during a prolonged operation, the instruments can with advantage be washed occasionally in saline solution. It is scarcely necessary to say that dry polished instruments are less likely to become infected than the wounds, or the hands of the operator. The large majority of septic cases arise, not from air infection, but from either contact or implantation infection. By contact infection is meant, for all practical purposes, the use of unclean instruments or hands; implantation infection is usually brought about by the burying of improperly sterilised silk.

Ligatures.—The sterilisation of and the whole question of the use of ligatures requires careful attention, in order to avoid such dangers as implantation infection, stretching of scars causing ventral herniæ, and other untoward results to which I will presently refer.

The substances you have seen used are silk, catgut, aluminium bronze wire, silkworm gut, and Michel's skin clips.

In almost every abdominal case the buried sutures have been of fine silk, catgut being only used in cases where asepsis could not be assured or when pus was actually present. You will recollect a series of appendix cases where fine silk was used to ligature the stump, and throughout the operation, and in contrast to these you have an illustration of the treatment of fulminating appendicitis in a case last year in the female ward in which every buried suture was of catgut. In the male ward two patients side by side, one a nephrectomy for tubercular disease, and the other a case on whom nephrolithotomy was performed for the removal of several renal calculi, illustrate a class of cases where it is difficult to decide whether silk or catgut should be used. In the first case the kidney was the site of multiple abscesses, and though tubercular pus may, as a rule, be considered sterile, a mixed infection is often present, and in all cases the resistance of the tissues against unavoidable infection is much lessened. Here, then, was a case where the renal artery, vein, and ureter required ligature. Any failure in the catgut would result in hæmorrhage, while the use of silk followed by infection entailed a very prolonged convalescence, the closure of the wound being delayed until the silk was either removed or came away spontaneously. I used silk in this case with the result I have mentioned. In the nephrolithotomy case micro-organisms undoubtedly accompanied the formation of the stones; yet it was tempting in the absence of visible sepsis, after uniting the kidney with catgut (here silk is contra-indicated, lest it predispose to the formation of fresh calculi) to bring the muscles together with silk, and so to guard against lumbar hernia. Here, again, it would have been better had I used catgut throughout, as the silk became infected and gradually presented, and was pulled away. Both cases have left hospital quite well after a somewhat prolonged canvalescence.

Silk.—The great advantage in the routine use of silk, especially in uniting aponeuroses in abdominal cases, is the mechanical support which it gives as distinct from absorbable catgut. I have been fortunate enough never to have experienced ventral herniæ after a laparotomy, with the exception of a case on which the Talma-Morison operation was performed for the cure of hepatic ascites, but the nature of this operation prevents proper closure of the abdominal wound.

Kocher, referring to the question of ventral herniæ, asepsis and suturing, says:—"But we can go still further and say that those who cannot bring themselves to employ permanent sutures, and who rely on absorbable catgut for buried sutures, can never hope to obtain as firm a closure of a wound as can be got with a buried organic non-absorbable suture."

In some instances aluminium bronze wire may with advantage supplement buried silk or replace it. In a large ventral hernia, after a laparotomy performed elsewhere, this material was used to bring the widely separated margins of the linea alba together, and the radical cure of an inguinal hernia was accomplished by the use of the wire in a patient who has just left the hospital. One or two boilings of silk may not render it sterile unless it be extremely fine, so, wherever practicable, the preparation of silk should entail an immersion in ether for twelve hours, in alcohol for twelve hours, and afterwards boiled and stored in 1—1000 corrosive sublimate, a second boiling being given immediately prior to operation.

Catgut.—Even when catgut is sterilised by a reliable method, its durability and strength often remains in doubt. The time in which catgut of given strength will be absorbed in such various tissues as the peritoneum, intestines, muscles and aponeurotic structures, is still a matter of uncertainty. I demonstrated to you one of the fallacies of a continuous catgut suture in the case of a girl from whom I removed a large cartilaginous foreign body from the knee-joint. On the second day after operation, owing to the mysterious disappearance of a small drainage tube, I re-opened the wound lest it had slipped into the joint unobserved. Though this was found not to be so, the following observation was noted:—"The continuous catgut suture which was used to unite the capsule and synovial membrane was found to have become absorbed at about the middle, rendering the entire suture loose and useless."

Probably, the simplest and most satisfactory way to sterilise catgut is that which I have now on trial. The raw catgut is rolled on glass slides and immersed for eight days in a 1 per cent. solution of iodine. It can be removed and washed in a little sterilised water or saline solution immediately prior to use. The catgut may remain in the iodine for a couple of weeks, but after that it becomes unreliable, and so, to save waste, any surplus remaining after the eight days' immersion may be stored in alcohol. The solution is made by dissolving a little potassium iodide in water, adding some powdered iodine and filling up the vessel to make a 1 per cent. solution.

Gloves.—I need not detain you long on the subject of the use of gloves. Most surgeons use them in septic and aseptic cases; yet they are not a necessity, bacteriological investigation having shown that the hand becomes spontaneously germ free, if not constantly exposed to reinfection. Such a leader as Kocher is not wedded to them, and Stiles does not use them. I have seldom operated without gloves, and I believe, under the conditions we are compelled to work, they are a great prophylactic measure against infection. Some surgeons are more careful to use gloves between operations when examining and dressing infected cases than at the actual work in the theatre. Kocher goes so far as to say:—"If a doctor finds it impossible to avoid loading his hands with pathogenic organisms, then he must leave operative surgery to others; but we do not see why a doctor who wishes to operate should not put on gutta-percha gloves when he has to make a digital examination of the mouth, throat, vagina, or rectum, or when he has to touch an unclean wound——" You have seen this principle adopted in the wards. Gloves are used in dealing with septic cases, and sterilised towels or sheets are employed for the dressings, whether in clean or infected cases, just as is done in the operating theatre. A punctured glove is worse than useless. They should not be worn too well fitting; the constant elastic pull, as the fingers unbend, becomes tiresome. Gloves may, if preferred, be sterilised dry in the caddies with the dressings after being well powdered. When the hands are dried by treatment with alcohol, and the gloves sterilised in this manner, any leak that may occur from a prick of a needle or tear from a sharp fragment of bone during the operation, is not of so much moment, for now the leak is from the wound into the glove, and not in the reverse direction, as is the case when the gloves are filled with fluid to facilitate the entry of the hand. The glove should always be immediately changed, and the hands washed, if a tear occurs during an operation. Gloves complete the aseptic costume of the operator by being pulled over the ends of the long sleeves of a sterilised coat, so that no part of the arm is exposed.

Large sterilised sheets cover over the entire patient, and are fixed to the skin immediately round the area of operation by minute skin clips made after the pattern of the American bullet forceps used in gynæcological operations. These clips, which, unfortunately, are seldom properly made in this country, pinch the sheets and skin together without leaving a mark, and without causing pain even in a conscious patient. Formerly the sheets, if in the close neighbourhood of the incision, were apt to slip into the way. By means of these forceps this is now avoided, and a minimum area of skin need only be exposed.

Anæsthetics.—To obtain success in surgical cases the question of the most suitable anæsthetic to employ must be given due attention. Chloroform should not be used as a routine unless by skilled anæsthetists, and is then only advisable in children, in aged people with chest ailments, and where more perfect relaxation of the abdominal muscles is needed than can be obtained with ether. In giving chloroform be careful to stop the administration during such procedures as the dilatation of the sphincter ani, the grasping of the prepuce with forceps prior to circumcision, and whenever the patient struggles or holds his breath. In all these cases the patient may unexpectedly take a deep inspiration, and, if the chloroform is pressed, receives an overdose. Always give the chloroform well diluted with air, remembering that cyanosis is a danger signal, and that disasters from chloroform anæsthesia have often occurred after the first few breaths.

Ether you may safely give after a little practice, chest complications being the greatest fear, but these can be avoided by giving a minimum dose, having a clean apparatus, and by care in the transference of the patient to or from the theatre, the head being, as a rule, covered with a blanket to prevent inspiration of the cold air of the passages after, say, an hour's operation in a very warm theatre. You have seen recently ether by the open method administered to my operation cases, the last patient, a thin, fragile woman, having a fracture of the upper end of the femur. The ether was given by a continuous drop on to a Skinner's chloroform mask, the latter being packed round with wool and gauze so as to prevent unnecessary evaporation and dilution. The absence of cyanosis and after sickness was remarkable, but the time taken to put the patient under, and the amount of ether used, was, however, rather excessive. In a case of a plethoric individual addicted to the use of alcohol, we were obliged to resort to the Clover's mask to produce narcosis, and to continue by the open method. Ether by the open method is ideal in those patients where one hesitates to give chloroform, and fears the bronchitis following the use of a closed apparatus.

LOCAL ANÆSTHESIA.

It is with the question of local anæsthesia that I wish specially to deal. You have seen a large number of cases operated upon after a novocain injection, including hernia, hydrocele, varicocele, varicose veins, removal of lipomata, sebaceous cysts, enlarged bursæ, circumcisions, hammer toe, ganglia, and almost every operation which comes within the category of minor surgery. There are two methods commonly employed to produce local anæsthesia; the one, the infiltration method you have seen most employed, the other, the regional method, is sometimes superior. The solution used has been until recently made by dissolving the commercial novocain-adrenalin tablet in 7 drachms (25 cc.) normal saline solution or water. This makes a ½ per cent. solution. Lately, half this strength has been found adequate, and so for general infiltration work I recommend you to use a tablet dissolved in 50 cc., or about 14 drachms—*i.e.*, ¼ per cent. solution. A very fine needle, supplied by Smith and Sheppherd, Stephen's Green, about a finger's length, is attached to a glass syringe of 10 cc. capacity, so that the needle lies at right angles to the syringe and horizontally as regards the skin. Suppose, now, it is desired to remove a varicose vein. The needle is passed into the subcutaneous tissue along the course of the vein; the solution is then injected, keeping the needle pressed against the under-surface of the skin during its gradual withdrawal. While the needle is being withdrawn, the novocain is introduced *pari passu* in the manner mentioned. If the vein is not visible, it is well to mark its position with a little iodine solution or a scratch with the knife immediately before the injection, for fear that when the injecting needle is removed, there will be no indication where the incision is to be made, and it is imperative that the latter should correspond exactly with the site of the injection of the anæsthetic. As many as three tablets may be used with impunity—that is to say, 150 cc. of ¼ per cent. solution—but such an amount is never required. After an experience of three years I have nothing but praise for novocain as a local anæsthetic. It lacks the toxicity of cocain, and has all its advantages. Novocain solutions can be boiled without deleterious effects (the adrenalin will not stand boiling), and so a porcelain capsule and a spirit lamp are useful adjuncts to the appliances already mentioned. A solution of novocain may be used instead of the tablets, to which a few drops of adrenalin may be added after boiling.

There are some patients who bring discredit on local anæsthesia—those nervous, hysterical cases which we occasionally meet with more frequently in men than in women. Thus I brought you into the theatre the other day to demonstrate the failure of local anæsthesia in a man whose finger required amputation. The stroke of a blunt-nosed forceps caused excruciating pain! The operation was completed under general anæsthesia. But this case and one other—a woman with a ganglion on the wrist—are the only two failures I can remember. Undoubtedly the use of local anæsthesia entails more trouble to the surgeon; the tissues must be divided with accuracy; no pulling or tearing or indiscriminate grasping being permissible. For these and other reasons disappointment is often felt by those beginning extensive local anæsthesia work, but everything requires practice, from the insertion of a stitch to the performance of the most intricate surgical operations. Amputations of the fingers and toes are better performed by the "regional anæsthesia" method—*i.e.*, injecting in a strong novocain solution (1 per cent.) into the course of the digital nerves proximal to the site of amputation, and waiting about 10 minutes until the finger distal to the injection becomes anæsthetised. This is a very effective method, and the operation can be performed quite painlessly. Again, if the same solution be injected into the ulnar nerve behind the inner condyle of the humerus, or as near to the nerve as can be gauged, the distribution of that nerve will become anæsthetic in a few minutes, a nerve block occurring and preventing the transmission of afferent or efferent impulses for over an hour. Regional anæsthesia may be supplemented by infiltration of the tissues to be divided. Patients are grateful when an operation can be performed without a general anæsthetic; it often means, not only the disappearance of that dread with which so many yield to unconsciousness, but they can with advantage eat a good breakfast before operation, enjoy their meals later on, and can even assist the surgeon by changing their position to suit his requirements. It is remarkable to hear men telling stories and discussing current events while varicose veins, for example, are being removed.

It is unwise to discuss the question of local anæsthesia with the average hospital patient; it should be adopted as a matter of course, and it is also unwise to allow assistants or nurses to question the patient during the operation as to what sensations they experience; you will very soon be informed of the fact if your work becomes painful. Occasionally the patient can tell when a knife and when a needle is being used, but without experiencing pain.

I must refer you to the excellent work of J. W. Struthers for all the details on the subject. Local anæsthesia is now following Continental practice more extensively in this country. The question of spinal anæsthesia, also, is full of fascination, but time does not permit me to discuss the relative advantages and disadvantages of the method.

Prior to the discovery of novocain, a ½ per cent. solution of cocain was used for infiltration anæsthesia, but now, if cocain is employed, a 1 in 500 normal saline solution with adrenalin is found sufficient. Cocain and novocain differ from the majority of other local anæsthetics, such as β eucain, in having an almost instantaneous effect when infiltrating the tissues. I am aware that many authorities state that a delay of a few minutes is necessary when using novocain, but that is not my experience unless where regional anæsthesia is employed.

Crushing of Pedicles.—The use of angiotribes (histotribes), or crushing forceps, in operations was advocated by Kocher, and Doyen, working independently. They showed what great advantages were to be gained by the powerful crushing of pedicles before applying, or instead of applying a ligature. Last month you saw in a thyroidectomy case the isthmus of the gland thus treated, as also the stump of an appendix; the turning back of a peritoneal cuff being so much waste of time. If the crushed stump be tucked into the colon and thus covered with peritoneum, it is the most rapid and effectual method. I have demonstrated to you how crushing an appendix divides the mucous membrane as if with a knife. In fact, all the tissues are divided by powerful crushing except the fibrous tissue which is surrounded by the ligature. The division and retraction of the mucous membrane in this manner disposes of the necessity of cauterisation with, say, pure carbolic acid; a ligature is applied to the crushed portion, and the appendix cut away immediately distal to it. You remember, after removal, I have shown you many times how if a crushing forceps be applied to the appendix, and you then lay it open with a pair of scissors, you find inside the mucous membrane sharply divided and retracted, and the crushed portion consists of nothing but fibrous tissue, forming a snug groove for the application of the ligature. It is a common fallacy to suppose that necrosis is produced by crushing; certainly, in intestinal work it would be impossible to produce necrosis by powerful crushing; the tissues are, on the contrary, with the exception of the fibrous tissue, divided as with a knife. You have seen the sacs of herniæ crushed, the stumps after resection of varicoceles, the ends of the intestine after resection, and prior to lateral anastomosis. This is the most rapid manner too of closing the intestine; a powerful crushing forceps is applied, a silk ligature secured round the crushed portion, and the stump beyond the ligature inverted and covered by circular or a few Lembert sutures. This is the best manner, also, to treat the proximal end of the duodenum in the operation of pylorectomy, where it is decided to perform gastro-enterostomy and closure of the remains of the stomach. Wherever a large pedicle is to be divided, first crush it, for this procedure reduces its size to a minimum, and forms a groove for the ligature which prevents the possibility of slipping.

There is scarcely an operation in which a crushing forceps cannot with advantage be made use of. It must be powerful to be effectual, and should be at hand as a matter of routine for every operation.

Saline Solution.—In conclusion, I will remind you of the many advantages gained by the general adoption of the use of saline solution, not only for the mechanical purification of infected wounds to which I have already referred, but in abdominal surgery. In bad cases of septic peritonitis arising from perforated gastric ulcer, gangrenous appendix, strangulated hernia, and the numerous other conditions with which you are familiar, great reliance should be placed on the continuous injection of saline solution combined with the Fowler position. I will explain the *rationale* of this treatment in a moment. In almost every abdominal case the use of saline injection into the tissues or into the rectum are accompanied by the greatest gratification to the patient. Thirst is effectually diminished; the nurses seldom, since the use of saline is adopted as a routine, draw attention to the thirst which patients were wont to suffer. In infected cases the toxins by this treatment are eliminated by increased diuresis, sweating, frequent action of the bowels; and by reversing the peritoneal lymphatic flow, their entrance into the circulation is impeded. At the same time the pulse tension is maintained, the tongue becomes moist, the facies Hippocratica disappears, and the mortality has been reduced in an astonishing way under its influence.

Some years ago I brought from Kocher's clinic in Berne the flask which you have seen so frequently used in the administration of saline solution, either into the tissues or into the rectum; this flask has more recently been adopted by Moynihan and other surgeons. It consists of a glass graduated vessel with a litre capacity into which fits a tight rubber cork with three holes. Through one passes a large thermometer, and the other two are traversed by glass tubes, one for the outlet of saline solution, the other for a corresponding inlet of air. From the former passes a rubber tube, about three feet long, to which is attached the hollow needle used for intra-cellular transfusion, or in the case of administration per rectum, a long flexible leaden tube perforated at the sides, lest fæces block the terminal orifice. This apparatus can be sterilised, complete, and during use the exact temperature of the solution can be read off; and maintained or diminished by placing the flask in a basin of water at the required temperature. By altering the water in the basin the temperature of the saline solution in the flask can be varied.

Sometimes during an operation involving much hæmorrhage, or the loss of a considerable amount of fluid as in cases of ascites, saline is allowed to slowly flow into the cellular tissue of the axilla or the outer side of the thigh, the flask being supported on a douche stand. After bad abdominal operations both axillæ are infiltrated through the needle with saline solution from the flask to the extent of about one pint into each armpit. When the patient revives after the anæsthetic, the long leaden tube is passed well up into the pelvic colon, and saline solution is allowed to trickle in, drop by drop, as recommended by Murphy; it is absorbed as quickly as it enters, and very large quantities are thus consumed. The flask need only be raised a few inches above the level of the patient's pelvis to promote sufficient flow. The temperature of the saline is kept constant at about 110° F. by renewing the hot water in the basin in which the flask stands. In children this continuous saline administration is not suitable, the sensation of the inflow into the bowel gives rise to an impulse to pass it out, and so the saline is not retained. In these cases, for example, the patient in the children's ward on whom I performed an emergency laparotomy for perforated colon following tubercular peritonitis, the method failed, and instead, abandoning the flask, we administered, at frequent intervals, intracellular injections simultaneously into both thighs by means of two needles attached to a funnel.

I think, after every abdominal operation, a saline should be administered as a matter of routine, but in acute suppurative cases the administration should be continuous for several hours and repeated after a short interval. In these cases, also, the Fowler position should be adopted, the patient being placed semi-sitting, so that the pus present may gravitate from the diaphragm towards the pelvis, from a position where absorption is rapid to a position which is fairly tolerant to the presence of pus. In this connection the manner in which cases are removed from, or to, the operating theatre is of primary importance, the direction of least resistance for the gravitation of the pus must be the pelvis where drainage tubes are provided for its exit.

In many cases other than abdominal, such as pneumonia following operations, extensive burns and all the affections producing toxæmia, frequent administration of large quantities of saline solution have afforded, for the reasons mentioned, most gratifying results.

Closure and Dressing of the Wound.—Michel's clips are always used where there is no tension. The angles of the incision are held up by means of two sharp hooks; the edges are then squeezed together with the finger and thumb of the left hand, and the clip inserted. Two forceps should be employed for the introduction of these sutures, the sister loading one while the other is actually in use. By this means, after a little practice, the closure of a wound becomes very rapid. Metal clips which are too pliable are worse than useless. I have had endless trouble in obtaining the correct variety. I have tried, and abandoned, the use of complicated self-loading instruments. Where it requires tension to bring together the edges of an incision, continuous silk or interrupted silkworm gut sutures are preferred. In uniting the abdominal parietes in young children, a single layer of the latter is used, but first each silkworm gut suture, following the fashion of Stiles, is passed through the finest possible piece of rubber tubing about an inch long. When the suture is tied, the tubing lies across the line of the incision, and prevents a transverse mark or cutting of the skin. The tubing is useful in these cases, for a single layer of sutures should remain undisturbed for nearly three weeks. The wounds are all dressed in the following manner:—A piece of folded gauze the length of the incision, and about a finger's-breadth, is laid along the incision over the sutures. This is held in position by a single layer of the same material which covers it and extends beyond it on all sides, and is painted lavishly with collodion with an ordinary sterilised paint brush. The collodion does not come into contact with the wound, but secures the dressing, and makes a very aseptic and reliable covering. Wool and a bandage may be added in certain cases, but, as a rule, are not required. Iodoform steeped in collodion (1-1000) is always at hand for wounds which are in danger of subsequent infection, such as hernia in children. The iodoform dries on the wound, and mechanically prevents the entrance of micro-organisms.

In all matters affecting technique it is necessary to have the co-operation of the nursing and resident staff, and in this I have been fortunate, for without the aid of our recent House Surgeons, especially Dr. Hunt and Dr. Arthur Knapp, the theatre sister and the nurses generally, I could have accomplished nothing.

There are many other points to which I would like to refer, but the time at our disposal is already at an end.

NOTE.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Cuthbert Lockyer, M.D., B.S., F.R.C.S., Out-Patient Physician, Samaritan Hospital for Women, Obstetric Physician in Charge of Out-Patients, Great Northern Hospital, etc. Subject: "Cancer of the Uterus."***

THE KING has sent a present of pheasants to the Chelsea Hospital for Women.

ORIGINAL PAPERS.

NOTE ON
THE PATHOGENY OF DIABETES.

By S. A. ARANY, M.D.,
Carlsbad.

Since Claude Bernard discovered in 1855 that the lesion of the calamus scriptorius of the fourth ventricle is followed by the appearance of sugar in the urine, the authors of that and the following decades were unanimous in considering diabetes as being caused by some pathological changes in the brain or in other parts of the nervous system. Further researches have shown that the puncture operation causes a decided diminution of the glycogen contained in the liver, and glycogen flows off in the shape of glucose with the urine. In starving animals whose liver does not contain glycogen, the puncture cannot produce any glycosuria. Bernard's experiment proves undoubtedly the influence of the nervous system upon the liver, but, on the other hand, injury to the liver without the puncture is also apt to produce glycosuria, and Murchison ("Clinical Lectures on Diseases of the Liver") points out the connection between cirrhosis of the liver and diabetes. Naunyn ("Der Diabetes Mellitus"), confirming Murchison's view, claims that, out of 426 cases of diabetes, in 109—viz., in more than 25 per cent.—enlargement of the liver was present.

Almost a century previous to Bernard's famous puncture, Cowley called attention to a serious case of diabetes in which partial atrophy of the pancreas was present, and he therefore claimed the diseased condition of the latter organ to be the cause of diabetes. Cowley's opinion was shared by many others, but it was not till the year of 1889 that it was corroborated by Mehring and Minkowski's ("Archiv. fur. Exper. Pathologie and Pharmacologie," XXVI.) experiment of extirpating a dog's pancreas, and this resulting in a diabetic condition of the animal. Minkowski's experiment has been tried by several authors, and they have found that only the total extirpation of the pancreas is able to produce a diabetic condition; whereas if even a very small portion of the organ is left behind no diabetic symptoms appear. This discovery led the authors to the belief that the assimilation of carbohydrates must be due to some function of the pancreas, which if in a diseased condition gives rise to diabetes.

The kidneys are supposed to be a third source of sugar, and although this has by no means been confirmed, a good many German authors—and amongst them Naunyn—are strongly in favour of this theory. It was the diabetic condition of animals injected with phloridzin which led to the belief that the kidneys themselves are able to produce diabetes. Animals thus treated pass a good deal of sugar with their urine, and at the same time there is no trace of hyperglycæmia present, whereas after the puncture operation and the extirpation of the pancreas, the glycosuria was always accompanied by hyperglycæmia. Having this fact in view, the authors concluded that the source of the sugar must be in the kidneys.

This may or may not be the case in phloridzin diabetes, but if we go through the literature of kidney troubles, we find that there are only solitary cases of kidney disease followed by the appearance of diabetes. Moreover, we find—and even Naunyn confirms this fact—that Bright's disease is very often a complication of diabetes, and soon becomes the predominant ailment, whereas glycosuria gets reduced to almost nil. Noorden ("Handbuch der Pathologie des Stoffwechsels"), who takes a more doubtful view as to the existence of renal diabetes, thinks that in the so-called renal diabetes the kidneys cease to be "sugar-proof" (*zuckerdicht*), and may thus be instrumental in producing glycosuria.

Mention must also be made of Blum's researches ("Nebennierenglycosurie Deutsch. Archiv. für Klin. Med.," 1901) to the effect that an extract of the suprarenal capsules is apt to produce glycosuria. Herter and Richards ("On Glycosuria Following the Injection of Adrenalin," *Med. News*, 1902) have shown that Blum's extract is but adrenalin, and Noorden cites a case of glycosuria which has been brought on through the administration of adrenalin, and rightly ascribes the glycosuria to the toxic action of the drug.

According to present-day knowledge, the organs which are instrumental in producing diabetes—or, to use the German author's expression—the diabetogen organs, are the following:—(1) The brain and the nervous system; (2) the liver; (3) the pancreas; (4) the kidneys; (5) the suprarenal capsules.

Now, everyone who had to deal with a large number of diabetic cases, and was fortunate enough to see his observations *intra vitam* confirmed by post-mortems, will admit that in a great majority of the cases the diabetogen organs are found to be either normal, or pathologically changed in a lesser degree, and which changes might possibly be brought on by the disease itself—viz., by the hyperglycæmia. If it were not for the presence of the hyperglycæmia, the cases in which no pathological changes are present could be styled, with the German authors, as renal diabetes, as, according to them, the very existence of glycosuria with no changes in the other diabetogen organs is, *ipso facto*, renal diabetes, whether there are or are not diagnosable changes in the kidneys. Be this as it may, the existence of glycosuria without hyperglycæmia seems to be very unlikely. Our tests for this latter are almost unreliable, and the non-existence of hyperglycæmia at the time of the test does not necessarily prove that it did not occur at all. Besides, we are far from knowing the exact amount of sugar contained by normal blood. It is doubtless that diabetes is always accompanied by hyperglycæmia, which in its turn is responsible for glycosuria. The non-existence of the former in phloridzin diabetes cannot be considered a proof to the contrary; it only tends to show that phloridzin does not produce any discoverable changes in the blood, although other toxins, as curara, morphine, strychnine, carbo-oxide, etc., produce hyperglycæmia. Autopsies of the literature show that lesions of the fourth ventricle and of the nervous system in general are very rarely the cause of diabetes, although we are all aware of the fact that the nervous system is undoubtedly involved in the pathogeny of diabetes. Mention has already been made of the connection between kidney disease and diabetes, and as far as liver complaints are concerned, we know that cirrhosis of the liver and gall-stones do not infrequently coincide with diabetes; but, on the other hand, there are far more cases of liver disease in which glycosuria cannot be traced. The liver of diabetics shows, as post-mortems reveal it, either no changes at all, or, if there are any, they are mostly of a cirrhotic nature, although fatty degeneration is not of infrequent occurrence.

As far as the glycogen of the liver is concerned, the amount of the same is just as often found decreased as normal, and if Frerich's experiment ("Zur Kenntniss des Meuschlichen Glycogens") of testing the glycogen of diabetic patients, *intra vitam*, is to be trusted, the amount of glycogen is usually diminished in diabetes.

Pathological changes of the pancreas occur more frequently, and they are only too readily looked upon as the producers of the disease. In the majority of cases these changes prove to be atrophic, and it remains to be proved whether this latter is not of a secondary origin. How little importance has to be attached to the diseased condition of the pancreas is clearly defined in Hale-White's "Diseases of the Pancreas and Diabetes" (*Lancet*, March, 1903), in which the author points out that, out of 142 cases of pancreas disease, only in 19 cases was diabetes present. Since Minkowski's experiment of extirpating the pancreas, nobody will doubt that the pancreas has something to do with producing diabetes, but the experiment does not entitle us to state that the pancreas is to be looked upon as the seat of the ailment. We know that brain tumours are apt to produce optic atrophy, but it does not necessarily follow that every optic atrophy is due to a brain tumour. The physiological functions of the pancreas are far from ascertained, and all we know about this gland is that it plays an important part in the assimilation of carbohydrates. In what way this function is performed is, in spite of the many theories of various investigators, quite obscure. The theory of an internal secretion performing the act of assimilation seems to be the most likely, and Minkowski's experiment is also in favour of it. Neither experiments on animals nor post-mortems give any clue as to how this function is controlled in diabetes, and all we can conclude from the post-mortems is, that in about 1-5th of the diabetic autopsies some pathological changes are found in the pancreas, but, in contrast, to these, there are a vast number of cases of pancreas disease in which no diabetes was traceable *intra vitam*. Does this not entitle us to suppose that the pathological changes of the pancreas in diabetes are of secondary origin—*i.e.*, brought on by the disease itself.

Whether there are, or are not, pathological changes in the diabetogen organs, whether this or that organ may be involved, one fact holds good—viz., that, at all events, hyperglycæmia is present. Hyperglycæmia is the direct cause of diabetes, and is even in such cases established in which the glycosuria has disappeared. Therefore, the theory of renal diabetes appears to be quite illusory, and there is no doubt that also in these cases there is an excessive amount of glucose in the blood, and if the investigators could not establish it, that is solely due to the inadequacy of the methods, and to the fact that opinions differ as to the exact amount of sugar contained by normal blood. This latter amounts, according to Pavy's investigations, to 1.5 per cent., whereas Naunyn and Noorden put it below 1 per cent., and I am strongly convinced that in certain cases even much lower values may be looked upon as hyperglycæmia, and in other cases values above 1 per cent. may be regarded as normal, as the limit between the two depends upon the individual case.

Taking it for granted that the hyperglycæmia is the cause of diabetes, the question arises, "What is hyperglycæmia due to in human diabetes?" Bernard Claude's famous puncture, and Minkowski's operation, only show how we are able to produce hyperglycæmia, and where to look for the centres which are responsible for the control of carbo-hydrates. But what about such cases in which our pathological knowledge cannot discover any appreciable changes in those centres? Is it not obvious that even if we can't disclose the changes, such must be present? And is it not probable that if the changes cannot be proved anatomically, they could possibly be established by bacteriological and chemical methods? Is it not more than likely that the hyperglycæmia is a certain kind of toxæmia brought on by some unknown bacterium?

We have seen that the administration of phloridzin produces glycosuria without hyperglycæmia, but, on the other hand, we also mentioned that some chemicals, as morphine, strychnine, etc., are able to produce temporary hyperglycæmia, and we don't think we are going too far in presuming that there must be a toxin which is responsible for the causation of human diabetes. This toxin, which for brevity's sake we beg to call glycotoxin, is most likely produced by a bacterium which may or may not be present in the digestive organs of healthy individuals, and which, if brought under favourable conditions, is instrumental in producing the glycotoxin. The action of the glycotoxin cannot be uniform, and necessarily depends upon the virulence of the toxin. In the alimentary or mild form of diabetes, as other authors call it, or in the first stage of the disease as I ("The Treatment of Diabetes Mellitus," *Medical Press*, March, 1905, and "Diabetes and Its Treatment," *The Indian Lancet*, May, 1905) call it if the glycotoxin represents the lowest degree of virulence, and its action consists in destroying to a greater or lesser extent the glycolythic ferment of the pancreas and in producing the condition known as hyperglycæmia, this action of the toxin is very likely of a local and purely chemical character, and seems to depend upon the ingestion of carbo-hydrates. The withdrawal of these latter surely attenuates, and in some cases probably annihilates the virulence of the toxin, which also accounts for the possibility of a cure.

In other cases the symptoms of diabetes diminish for a more or less protracted period, to resume again with greater violence, which shows that the toxin has increased in virulence, and the disease represents the grave form, or, as I ("Dietary in Diabetes and Gout," *The Medical Press*, January, 1906; "Some Points in Diabetes," *The Lancet*, February, 1907) call it, the second stage of diabetes. At this stage of the disease the sugar contained by the blood is not only derived from the carbo-hydrates ingested, as we know that the withdrawal of the carbo-hydrates is not followed by any appreciable reduction of the hyperglycæmia, but also and chiefly from the breaking down of bodily tissue, which is proved by the presence of oxybutyric acid.

This catabolism speaks undoubtedly in favour of the toxic nature of the disease, and so do the acidosis and its consequence—the diabetic coma. The oxybutyric acid appears not only in diabetes; we also meet with it in various infectious diseases, as Külz ("Beiträge zur Kenntniss der B. Oxybutter-säure Zeitschr.-für Biologie," Bd. XXIII.) has shown it, and no doubt can be entertained that its appearance in the blood is due to reduced oxydation, which latter is, it goes without saying, also responsible for the hyperglycæmia. This course seems to be quite clear if we bear in mind that most toxins produce reduced oxydation, and as far as acids are concerned Naunyn ("Der Diabetes Mellitus") and others have proved it that besides retarding the oxydation, acids are also apt to produce glycosuria. It is, therefore, highly probable that the glycotoxin's action chiefly consists in producing acids of some kind or the other, which in their turn are responsible for the retarding of the process of oxydation.

We know that the assimilation is but a process of oxydation, and this seems to be largely dependent upon the alkalinity of the blood. Now, if the alkalinity of the blood is being reduced by the glycotoxin, the glycolithic ferment will, as a matter of course, be either partially or totally prevented from performing its action, and the condition known as hyperglycæmia ensues. The fact that in the alimentary form, or, as I call it, in the first stage of the disease, oxybutyric acid cannot be traced, does not necessarily imply that the hyperglycæmia is not due to the reduced alkalinity of the blood, as the absence of oxybutyric acid does not exclude the presence of some other acids, which our inadequate methods of blood-testing so far could not precisely establish.

The toxic nature of the disease is most clearly proved by the so-called acute cases which terminate fatally through coma in the course of a few weeks, and sometimes in a few days, and which I suppose to be produced by the glycotoxin of the greatest virulence.

The acidosis attains its height in the condition known as diabetic coma, which, according to present-day conception, is due to the action of the oxybutyric acid upon the blood. Whether this action is due to the oxybutyric acid only, or to its derivants, the diacetic acid and acetone as well, has not been decided yet, although Albertoin and Pisenti ("Azione dell' aceton e dell' acido acetacetico. Arch. d. la scienz. med.," XI., 1887) have shown that even as large doses of acetone as 2 drachms per diem could not produce symptoms of intoxication in rabbits by the continuous administration of the above dose for three weeks. On the other hand, Walter ("Uber die Wirtenng. der Säuren im tierischen Organismus. Exp. Path. Archiv. 7, 1877) succeeded in producing typical coma in rabbits through the administration of large doses of hydrochloric acid, which experiment justifies the supposition that the oxybutyric acid is not necessarily the only producer of coma, and in case of the improvement of our present methods of blood-testing, I should not be at all surprised to hear that the oxybutyric acid is only a derivant of an acid of far greater virulence than the former.

An unmistakable proof of the toxic nature of diabetes is Roque, Dévic and Huguenecq's experiment ("Coma diabetique, Revue de Médecine," 1892), but it is to be regretted that they only took the acidosis into consideration. The above authors injected the blood of a comatose patient into the veins of rabbits, and produced thereby toxic symptoms of the utmost severity; whereas if they increased the alkalinity of the blood injected, the toxic symptoms appeared to be of lesser intensity. Lépine succeeded in crystallising a substance ("Diabète produit par toxines uriques") from the urine of diabetic patients which, if injected into veins of dogs, possessed the quality of producing glycosuria. It would have been of great interest if these authors had investigated the toxic action from a bacteriological point of view, and it is more than likely that researches in this direction will sooner or later establish the bacterial nature of diabetes.

The fact that the diabetic blood, if its alkalinity has been increased, acts less toxically, does not imply that the blood acts only through its acidity as a toxin. All of us who have had to deal with cases of diabetic coma well know that the administration and intravenous injection of alkali are able to delay the appearance of coma, but cases in which these drugs could prevent the appearance of coma are not described in literature. On the other hand, Riess ("Coma diabetram sine diabete Zeitschr. für Klin. Med.," Vol. VII.) and others have described typical cases of coma in carcinoma, pernicious anæmia, and other diseases, in which emaciation takes place, and in which diabetes has been excluded, and it is a very well-known fact that profuse bleeding also produces a condition which is quite identical with diabetic coma. Taking all this into consideration, one arrives at the conclusion that coma must be produced by some changes in the blood, and it becomes quite evident that it is not only the reduced alkalinity of the blood to which the coma is ascribable, as such is surely not the case in coma produced by bleeding. The fact that carcinoma and pernicious anæmia are able to produce coma admits the supposition that also in diabetic coma there must be a toxin of far greater virulence than that of the organic acids found in the blood of diabetics, and which toxin not only reduces the alkalinity of the blood, but also produces some changes in the blood corpuscles, as is surely the case in pernicious anæmia.

The question of diabetes being a contagious disease has been discussed by various authors, and Boisumeau ("Diabète des mar., Gazette hebd.," 1897) mentions 101 cases of diabetes of married couples, and Schmitz ("Kann. der Diabetes übertragen werden?" *Berl. Klin. Woch.*, 1890) refers to 26 patients who have seemingly enjoyed robust health until they acquired diabetes through friendly intercourse with diabetic patients. Still more interesting is Naunyn's case ("Der Diabetes Mellitus"), referring to a young lady who stayed for a time with friends—*i.e.*, a married couple, both of whom were sufferers from diabetes, and acquired the disease, which, however, assumed only a transitory character. I myself have also had 10 married couples suffering from diabetes in my care, but am rather doubtful as to the contagious nature of the disease.

As far as heredity is concerned, it must be admitted that it is to be traced in at least one-fifth of the cases of literature, and everybody who sees a good deal of diabetic patients has had occasion to treat several members belonging to one and the same family for diabetes. However, this fact must not be misunderstood, as it does not signify that diabetes, as such, is hereditary; it only allows of the supposition that there must be a predisposition for diabetes in certain families. This predisposition, which, as we know, is not peculiar to diabetes only, but plays a very prominent part in tuberculosis as well, may be transmitted from parent to child. On the other hand, in four-fifths of the cases heredity cannot be traced, and there are also many instances in which the descendants of diabetic parents never showed any symptoms of diabetes, which entitles us to assume that, although it cannot be denied that there is a diabetic predisposition in certain families, diabetes may attack anyone whose constitution does not prove resistant against the toxin of diabetes.

The almost general belief that Jews are more prone to diabetes than the other races is by no means justified, and originates from the fact that we consulting physicians see a good many cases belonging to the Hebrew faith. This is, however, no criterion for a just percentage. Everybody having an international practice must have noticed that the lower classes of Jews are, very likely owing to their great intelligence, more mindful of their health than the lower classes of other nations. My international practice has shown me that if a very poor Polish Jew notices the first symptoms of diabetes, he immediately sees his local doctor, and if this latter advises him to go to Carlsbad, he is quite willing to do so, even if he has not got more than 40s. in his pocket. On his arrival at Carlsbad, he would inquire and find out the name of "the best doctor" in town, as he feels sure his case requires the advice of "the greatest authority," no matter whatever his fee is, as the Polish Hebrew is quite aware of the fact that no authority can make him pay. This ambition to get well by all possible and impossible means accounts for the seemingly large percentage of Jewish cases, but it is a quite erroneous idea that Jews are more prone to diabetes than other races.

In summing up the facts we have discussed in the present treatise, one arrives at the following conclusion:—That, whereas lesions to or the removal of some of the so-called diabetogen organs are apt to produce diabetes in animals, in the majority of cases of human diabetes there are no changes in the diabetogen organs, the chief feature in common between the two kinds of diabetes being in the hyperglycæmia only, which condition can also be produced by certain alkaloids and acids. It has further been pointed out that the appearance of acids in the blood of diabetics is a simultaneous phenomenon of the disease, and as physiological researches have proved that the appearance of acids in the blood retards the process of assimilation, the loss of the assimilation of carbohydrates in diabetes is probably due to the appearance of such acids. It is also highly probable that the production of these acids is effected by a toxin produced by some unknown bacterium which may or may not be present in the system of the healthy individual, and which, if brought under favourable conditions, is apt to produce human diabetes.

In spite of the fact that there are a few cases in literature in which diabetes attacked married couples, and, in spite of the evidence of some authors that in certain cases the contagious origin of the disease seemed to be traced, it would be too early to allege that diabetes is a contagious disease, as the number of cases referred to is diminishingly small in proportion to the very much larger number in which contagion could not be traced.

In conclusion, it must be admitted that, although there is a so-called diabetic predisposition in certain families, diabetes, as such, cannot be inherited, and the belief that certain races are more prone to it than others is also quite erroneous, and is only due to misjudged statistics.

LETTSOMIAN LECTURES, 1908.

TUBERCULOSIS OF THE KIDNEY. (a)

By CHARTERS J. SYMONDS, M.S., LOND., F.R.C.S.,

Surgeon to Guy's Hospital.

After paying a tribute to the memory of Dr. Lettsom, and thanking the Council for the honour they had done him in requesting him to deliver the lecture, he explained that the object of the first lecture was to relate the particulars of cases illustrating the early signs of renal tuberculosis and the effects of the operations performed.

Of the early symptoms the first to which attention was called was that of renal colic. A typical instance was the case of a young lady of twenty, who had the first attack two years before, the second a year after the first, and the third just before she was seen. In the interval she had been in apparently good health. Albumin was found to be present three months before she was seen, together with a little pus in the urine. The case was looked upon as one of renal calculus. Tubercle bacilli were examined for specially after the X-Rays gave a negative result, and were found. The cystoscopic examination showed tuberculosis of the bladder round the right ureter, with swelling of the ureteric orifice, the left side being healthy. On this evidence the right kidney was removed, the ureter being left, partly because the patient had recently suffered from an attack of scanty urine; partly because she was delicate and it was unwise to prolong the operation; and, finally, for fear that prolonged narcosis might be injurious in the presence of inadequate renal action.

(a) Abstract of Lecture I, delivered before the Medical Society of London, February 3rd, 1908.

The kidney showed an old tuberculous centre in the lower pole, evidently of long standing, with fresh miliary tubercles in the cortex and in the pelvis. Under tuberculin treatment this patient has completely recovered.

To further illustrate this initial symptom. A patient of 46, who had been out of health for two years, with no localising symptom, had a sharp attack of renal colic, followed by vesical irritation. He had a second attack in every way typical of renal colic, and it was thought that a small calculus had passed into the bladder. Nothing being found on examination, the urine was examined for bacilli, and these were found in fair numbers. The cystoscope showed a healthy bladder, with prolapse and œdema of the right ureteric orifice. The kidney, being removed, showed old cicatricial disease with marked contraction of the lower pole. This evidently was of long standing, and probably explained the early malaise. There was recent miliary tubercle in the cortex and in the pelvis. All the bladder irritability disappeared after the operation.

Next, vesical irritation as the only symptom was illustrated by the case of a young woman who had this trouble alone for twelve months, varying in intensity. There was no unilateral kidney pain. The bladder was found by the cystoscope quite healthy; the lips of the right ureteric orifice were swollen and marked by small white elevations. The kidney was removed and showed extensive disease of the lower half, with fresh clumps of tubercle in the cortex and the pelvis. The ureter was removed at the same time, and a rapid recovery followed, with immediate disappearance of all the symptoms.

In a lady of 40 the only symptom complained of for at least two years, and possibly for five, was from time to time an abdominal uneasiness, hardly amounting to pain. This sensation occurred chiefly in the night, lasted about an hour, was followed by a bad night's rest and a day of lassitude. Nothing was found on examination. Subsequently vesical irritation began, and later tubercle bacilli were found. Search was specially made for these because of the large amount of albumin in the presence of a little pus. In this case the bladder showed miliary tuberculosis and tuberculous ulceration near the right ureteric orifice, but the margins of the aperture were normal and the efflux of urine clear.

On this evidence tuberculin treatment was carried out, but without improvement. After ten months' treatment the patient suddenly became ill with high temperatures, rigors, passed a large quantity of pus, and developed a large painful renal tumour. Nephrectomy was performed, the ureter being left. The kidneys showed several cavities filled with pus; obliteration of the greater part of the pelvis with one ulcerated channel leading from some of the larger cavities to the ureter. The appearance suggested long duration and a recent communication between the pus cavities and the ureter.

The last case related was that of a lady of 30, who, after more than a year's vesical irritation, without any renal pain, was seized with rigors and hyperpyrexia. Coming under Mr. Symonds' care, after two months' illness, she was found very emaciated, delirious, and exhibited all the signs of septicæmia. The urinary tract being suspected, an abdominal exploration was made, and the left kidney found to be somewhat enlarged. Exposed and incised through the loin, pus was evacuated, followed by subsidence of all the symptoms. After a time the kidney was removed, and proved to be tuberculous. The loin, sinus and bladder symptoms persisting, the whole ureter was removed, and the patient made a complete recovery, being at the present time (ten years from operation) quite well.

The principal points commented upon in the lecture were the necessity of examining the urine in cases of renal colic in young people; the importance of vesical and urethral irritation as a symptom of renal disease, and especially of tuberculosis; again, that renal tuberculosis should be suspected when the amount of albumin in the urine is of greater amount than can be explained by the pus.

A special tribute was paid to the value of the cystoscope, and reference was made to papers read before the Society by Mr. Hurry Fenwick, and the lecturer acknowledged the help he had obtained in this regard from Mr. Pardoe.

Charts showing the opsonic index in two of the cases, where the tuberculin treatment had been carried out by Dr. Eyre, were also exhibited, together with lantern slides and water-colour drawings of the kidneys removed, as well as the specimens themselves.

SOME NOTES ON

INFANT FEEDING. (a)

BY HUBERT ARMSTRONG, M.D. VICT., CH.B.; M.D. LIVERPOOL;

Assistant Physician, Liverpool Infirmary for Children.

THE subject of infant feeding is a very extensive one, and with the time at my disposal limited, my intention now is only to touch upon one or two points which have been impressed upon me by a growing experience at the Liverpool Infirmary for Children, and to which I hope it will not be a waste of your time to listen.

Now, before a medical audience, I should like to leave unsaid that though there are many imitations, and many so-called foods that are very far from being imitations, there is no real substitute for the mother's milk. But the fact remains that in my experience cases are not infrequent where, according to the mother's statement, the infant has been taken from the breast under medical advice on what have appeared to me entirely insufficient grounds. I lay stress on the "according to the mother's statement," because it may so easily be a perversion of the truth. So many women only want the excuse to refrain from this somewhat irksome duty that, when consulted by one for the first time, I am sure it is better not even to mention the possibility of weaning, for fear of one's words being twisted to suit her inclinations. If the mother thinks her child is not thriving on the breast, have the infant weighed, and the weight recorded, regulate the woman's diet and habits, and—most important—the frequency with which she suckles the baby. This, of course, should be two-hourly during the first month, every two and a half hours during the second and third, and three-hourly subsequently. Too prolonged intervals, commonest among the upper classes and women who have to go out to work, render the milk too watery, tax the infant's staying powers, and are just as bad as too frequent nursing, a common fault among the poor and a very potent source of infantile dyspepsia. Haste must also be avoided: each feed should take from fifteen to twenty minutes. Constantly the insistence on regularity in these matters, particularly the frequency, is all that is needed to convert a whining, fretful baby into its mother's delight by day and the father's joy at night, while an increase in the weight will both gratify you and justify your resolution not to be responsible for unnecessary weaning.

(a) Read at a meeting of the North Wales and Lancashire and Cheshire Branches of the British Medical Association, at Chester, on April 10th, 1907.

Let us suppose a loss in weight, or some other legitimate reason for weaning; what is to be done? Now, if you read the latest and most up-to-date works on infant feeding, you would be led to imagine that there is but one hope for the alimentary salvation of such a child (putting aside the nowadays extinct "wet-nurse"), and that lies in a more or less complicated mixture, manufactured in a laboratory specially devoted to the purpose. This is the sort of prescription you must write:—

℞ Fat	3.25	per cent.
Lactose ...	6.50	,,
Whey proteids	0.75	,,
Caseinogen ...	0.40	,,
Alkalinity ...	5.00	,,

Eight feeds of six ounces. Interval 2½ hours. (*b*)

All this is not really so complicated as it appears, if you had your laboratory. Undoubtedly the percentage method is the most scientific, and in time to come will be the one we shall employ whenever possible. It is also the most expensive; in addition it is, in all except perhaps a very few cases, quite unnecessary.

In the large majority of cases there is no need for anything more than a simple moderate dilution of ordinary good cow's milk. Milk from one cow is quite unnecessary—rather, in fact, to be deprecated, as more liable to vary than the average of a herd. The fresher it is the better, and of course it must neither have been deprived of its cream nor had any preservative added. I have here a table I drew up some time ago, which was approved by my colleagues at the Children's Infirmary, and is in daily use among the out-patients there. The keynote is simplicity.

Age.	Number of Feedings in 24 Hours.	Interval between Feedings in Day Time. Hours.	Number of Feedings at Night. 10 p.m. to 7 a.m.	Quantity for each Feeding. Milk. Table-spoonfuls.	Water. Table-spoonfuls.	Sugar. Tea-spoonfuls.	Total quantity of Milk in 24 hours. Table-spoonfuls.
1st week... ...	10	2	2	1	2	⅓	10*
2nd to 4th weeks	10	2	2	1½	2½	½	15
2nd month ...	8	2½	1	2	3	½	16
3rd ,, ...	8	2½	1	3·5	3	½	32
4th ,, ...	7	3	1	5	3	1	35
5th ,, ...	7	3	1	6½	3	1	45½
6th ,, ...	6	3	0	9	3	1	54
7th ,, ...	6	3	0	10	3	1	60
8th ,, ...	6	3	0	11	3	1	66
9th ,, ...	6	3	0	12	3	1	72

* Twenty tablespoonfuls make half a pint.

During the first week 1 tablespoonful of milk to 2 of water is given; to the end of the first month, 1½ of milk to 2½ of water; during the second month, 2 of milk to 3 of water; and this last figure (*i.e.*, 3 tablespoonfuls of water) remains unaltered for the rest of the bottle-feeding. At the beginning of the third month 3 tablespoonfuls of each are being given, and the milk is gradually increased in amount; at the beginning of the fifth month it is 6 to 3; by the sixth, 9 to 3; and by the ninth, 12 to 3. Of course each bottle is suitably sweetened; and if the total quantity proves insufficient in the case of any particularly lusty infant, more may be given, preserving the proportions. I do not pretend that this is "humanising" the milk. It is *not*. The proteid content is far higher than in human milk. But if with the proportions given you combine ordinary cleanliness in the storage, in the bottle and teat, etc., and a rigid insistence on the regularity in times of feeding mentioned before, as a rule the child's digestion will cope with the excess.

Do not be misled by a little vomiting or "possetting" into altering the proportions of milk and water without first appealing to the weighing machine. If the child is putting on weight, there is no need to worry about the former.

For better-class patients who can afford fresh cream, the latter may be substituted for a proportion of the milk, or, if it agrees well, added with advantage to the bottle constituted as mentioned.

Babies are like many an adult in one respect; for one thing they do not like in large quantites is *water*. Too great a dilution is one of the most frequent causes of dyspepsia and wasting. We are all constantly seeing cases in which a child (say of 4 or 5 months) is getting 2, 3, or 4 of water to 1 of milk. Consider the amount of water with which the poor thing is deluged in order that it may get the insufficient nourishment in the attenuated mixture. In actual cases of this sort I have calculated that infants have been given 10 to 12 ounces of milk a day when they should have been having 20 to 30. Small wonder they wasted, and less that their tired stomachs resented the hydropathic treatment they were undergoing! Whole milk is far more likely to agree than these excessive dilutions.

Small doses of hyd. *c.* creta (apart from any syphilis) have often a beneficial effect if there is a little tendency to vomiting, with curdy stools—say, quarter or half a grain, with an equal amount of rhubarb and bicarbonate of soda, three times a day. Another powder which I have found of use, though more in acuter cases of vomiting, and combined with a temporary cessation of feeding, is one of bism. carb., gr. iij.-iv., and calomel, gr 1/20-1/12, three or four-hourly.

If the child feeds pretty well but does not gain weight, a teaspoonful of lemon or orange juice, sweetened, once a day, will often produce the desired result. I find myself, and indeed it is the experience of most, that the systematic weighing of infants is a great aid in guidance as to how much of mothers' statements to believe. Many mothers, especially first ones, are unduly pessimistic. It also acts as an incentive to the mother to follow up one's directions thoroughly when she sees the visible result as recorded by the scales.

Some babies seem to get tired of the unvaried diet of milk and water. In their case the addition of a teaspoonful of Mellin's food to one or two bottles in the day will tempt their jaded appetite. The same addition also may be made as a corrective of constipation, but there is no need for Mellin's or any other food *as a food*, till at least the seventh month. They are so consistently

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(*b*) From "Nutrition of the Infant," Vincent. 2nd Edition. 1904.

followed by rickets when given before that age that, although some are worse than others in this respect, they are all better avoided.

Personally, I prefer the milk *not* sterilised. Systematic sterilisation is a frequent source of scurvy; and if the practice be adopted, anti-scorbutic treatment ought always to be carried on concurrently with the feeding. Sterilised milk often disagrees; it will also keep indefinitely, and stale milk is distinctly bad for the child. If sterilisation is to be done, it should be done twice a day. Exceptionally, during the hot summer weather, for instance, the advantages outweigh the disadvantages; but obviously sterilising is tackling the pure milk problem at the wrong end.

I have found but little, if any, advantage in barley water over plain water. It also should be made twice a day, as it goes sour even quicker than milk. It is not a food for young children, and, as often given to supplement the breast, it is practically starvation diet.

Cream and whey mixtures, though theoretically the soundest, are the most difficult to prepare satisfactorily outside the laboratory. Consequently, I reserve them entirely for the first week, for cases—and they are really comparatively few—in which a fair trial of the milk and water proves a failure, and for periods when the stomach is temporarily upset from one cause or another.

THE PATHOLOGY OF

CONGENITAL HYPERTROPHY OF THE PYLORUS

IN RELATION TO TREATMENT (a).

By EDMUND CAUTLEY, M.D., Cantab, F.R.C.P. Lond.,

Physician to the Belgrave Hospital for Children, and to the Metropolitan Hospital.

Accepting the view that there is such an affection as pyloric spasm, and that the action of the pylorus is that of the closed door which only opens in response to duodenal stimuli, the author argued that there is no evidence that spasm could cause hypertrophy. Almost all physicians had found anti-spasmodic drugs of no value in treating pyloric hypertrophy, a remarkable fact if the symptoms were due to spasms grafted on, or causing hypertrophy. Moreover, spasm might occur at any age, and yet these cases of hypertrophy were peculiar to the first few months of life, and there was no evidence of spasm at a later age causing hypertrophy. Recovery from pyloric spasm under medical treatment in cases mistaken for true hypertrophy had led to an unduly favourable estimate of the value of medical treatment in treating hypertrophy. The latter affection varied from a degree of hyperplasia, which was fatal unless treated surgically, down to a slight hyperplasia, which was compatible with life if no secondary affections occurred. These affections, viz., dilatation of the stomach, gastric catarrh, and occasionally acute oedema of the pyloric mucosa, were due to contraction of the muscle. In mild cases the degree of contraction might prevent sufficient nutritive food passing through the pylorus, and yet not set up the secondary symptoms. Three of his cases had been of this type, and under medical treatment had succumbed to marasmus, although food was present in the intestine after death. It was these cases in particular that made one critical of the assumed value of diet and lavage. Drugs he had found useless. A diet of whey or albumen water, carefully regulated, would suit such cases for a time, but as soon as the strength of the food was increased, secondary symptoms arose. On the assumption that the condition was produced by hyperchlorhydria, cases had been treated by undiluted cow's milk. Such a food had proved useless in his hands, and he suspected that the successful cases were due to pyloric spasm. Recent observations by Miller and Wilcox supported the view that there is no excess of acid in these cases, and all clinical and pathological evidence was in favour of the weak nutritive fluid rather than undiluted milk. Lavage would be useful in hyperchlorhydria and pyloric spasm, but it would hardly be expected to be of value in cases of mild hypertrophy without secondary symptoms. It seemed unnecessary if food were passing through the pylorus, if vomiting was absent, and if there was little or no dilatation. There were undoubted cases of this type. It was of great value in curing secondary dilatation and gastritis, but it only cured these secondary affections, and not the hypertrophy, and might place the child in the *statu quo ante*. Then, if the degree of hypertrophy and contraction was compatible with life, the child might recover. He regarded it of vital importance to differentiate spasm from hypertrophy, and that the medical treatment of true hypertrophy should not be unduly prolonged, for the greater the degree of marasmus previous to operation, the smaller is the chance of the child's recovery.

CLINICAL RECORDS

OPTIC NEURITIS IN CEREBRAL TUMOURS

By L. PATON, M.B.Cantab., F.R.C.S.

This paper is based on the records of 252 consecutive cases seen at the National Hospital, Queen Square. In 202 of those the localisation of the intracranial tumour was definite, and 148 were confirmed by operation or post-mortem. Of the 202 cases, 38, or 18.8 per cent., had no neuritis, 12 had only very slight neuritis, the edges being at no period completely blurred, 27 were in a condition of post-neuritic atrophy when first seen, and the remaining 125 had marked neuritis. Mr. Paton pointed out that the great majority of cases without neuritis occurred in subcortical and pontine tumours. The percentage of cases with no neuritis in tumours of those two areas was, respectively, 38 per cent. and 43.5 per cent. He pointed out, further, that when sub-cortical tumours developed optic neuritis, it almost invariably indicated that the growth had involved either the grey matter of the cortex or the grey matter of the base, and that when pontine tumours developed optic neuritis, it practically, without exception, indicated very definite involvement of the cerebellum. He showed that in tumours of the cerebral cortex the intensity of the neuritis seemed to vary inversely with the distance of the tumour from the anterior pole of the middle fossa. He adduced evidence to show that the nature of the growth had little, if any, influence on the development of optic neuritis, except in so far as the nature of the growth might influence its position. He stated that the figures showed that very little reliance could be placed on differences in the intensity of the neuritis as indicating the side of the tumour, and that in the cases of frontal and of cerebellar tumour neuritis was just as frequently most marked in the optic disc of the opposite eye as it was in the eye on the side of the tumour. The neuritis commenced more frequently in the eye on the side of the tumour than in the opposite eye, but even here the preponderance—23 to 13—was not sufficiently marked to make the sign one of much value for localising purposes. He described in detail the development of the macular changes seen in intense cases of tumour neuritis, and showed that these changes were most probably produced by an overflow of œdematous fluid from the much swollen disc into the nerve fibre layer, and that the presence of very

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(a) Abstract of Paper read before the Society for the Study of Disease in Children, Jan. 17th, 1908.

well marked macular fans was compatible with the retention of perfectly good vision. The causation of the temporary attacks of blindness, lasting from a few seconds to half an hour, was discussed, and it was shown that these were probably not associated with optic neuritis, as they had been observed three times in cases when no optic neuritis developed, and in other cases these fleeting amblyopias had occurred before ophthalmoscopic evidences of disc change were present. It was suggested that these attacks were due to sudden rises in intraventricular tension, causing a bulging of the thin floor of the third ventricle, and to direct pressure on the chiasma. The attacks were invariably accompanied by increased headache and giddiness. He pointed out that there was no evidence in favour of optic neuritis in these cases being due to an inflammation descending from the basal meninges, nor was there evidence in favour of its being due to pressure of fluid in the vaginal space. The clinical evidence against it being a descending inflammation in the nerve trunks was even stronger, nor was there any more evidence in favour of the neuritis being produced locally by the action of toxins, or of its being a vaso-motor phenomenon. He regarded our knowledge as, as yet, insufficient to justify any definite theory as to the causation of optic neuritis, but a general review of the subject in its clinical aspects inclined him to the view that in so-called optic neuritis there was simply a manifestation locally of a general œdema of the cerebral tissues, due to the irritation set up by the tumour as an actively-growing foreign body.

OPERATING THEATRES.

GREAT NORTHERN CENTRAL HOSPITAL.

Pyonephrosis, with Displaced Heart.—**Mr. Arthur Edmunds** operated on a woman, æt. about 45, who had been suffering from a lump in the left side of the abdomen. This had not caused any very marked symptoms, and although the swelling had been diagnosed as an enlarged kidney, and the patient had been advised to submit to operation, she had refused all treatment. For a short time, however, before her admission to the hospital, the tumour had begun to cause a considerable amount of cardiac disturbance, the heart being displaced upwards and slightly to the left. On admission, the patient was in a critical condition; the abdomen was greatly distended, and was dull all over the left side, the boundary of the tumour passing beyond the middle line. The apex beat was in the third intercostal space slightly outside the nipple line; the pulse was small, rapid, and intermittent; there was marked dyspnœa; the urine contained pus in microscopic quantities only. It was obvious that there was a large cystic swelling on the left side of the abdomen which from its position behind the colon was probably the kidney. An attempt at a radical operation was clearly out of the question. Accordingly, the patient was anæsthetised, the tumour exposed through the ordinary lumbar kidney incision. An incision was then made into the organ, and several pints of pus evacuated. Large drainage tubes were fixed in position, and the patient returned to the ward. Mr. Edmunds said this method of opening such large swellings was, on the whole preferable to tapping with a trochar. It can be performed rapidly, with but little shock, and enables the surgeon to get some idea of the existing condition of the deeper structures. Care must, however, be taken not to allow the fluid to escape too rapidly, as this is liable to produce a fatal dilatation of the heart. The patient bore the operation well, but it was some time before her heart regained its balance, and it seemed safe to proceed to further treatment. All this time the pus had been pouring freely from the wound, but there had been no spreading infection of the surrounding cellular tissue.

The wound previously made was now opened up and extended in both directions. The whole kidney was then excised. This was extremely difficult, as there were dense adhesions in all directions, and it was impossible to avoid opening the peritoneum widely. The vessels were secured without difficulty, however, and the ureter was found normal. The whole wound was packed, the packing being subsequently replaced by drainage tubes. Mr. Edmunds said the case was obviously one of an infected hydronephrosis of a non-calculous character, the obstruction being due to a malposition of the ureter at its junction with the pelvis of the kidney. It would, of course, have been preferable to have excised the whole tumour at the first operation, but the patient's condition was such as to entirely preclude such a procedure. The healing was slow, but the patient made an excellent recovery.

TRANSACTIONS OF SOCIETIES.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, January 17th, 1908.

Mr. Sydney Stephenson, F.R.C.S., in the Chair.

Dr. Edmund Cautley read a paper on the

PATHOLOGY OF CONGENITAL HYPERTROPHY OF THE PYLORUS IN RELATION TO TREATMENT,

an abstract of which will be found on page 153.

Dr. G. Carpenter read notes of a case of

CONGENITAL HYPERTROPHIC STENOSIS OF THE PYLORUS,

which he had treated in conjunction with Dr. D. J. Munro, of Brixton, and which had recovered under medical treatment; diet, lavage and drugs being the methods employed. The infant was two months old. It was breast-fed, and in good health for the first week, but, the bottle being substituted, it gradually lost ground, and, as the parents said, "in spite of being fed on a variety of foods, it was sick after everything." At the time Dr. Carpenter saw it, the infant vomited accumulated feeds, it was constipated, and was passing scanty and concentrated urine. It was wasted, and so weak and ill from starvation that it was thought it would not live through the night. The diagnosis was confirmed by the detection of the typical pyloric tumour as large as an almond and as hard as gristle. There was associated gastric peristalsis in the direction of the tumour. Owing to the infant's condition, operative treatment was considered out of the question. It was ordered 2-oz. feeds of whey every two hours, drop doses of laudanum every four hours, and gastric lavage. This was on May 22nd, and on the following day the opium was reduced by half because of somnolence, and was finally discontinued on June 6th. During the treatment an attack of œdema, associated with albuminuria, difficulty of breathing, and also swallowing, came on. He coughed at his feeds, had to be propped up with pillows, and often had to be held up by his feet, as he choked and went black in the face. The infant weighed 7 lbs. at birth, 5 lbs. 13 ozs. on May 22nd, and on June 14th 5 lbs. 7 ozs. On June 7th humanoid milk was given (2-oz. feeds), and on the 14th milk 1 part and water 2 parts (2 to 3-oz. feeds) was substituted. Lavage was discontinued on June 20th. During the first week of milk and water diet it lost 5¼ ozs. in weight, but after that it began to forge ahead and gained on an average an ounce a day. It vomited for the last time on June 28th. Day by day it took increasing quantities of milk and water, rising from 18 ozs. daily to 30 ozs. on July 6th. While on whey the bowels were open once daily, and the motions were green, but after it had been on milk and water for a week, the stools became quite natural, and numbered 2—4 in the 24 hours. At 7½ months old, the middle of October, he weighed 16 lbs., and was a normal baby, and he is still (January, 1908) doing well. Dr. Carpenter laid great stress on discovering the pyloric tumour, as, without detecting it, it was impossible to be sure that the case was an example of hypertrophic pyloric stenosis. For pyloric spasm and infantile dyspepsia produced symptoms which could not be distinguished from the state in question. Vomiting of accumulated feeds, projectile vomiting, gastric peristalsis, constipation, and scanty urine could all be present without any tumour to account for them. He said that it was necessary to detect the tumour to prevent the mistake of operating upon cases where no tumour existed. He claimed that hypertrophic stenosis of the pylorus was a congenital condition, an abnormality of development and not a secondary muscular affection, the result of spasm, as claimed by Heubner and others. He said that in the cases he had examined microscopically not only was the pylorus muscle hypertrophied, but the stomach muscle also, usually about the pyloric third or fourth. Sometimes all the stomach muscle was hypertrophied, but in that case also the brunt of the enlargement fell on the pyloric end. The musculature of the pylorus was an exaggerated condition of the normal, in which the circular fibres greatly preponderated. He thought that the occlusion of the pylorus might be due to reflex spasm, or, as he would suggest, in some cases to œdema or congestion of the mucous membrane, analogous to the congestive stricture of the urethra. But whatever the explanation of the obstruction of the pyloric channel might be, he considered that dyspepsia was at the root of the illness. Cure the dyspepsia, or, better, avoid the dyspepsia, and the pyloric tumour could be very well left alone. He thought the secret of successful treatment lay, as in all infantile dyspepsias, in the discovery of what form of cow's milk (in the absence of suitable suckling) was least obnoxious to the infant's stomach. Feeds should be small, given regularly, and, above all things, the milk should be clean and fresh. In addition to this, gastric lavage was a well-tried and efficient remedy. Antispasmodic drugs could be used, but they did not appear to do much good. He thought that even the most hopeless-looking cases should not be abandoned by the physician, but submitted to dietetic treatment, and to those drug remedies which had proved beneficial in dyspepsia. As the result of medical treatment, he thought that in the future there would be more medical successes and fewer surgical failures. He thought that if the surgeon were called in, it should be late and not early. What the remote future had in store for the cases cured by the physician time would tell, but Seefisch had reported three cases that had to be operated upon before they were twelve years old, so it was possible that the visit to the surgeon would be merely postponed. If that were so, it was then even better for the child, as the mortality of the operation would be greatly reduced.

In the discussion following the reading of these papers,

Dr. **Sutherland** protested against the assumption that if pyloric stenosis were cured medically, it must have been in such a mild form that it would have recovered without treatment. Operation was a very serious matter, and many infants who had stood the operation died afterwards from bowel trouble of some sort. He did not think that, for a complete diagnosis, one should be able to feel a pyloric tumour, as the pylorus was a very uncertain thing to feel in an infant. The diagnosis could be made if vomiting, constipation, wasting, and marked visible peristalsis were present. Where trouble arose when breast milk was given, the fault was not with the milk, but with the manner of feeding. Small feeds of the most digestible material were required, and if there was a residue of food left in the stomach after washing out for a day or two, the infant was not having suitable food.

Mr. **Lockhart Mummery** said that it was scarcely possible to have a more unsuitable subject for a severe operation. The child was very young and badly nourished, and had probably been vomiting all the nourishment given to it for some days before. Very few cases died on the table. The only patients in which the prospect of operation was good were those seen early before there had been wasting, and in whom there was a fair amount of fat.

Dr. **Charles W. Chapman** said that in the condition under discussion there was a great deal of irritation causing the closure, and he was therefore surprised that no one suggested the administration of carbonate of bismuth. It might be given freely in as much as teaspoonful doses.

Mr. **Hugh Lett** said the members were much indebted to the readers of the papers, as the subject was one of great importance. Surgical treatment was a very serious matter, and in many cases, by the time that the surgeon was called in, the condition was practically hopeless. The physician should be clear at the beginning of his treatment how long he would continue medical measures, lest by unduly prolonging them the prospects of operation were affected. He advocated the claims of gastro-enterostomy as being simpler than pyloroplasty, and safer than Loreta's operation.

Dr. **Reginald Miller** suggested that the symptoms of pyloric stenosis were entirely referable to spasm. First, because of the onset of the disease. At the Clinical Society last year, 40 cases were collected, and in 70 per cent. of them the onset did not occur until the third or fourth week of life. He had a case in which diarrhœa preceded the onset of the symptoms. It was true that many babies vomited from birth, but not sufficiently to cause wasting, and the well-marked constipation was frequently absent during the first two or three weeks of life. That suggested that there was not marked blocking at the pylorus as a congenital lesion. Secondly, only the circular coat was hypertrophied, and he agreed that if it were spasm, the longitudinal coat would be hypertrophied. But if the longitudinal coat were hypertrophied, presumably there would be no symptoms. Thirdly, that although the baby did not live, yet as the result of lavage and careful dieting, it usually died of diarrhœa, showing that the pylorus was once again patent, and that something had happened, for presumably the spasm had been relaxed. A fourth and controversial point was that a few cases got well in which gastric peristalsis was observed week after week, and in which the tumour might be palpable for weeks. Such cases strongly simulated the real condition which Dr. Cautley referred to, and he, Dr. Miller, thought they were quite identical.

Dr. **T. R. Whipham** showed a case of congenital heart disease in a girl of 17. There was no cyanosis or clubbing. There was a history of slight rheumatism in the feet three years previously, but none of rheumatic fever or chorea. The left ventricle was greatly hypertrophied, and over the upper part of the sternum there was a marked thrill. In this region, and to the right, a loud systolic murmur was audible which could be heard all over the præcordium. There was no polycythæmia. The diagnosis was some malformation of the great vessels, possibly a patent ductus arteriosus.

A case of syphilitic synovitis of the knee-joint in a boy, æt. 7, was shown by Dr. **Porter Parkinson**. He was the subject of congenital syphilis, and the effusion followed periostitis of both tibiæ. There was marked effusion, but no pain or tenderness, and no alteration in the bony structure of the joint.

Dr. **Parkes Weber** said he believed that in syphilitic joint diseases the Röntgen rays were of great use in diagnosis.

Dr. **Sutherland** said it was contrary to his experience to find rapid improvement under mercurial treatment. In his experience fluid came and went, and recurrences were very common. He had seen cases which had been operated upon, and yet the condition recurred.

Mr. **Hugh Lett** considered it a typical case of synovitis of the knee due to inherited syphilis, and he thought these cases were important, as they were occasionally diagnosed as being due to some other cause. He had seen several cases which had been treated with splinting for some time in consequence of a diagnosis of traumatic synovitis having been made. In another important variety of the congenital syphilitic joint there was considerable thickening of the synovial membrane, with little or no effusion into the joint. Both these types—viz., with or without effusion—were occasionally treated as tuberculous joints. The most striking feature in these cases was the absence of pain on movement.

The **Chairman** said he thought the way mercury was used had something to do with the result. Some of the syphilitic joints associated with interstitial keratitis yielded to intra-muscular injection of mercury.

Dr. **Porter Parkinson**, in reply, said there was evidence of thickening in the tibiæ due to periostitis. The effusion in the knee-joint appeared while the child was under mercurial treatment for periostitis of the tibia. Whilst Scott's dressing was beneficial, he thought it was due to the pressure exerted. In most of such cases he did not think there could be much difficulty in the diagnosis, but he had recently read a paper contributed to a French journal stating many mistakes had occurred between that condition and tubercular joint disease.

Dr. G. A. **Sutherland** showed a case of cretinism in a boy, æt. 9, who was seen in November with typical signs of cretinism present. He improved very markedly under thyroid treatment. Growth in the long bones was very delayed, and pituitary extract had been given without any benefit so far. He asked if any member had seen any improvement from pituitary extract in a similar condition.

Dr. **Parkes Weber** said he had never seen any improvement of any condition from pituitary treatment. He had never used it himself.

Dr. G. A. **Sutherland** also showed a case of tubercular peritonitis in a girl, æt. 9. When first seen in September the case seemed hopeless; there had been signs of tubercular peritonitis for five months. She was wasted, and in a stuporous condition. She suffered from diarrhœa, and had delirium at night, and hallucinations during the day. She is now convalescent, and the signs of active tuberculosis have subsided, although the abdomen is still distended.

Dr. **Cautley** agreed that the prognosis in uncomplicated tubercular peritonitis was eminently favourable if there were no tubercular masses and no purulent effusion. When patients died, it was found that they had secondary complications, such as tuberculous disease in the lungs.

Dr. **Carpenter** said tubercular peritonitis seemed to be the least fatal of tubercular affections, but in many of the cases there was meningitis, and in some the lungs were affected later. He had followed up a large number of cases of tubercular peritonitis, and had been surprised at the large number who had subsequently died.

Dr. **Sutherland** agreed that many such cases died, and that they did so from some such complications as had been mentioned. When gradual improvement was noticed in this child, he put her on a proteid and non-fermentative diet, and under that the condition improved rapidly, and the abdominal distension subsided. The combination of open-air treatment and diet brought about the cure. Drugs had no part in it.

Dr. **McMaster** (for Dr. Guthrie) showed a case of acute polio-encephalitis following measles. The patient, a girl, æt. 5, was well nourished and intelligent, but had spastic diplegia. There were no ocular symptoms; there was weakness of the muscles of the back, so that she could not sit upright and could not hold her head up. The condition simulated one of congenital spastic diplegia.

Mr. P. **Lockhart Mummery** showed a case of supernumerary auricles in a boy of three months. On each side of the head there was a supernumerary auricle situated just in front of the external auditory meatus. On the right side it was about half the size of the normal ear; on the left side it was much smaller. There were no other congenital defects.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, JANUARY 30TH, 1908.

The President, Mr. R. **Marcus Gunn**, F.R.C.S., in the Chair.

THE following card specimens were shown:—

Mr. E. E. Henderson: Sections from case of Sarcoma developing under Calcareous Plate.

Mr. P. C. Bardsley: A New Form of Scotometer.

Mr. S. Stephenson: A case of Buphthalmia apparently cured by the performance of Iridectomy.

Dr. L. Guthrie and Mr. S. Mayou: Right Hemiplegia with Obstruction (? thrombosis) of the Left Common Carotid and Central Artery of the Retina, with Perception of Light in the Eye.

Mr. G. H. Goldsmith: Optic Neuritis.

Mr. J. S. Horsford: Essential Shrinking of the Conjunctiva.

Mr. C. Wray: Sympathetic Iridocyclitis.

PAPERS.

Mr. S. **Mayou**: Microphthalmia, resembling Glioma, with Lenticonus and Hypertrophy of the Ciliary Body.

Mr. Mayou said the case belonged to the class of phthisis bulbi. Some of those cases had been of inflammatory origin, but this, and possibly some of the other cases, were attributable to the imperfect development of the mesoblast, and it entering the ocular cleft to form the vitreous. The child was 6 months old, and was admitted under Mr. Hancock. The mother had noticed that the left eye was very small from birth, but the child had no other deformities. There were no signs or history pointing to congenital syphilis. The right eye was normal in size, and there was nothing abnormal in the fundus. In the other eye there was a well marked pupillary membrane. Behind the lens, which was clear, was a yellowish-white reflex, with vessels on it, similar to that seen in glioma and pseudo-glioma. As diagnosis was doubtful, enucleation was performed, and the child made a good recovery. The eye was hardened in formal, and sections cut antero-posteriorly. The optic nerve was removed, and cut in transverse section. The globe measured 15 m.m. antero-posteriorly, 10 vertically, and 10 horizontally. The sclera showed no change. The angles of the anterior chamber were imperfectly formed, owing to incomplete separation of the iris from the back of the cornea. The ciliary body was free from signs of inflammation. Behind, and lying on the pars plana was a large mass of pigmented and unpigmented cells, derived from the ciliary body. Towards the outer part was an attempt at alveolar formation. The retina was detached, but did not stop at the ora serrata, but passed close behind the ciliary process, where it was continuous with the anterior layers of the epithelial cells and the mass mentioned. The lens was thickened and thrown into folds, and consisted principally of neuroglial tissue, but possessed no regular structure. The retinal detachment was of earlier date than the hæmorrhage. The choroid presented a coloboma below, but the blood vessels were not thickened. The lens showed a condition of posterior lenticonus. The central artery was well developed, and showed no changes in its walls. Generally in such cases the distortion of the posterior part of the lens was associated with a persistent hyaloid artery, or a gap in the posterior part of the lens capsule, but neither of those conditions was present in this case. There was a hypertrophy of pigmented and non-pigmented epithelial cells, the reason of which it was difficult to understand, unless it was due to nutritional disturbance in the line of separation of the two layers in the primary optic vesicle.

Mr. L. **Paton** read a paper on OPTIC NEURITIS IN CEREBRAL TUMOURS, an abstract of which will be found under the head of "Clinical Records."

The following two papers by Mr. Simeon Snell were, in his absence, taken as read: Carcinoma of Orbit originating in a Meibomian Gland.

The case occurred in a woman, æt. 63. In 1904 another surgeon had removed a lump from the right upper eyelid. In July, 1905, there had been a recurrence at the site of that scar reaching back to the orbit, and about the size of a walnut. This was removed with the portion of eyelid, but in June, 1906, there was another recurrence, and then the eyeball was removed and the whole orbit cleared out, and chloride of zinc paste applied. Still further recurrence had occurred, and the orbit was filled with a large ulcerated growth, and the preauricular and cervical glands were enlarged. Dr. A. E. Barnes reported that it was a spheroidal-celled carcinoma, and was of opinion that it had probably originated in a meibomian gland. Mr. Treacher Collins corroborated this.

The second paper was on Coloboma of Iris in each

Eye, occurring in five generations. Mr. H. was the first person seen, and he had a large coloboma in each eye, down and out. The defect was known to have existed in his grandmother, in her sister, and in his mother. Mr. H. had six children, three of whom were affected, and of these, two had children—one three children of which two were affected, and one one child affected. Mr. H. was the only child of his father, but his mother had, by a second husband, five children of which three were affected. One of these had three children, two of whom were affected. The other had one child, which was not affected. In all, of 41 persons, 12 are affected—five males, seven females. In the great-great-grandchildren, the defect was complete aniridia.

HARVEIAN SOCIETY OF LONDON.

Meeting held Thursday, January 23rd, 1908.

Dr. G. A. Sutherland in the Chair.

The evening was devoted to the showing of
CLINICAL CASES AND PATHOLOGICAL SPECIMENS.

Dr. Sidney Phillips showed: (1) A case of splenic anæmia in a child. The liver, spleen, and lymphatic glands were enlarged, and the blood showed the usual signs of anæmia, but no leucocytosis. The case was discussed by Dr. Sutherland. (2) A case of Landry's paralysis in which recovery had taken place.

Mr. Clayton-Greene showed: (1) A case in which rupture of the liver had occurred from abdominal injury. An operation was performed within seven hours of the accident, and recovery followed. (2) A specimen of cirsoid aneurysm of the arm and forearm. The arm had been amputated owing to the extensive involvement of the vessels. This was discussed by Dr. Low.

Dr. Willcox showed: (1) A case of greatly enlarged lymphatic glands on both sides of the neck, which he regarded as due to lymphadenoma with tubercular infection superadded, the latter having been proved by investigations of the opsonic index. The case was discussed by Dr. Sutherland. (2) A case of enlarged liver and spleen, with leucoderma. This was regarded as cirrhosis of the liver. Dr. Langmead discussed the case.

Dr. Langmead showed a case of third nerve paralysis, which was discussed by Dr. Sutherland.

Dr. Carmalt Jones showed a case of arterio-sclerosis, with a vascular lesion, giving rise to a crossed sensory lesion.

Mr. W. V. Low showed a case of Charcot's disease of the knee-joint, with spontaneous fracture of the tibia on the same side. There were well-marked signs of tabes dorsalis.

Mr. Crisp English showed: (1) A case of Charcot's disease of the ankle-joint, which was discussed by Mr. Kelly. (2) A specimen of large fibroma of the breast.

Mr. Lawrence Jones described: (1) A case of musculo-spiral paralysis. (2) A specimen of ureteric calculus.

Mr. Maynard Smith showed a case of injury to the brachial plexus, followed by a root paralysis, which recovered after operation. The case was discussed by Dr. Willcox.

Mr. E. Morris showed a skiagram of a supernumerary thumb.

Dr. C. Singer described the drawings, microscopical and pathological specimens, of a case of exophthalmic goitre which had recently been under his care.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

Meeting held Friday, January 31st, 1908.

The President, Dr. Walker Downie, in the Chair.

Before proceeding with the business of the evening Dr. Walter Downie made sympathetic reference to the sudden death of Professor Sir Thomas McCall Anderson, who became a member of this Society in 1861, and held office in it both as President and Vice-president.

Dr. Albert A. Gray read notes on a case of abscess of the temporo-sphenoidal lobe of the brain, with rupture into the lateral ventricle. He described the condition of the patient—(a girl, aged 7 years)—before she was operated on; the operation, and the condition of the patient for 14 days after the operation till death occurred. He also read the notes of the post-mortem examination, and showed specimens of the temporal bone and the brain of the case, illustrating the pathological conditions that gave rise to the symptoms and caused death.

The chief interest in this case was the length of time the patient lived after the rupture of a cerebral abscess into the lateral ventricle of the brain; the temporary improvement in the general condition that resulted from the operation which effected the evacuation of the purulent contents of the lateral ventricle.

The abscess was due to chronic middle ear disease, and acute symptoms had existed for three weeks before admission to the hospital. Three days previously the symptoms increased, paralysis of the face came on, and the patient was almost comatose, only uttering a querulous cry when roused. The radical mastoid operation was at once performed, but no abscess was found nor any opening leading to the brain. The lateral ventricle got tapped in the course of the operation, and a large quantity of watery pus gushed out. The wound was dressed in the ordinary way. The patient's condition improved immediately after the operation. On the second day coma had passed off, and by the fourth day the facial paralysis had disappeared. The neutral condition was quite normal, and the patient answered questions intelligently. On the tenth day the patient became apathetic and did not care for food, then twitching of the hands began, and on the fourteenth day after the operation death occurred from meningitis.

In cases where cerebral abscess ruptures into the lateral ventricle death generally follows in twelve to twenty-four hours. Here there was a temporary recovery after the pus was evacuated from the lateral ventricle, which was no doubt due to the relief of the intracranial pressure. In the discussion which followed it was suggested that it might be possible to save the patient's life in such cases by draining thoroughly the lateral ventricle as well as the operation wound. This it was pointed out might prevent the spread of infective material to the lateral ventricle of the opposite side, to the third ventricle and to the fourth ventricle which in this case had taken place, and which set up the septic basal meningitis that lead to the death of the patient after the symptoms due to the abscess itself had disappeared.

Dr. Kelly read a short paper written by Mr. Freeland Fergus, the subject of which was "Lachrymation." The various causes, and the treatment of this condition were indicated, and a short discussion followed.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 2nd, 1908.

Hæmophilia.

Histological study has been found incapable of explaining the cause of hæmophilia. Chemical examination of the blood, however, has thrown some light on it. It is admitted to-day that the affection is connected with some trouble of coagulation produced by imperfection of the ferments of the blood, which is proved by the fact that a cure can be obtained by injecting fresh serum which contains the ferments of the blood. Such is the conclusion formulated by Dr. L'Abbé at the Medical Congress held last October, and that this bad quality of the blood ferments is due to deranged functions of certain organs (liver, suprarenal capsules, thymus, thyroid ovaries), or from other undetermined causes.

However, what is necessary to know is the method of curing the disease.

The ordinary methods fail in general. Perchloride or iron, antipyrin, ergotin, have been employed without much effect. According to Sahli, adrenalin was successful in some cases, and L'Abbé obtained a cure by the injection of half a milligram of adrenalin. As a local application—bleeding gums, vegetations—it has also produced good results.

Subcutaneous injections of gelatine in artificial serum (1—5 per cent.) at the dose of from 1 to 3 ozs., did not deserve the success attributed to them.

Chloride of calcium plays, as everyone knows, an important *rôle* in the coagulation of the blood. The application of a solution of chloride of calcium (1—100) on a bleeding surface favours coagulation and arrests the hæmorrhage. Taken internally, the salt exercises a hæmostatic action, both preventive and curative, on the condition that its use is prolonged. Lactate of calcium is superior to the chloride, according to Paramore and Wright, which, however, L'Abbé contests. For him the salts of calcium taken internally possess a very problematic hæmostatic action.

Of all the methods of treatment, the most active is the intra-venous injection of half an ounce of fresh serum; immediately the hæmorrhage ceases, and an operation can be undertaken without danger. At the end of a few weeks the effect is spent, and the injection must be repeated. The remedy has also been employed with success subcutaneously; practitioners who might hesitate to inject the serum into the vein can always employ the more simple method.

The fresh serum should not date over 15 days. The serum of the horse, the rabbit, or of man may be employed, and, in the absence of these, anti-diphtheritic serum might be used.

The hygienic treatment should not be neglected—sea or mountain air, tonics, cacodylate of soda, discodide, methylaisinate, etc.

Treatment of Polyuria.

Intense polyuria constitutes frequently a very grave affection. It brings about rapidly a state of emaciation which terminates in cachexia; it is accompanied by frequent desire to urinate, intense thirst, and an exaggeration of the appetite which fatigues the stomach. All these symptoms are especially well marked in polyuria, associated with glycosuria and phosphaturia. Frequently, however, the cause cannot be determined, and the treatment has to be addressed first to modificators of the nervous system, then to those of arterial tension, and finally to derivatives. Amongst the former, valerian, says M. Plicque, takes the first place. It is generally given in the form of extract on account of its disagreeable odour. Twenty grains three times a day is considered a proper dose, although it might be increased.

Antipyrin possesses the double advantage of moderating the spinal irritation and diminishing the urinary secretion. Given in 10-grain doses four or five times a day, or every hour in bad cases, antipyrin succeeds admirably in diminishing the quantity of urine. It should be used, however, with caution in polyuria of renal origin, as it might irritate the kidney. Salicylate of soda may be tried in gouty and rheumatic subjects, but is counter-indicated in albuminuria. It sometimes acts very rapidly.

Belladonna and opium should be employed with much reserve. They are specially indicated in polyuria accompanied by vesical tenesmus, nocturnal incontinence, frequent and painful desire to urinate.

Bromide of potassium is especially useful in polyuria of diabetic patients, and also in that of epileptics.

Iodide of potassium or of sodium give the best results in polyuria due to arterial tension, but their effects require several weeks to become manifest. The doses should not exceed 20 grains per day.

Ergot of rye, or ergotin, has been employed with varying success. Hydrastis and hamamelis are less active, but more easy to moderate in their effects than ergot of rye. The co-existence of hæmaturia would be an indication of their use.

Derivative agents, as purgatives, sudorifics, should be employed only occasionally, and are specially indicated in polyuria of nervous origin.

GERMANY.

Berlin, Feb. 2nd, 1908.

At the Medizinische Gesellschaft, Hr. H. Senator spoke on

Diabetes in Married Couples (Diabetes Conjugalis) and Its Communicability.

He took notice of some earlier statistics regarding the frequency of the occurrence of diabetes in married couples, and which, as a whole, amounted to 1⅓ per cent. This estimate was not correct, as, as H. Leo was the first to point out, it was not determined in the inquiry how many of the diabetics were married, concerning which point, in the case of men, at least, no indication whatever was given. We knew nothing of the period of incubation of the disease, but a minimum of six months had been accepted, when the possibility of transmission had been considered at all.

From observations made in his private practice, the speaker had ascertained that, amongst 516 diabetics who were married, there were 21 married couples, of which, however, 3 were almost simultaneously attacked; 18 cases, therefore, remained to be considered—3.5 per cent. If those cases were deducted that had been married barely a year, the percentage was higher—viz., 4 per cent., a percentage that gave food for thought. In four of the diabetic couples there was a hereditary tendency on both sides, so they must be left out in considering the question.

The speaker then quoted a number of statements from the literature of the subject that appeared to be in favour of the transmission of the disease, and related himself the case of a medical man practising in a small town of 2,500 inhabitants: in one street of this town there were six diabetics, and a case was known to him in which the second wife of a diabetic, whose first wife died of the disease, also fell a victim to it.

There were also experimental observations in which a dog into whose intestinal tract intestinal contents of a diabetic patient were introduced, excreted sugar; there was also the case of guinea-pigs who excreted sugar after subcutaneous injection, but this had not been confirmed from other sources.

He asked practising physicians to contribute to the solution of this question. It was only by the family doctors working together that it could be solved, as they only were in a position to take note of all the conditions.

Hr. Neumann had instituted an inquiry in Potsdam through the medical men and apothecaries there, and could discover nothing that pointed to any infectiousness of diabetes. Private practice alone must not be made use of in the inquiry, but practice amongst paupers as well.

Hr. Albu attributed an important *rôle* to accident, when both husband and wife suffered from such a widespread disease.

Hr. Ewald also doubted the infectiousness of the disease, and considered that the observations that had been made in that direction were not convincing.

Hr. Senator participated in all these doubts, but by bringing the subject forward he hoped to stimulate further inquiry.

In a case of diphtheria bacillus and streptococcus sepsis that recovered (*Deutsche Med. Zeitung*), Dr. Philip Mahler employed injections of serum. On the left thigh into which the injections were made, a cutaneous eruption appeared (a number of circumstances were against it being erysipelas). The writer took it to be a primary necrosis set up by the injections. No similar case had been recorded.

Dr. Ernst Rieben, of Bern (*ibid.*), has been interesting himself with the solubility of pills in the gastro-intestinal tract, his investigations being carried out in the Institute for Medical Chemistry and Pharmacology of that city. Amongst other things, he found that pills coated with silver leaf were not nearly so readily absorbed as pills without that covering.

AUSTRIA.

Vienna, Feb. 2nd, 1908.

Tetanic Deformity.

At the meeting for "Innere Medizin," Lehndorff presented a twelve-year-old boy with great deformity of the spinal column and ribs, the result of a severe attack of tetanus.

About the middle of May he got his ankle injured. In a few days after tonic spasms commenced in the muscles of the body and extremities, with opisthotonos, abdominal muscles as tense as boards, accompanied with spasmodic attacks of dyspnœa. After treatment with serum and chloral, the spasms relaxed, but the deformity of kyphosis in the dorsal vertebræ persisted, while the scapulæ were raised higher and twisted towards the sternum. The ribs at their cartilages were bent inwards, and the thorax quite distorted. All the muscles of the child are well developed and strong, and the electric movement normal. There is no pain in the bones, and the Röntgen rays show a normal structure.

There is no case in the literature of the subject where this distortion of the skeleton is recorded, and no doubt can remain that the deformity was the result of the long-continued contractions and bending of the young structure.

Female Milk with Rennet and Acids.

Brenenfield read a paper on the action of rennet and acid on milk, but more particularly on female milk. The casein of cow's milk was easily acted on by both rennet and acids, but human milk was not curdled by either. If, however, human milk be centrifugalised, and one-tenth of a solution acidified, 2.4 per cent. added, and the whole raised to 40° C., = 104° F., coagulation at once sets in; but if the temperature is raised still higher, the coagulation disappears and no curd is observed. If alkali be added to exactly neutralise the acid, the mixture with the female milk will instantly coagulate. It thus appears to be the acid that produces the curd in human milk and not the rennet.

Escherich said his experience was just the opposite in the treatment of children. If an infant be given rennet after a meal, a fine flocculent clot will be formed in the stomach; if a small quantity of acid be added, the clot is rapidly dissolved, leaving the whole in a fluid condition.

Fränkel thought the casein of human milk could not be the same as that of the cow, because the albuminoid reacted differently, and the quantities were not in the same proportion. With acid in cow's milk, 83 per cent. of the nitrogen will be thrown down, while the same acid will only bring down 16 per cent. of the nitrogen in human milk. No specific rennet action exists, as the rennet from the human stomach will not coagulate the milk from a female. The casein in both differs widely in the amount of phosphorus they contain.

Again, if the filter be made finer with acid in the human milk, and placed in vacuo at 30° Cent., another albuminoid body will come down containing a large quantity of sulphur. This seems to be the body that comes down when the acidity is concentrated in the stomach, forming a flocculent mass.

Iodglidine.

In a lecture by E. Schmid, iodglidine was praised as a new drug of wonderful merit in the treatment of arterio-sclerosis and asthma. The substance is a non-irritant vegetable combination, which he has prescribed for a year now with excellent results. The iodate combination with the vegetable substance makes it easily borne and more readily assimilated than any other preparation on the market. Hitherto the toxic effect of the drug has been a drawback, limiting its use and often disappointing the prescriber owing to cardiac depression, vomiting, etc. The happy combination of vegetable albumin prepared according to Klopfer's idea removes all these disadvantages from the administration of potass iodide, as the iodine is already incorporated with albumin and ready for absorption which hastens its transfusion. Schmid next illustrated his success by reading a few cases which he had treated with the drug.

E. G., æt. 58, a metal worker, well nourished, but pale, with anxious features and pulsus tardus—60 per minute—but regular. Both radial arteries were rigid and serpentine. He frequently complained of pain and pressure in the chest, with great dyspnœa. No trace or history of syphilis was present. After 14 days' administration of two iodglidine pastilles, containing 0.5 gramme each, three times a day, and thus representing 0.3 gramme of the iodate of potassium, or 4.6 grains of the drug, the feeling of pressure, weight, and anxiety quite disappeared. He advised the iodglidine to be suspended for a week to observe the effects. The attacks did not come on at regular intervals as heretofore, but a heavy, uneasy pressure lingered over the chest. Again, the two pastilles of iodglidine were recommended for another 14 days, and this was succeeded by a perfect disappearance of all the uncomfortable feeling and pain. No pressure nor difficulty of breathing is now experienced; neither was any trace of iodism observed during the whole course of treatment.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Late Professor Pettigrew, St. Andrews.—The death of Dr. J. Bell Pettigrew was announced on January 30th. He had been in failing health for some years, so that the news was not altogether unexpected. He was born in 1834, and was trained in medicine in Edinburgh, where he graduated after a distinguished course of study. In 1860 he was appointed Croonian Lecturer to the Royal Society, and in 1872 he began to lecture on physiology in Edinburgh. Two years later he was elected to the Chandos Chair of Medicine in the University of St. Andrews, and held that post up to the time of his death. The Chair was converted into a Chair of Physiology by the University Commissioners about ten years ago, in connection with the rearrangement of the teaching consequent upon the amalgamation of the Dundee colleges with St. Andrews University. During the latter years of his professoriate Dr. Pettigrew had withdrawn from active work in the way of lecturing, and filled the leisure he enjoyed by engaging in research. Dr. Pettigrew's early investigations concerned the mechanism of circulation, and he published important papers on "The Muscular Fibres of the Heart" and "The Valves of the Vascular System." He made a hobby of aëronautics, and in 1867 published a memoir on the "Mechanism of Flight." He was also a connoisseur of violins, of which he possessed a remarkably fine collection. His interest in public affairs was not restricted to those of his own profession, for, in addition to being for some years a member of the General Medical Council, he threw himself into municipal politics, and took an active part in promoting local railway enterprise. He is survived by a widow, but no family.

Ruchell Fever Hospital, Glasgow.—The Local Government Board has decided to hold an inquiry into the affairs of this hospital, and has appointed Sheriff Crawford, K.C., assisted by Prof. Harvey Littlejohn and Mr. A. Murray, to investigate and report. It will be remembered that the Local Government Board deputed Professor Littlejohn to make a preliminary inquiry about a fortnight ago, in consequence of complaints made by the resident medical staff.

Morison Lectures on Insanity.—This year's course of lectures was delivered on January 27th, 29th, and 31st, by Dr. Lewis Bruce, Superintendent of Murthly Asylum, in the Royal College of Physicians, Edinburgh. The subject of the lectures was "The Symptoms and Etiology of Mania."

BELFAST.

Public Health.—During the past week there has been a slight but distinct recrudescence of the epidemic of cerebro-spinal meningitis. This epidemic began about a year ago, reached its height last spring, and died down in the autumn, there being only a very few cases reported each month for some months now.

Ten cases were reported last week, and there are at present in the Purdysburn Fever Hospital 19 cases under treatment. There are probably a good many more in the city, as of late the cases have not generally been sent to hospital. The Notification of Births Act comes into force in Belfast this month, and the local executive of the Women's National Health Association have already asked the Superintendent Medical Officer of Health to supply the Association with a list of all births in the city, so that they might render assistance to both mother and baby when needed. As the births number some eleven or twelve thousand annually, the Association will have plenty of work to do.

Belfast Hospital for Sick Children.—The annual meeting of this hospital was held last week, when Mr. T. S. Kirk, F.R.C.S., read the medical staff report. In the intern department last year there were treated 269 medical cases, 361 surgical, and 17 eye cases. The operations numbered 352, and there were 45 deaths. The general report showed an average expenditure upon in-patients of 2s. 4½d. per day, and the annual cost per bed occupied £50 2s. 2d. Among the speakers at the meeting was Dr. P. R. O'Connell, J.P., one of the surgeons to the Mater Hospital, who spoke in a most friendly way of the excellent work done by the medical and surgical staff.

LETTERS TO THE EDITOR.

LAW REFORM AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—One is always reluctant to write a word in opposition to a paper which devotes itself to raising the honourable position of medicine. Sometimes, however, a paper, in attempting so great a task, may fall into an error and thus produce the very opposite effect to that intended. In a leader in your issue of the 22nd ult., you say, under "Law Reforms and the Medical Profession":—"Of all the coming reforms, there appears to be no single one of more direct or urgent importance than that which asks for some re-adjustment of the present system, whereby opposing expert evidence is now tendered by both parties in a law-suit. A more costly device for getting at the truth could hardly be imagined than that which brings into court on either side an imposing array of more or less eminent expert witnesses." You then proceed to ask: "Why should not a body of experts be appointed to sit permanently and decide upon all medical points submitted to them for consideration?" The answer to this question of yours is that which you yourself give further on in the same article, when you speak of "the spectacle of half-a-dozen bigwigs in the witness-bog flatly contradicting half-a-dozen colleagues of equal standing." As, since you make no suggestion that the six bigwigs on one side or the other are dishonest when they flatly contradict each other, is there not some other cause beyond partisanship which makes them so widely differ? The answer is that there is another and greater cause, and one which will last for all time, and that cause is summed up in the few words that, the science of medicine being infinite, opinions must differ. Those who are familiar with the discussions of medical societies must recognise the insurmountable difficulties which beset the science of medicine at every turn, and cause the opinions of equally eminent men to be so diametrically opposed. Nowhere, then, is the value of an arbitrator of more advantage to the litigants than in a case where scientific experts honestly disagree. There is no one, in the writer's opinion, more capable of drawing sound deductions from conflicting opinions, and of giving sound advice to a jury, than a High Court Judge, unbiassed and untrammelled by scientific knowledge of medicine, yet having had laid before him, as plainly as possible, the theories of both sides. So much in favour of the present system. Now, against the proposed alteration, no matter how large the number of members of the proposed board, there would still be opposing theories held by its members. Further, a preliminary expert examination, with its attendant likelihood of disagreement, must mean the assemblage of a number of eminent men at an enormous expense to the ratepayers, an expense at present very properly borne by the litigants, or the established board would ere long fall into the usual perfunctory body consisting of only just sufficient in number to constitute a quorum, and composed mostly of the same individual members whose questions, judgments and reports would savour very much of mechanical results. For it must not be overlooked that in all similar bodies, such as committees, etc., there are two or three (sometimes only one) who practically do all the work. Then, again, medicine and surgery have their fashions and cranks, which would not be submitted for the impartial judgment of an outside court. If the question is to be decided by technical experts, what will be the position of the jury, the boast of every Englishman? The tendency of the present day is to make more and more appointments, with the result that the public are gradually losing their individuality, medical men their self-confidence, and the country is overrun by those whose sole aim appears to be to magnify the importance of their individual appointments, increase the scope of their offices, and reduce the science of medicine to something little better than a clerkship.

I am, Sir, yours truly,

R. H. H.

February 1st, 1908.

To the Editor of The Medical Press and Circular.

Sir,—With regard to your leader in The Medical Press and Circular, January 22nd, *re* "Law Reform and the Medical Profession," I should like to ask—Why should not such a course as you propose be taken in all cases of disputed medical evidence in all civil actions, and a report be placed before the Court?

(1) Of facts admitted on both sides.

(2) Statement of differences in opinion, such differences being supported by a statement of the grounds upon which such differences of opinion are based.

(3) A summing-up by the "Official Referee" of the case as a whole, and his opinion of it.

The fees should be paid as "divided costs" between plaintiff and defendant.

I do not know if I make my meaning very clear upon this latter point. What I wish could be avoided is party worship.

Both sides might nominate men in whom they had confidence, but they should not go into the matter in any way tied to support the case of those who nominate them; they should have no reason to feel biassed. The one idea in their minds should be, "What are the facts of the case as they appear to me, and what opinion have I formed from what I regard as established facts, no matter how they may tell for the plaintiff or for the defendant?" The present state of affairs is indeed lamentable, and makes medical evidence a byword and a subject for scoffing with the laity.

Sincerely hoping that some radical reform may be effected at no distant date, and thanking you for having drawn attention to so grave an evil,

I am, Sir, yours truly,

John W. Martin.

Sheffield, January 24th, 1908.

NURSING HOME CHARGES.

To the Editor of The Medical Press and Circular.

Sir,—Although the question I am desirous of raising herein is somewhat outside the scientific field of surgical practice, I trust you will kindly allow me to ventilate it, and afford me, possibly, the authoritative answer I desire.

A relative of mine at present in a private nursing home for a somewhat serious operation to her hand, though well able to walk to the operating theatre, had naturally to be carried back to her room on a stretcher (up a winding staircase) after the anæsthetic. The men who transferred the patient thus are, I may say, permanently employed by the home, performing other duties as well. In her last weekly account, just rendered, appears the item, "Bearers, 4s." This is not a large amount, I know, but is it not somewhat unusual and unreasonable?

In the next place, it has been my experience that the inevitable extras, such as dressings, visitors' teas, etc., are invariably left to the end, when they cannot easily be checked. Is there sufficient justification for this?

I readily admit that there may be cases where neither the patient nor relatives would care to be worried while the former is in a critical condition.

I am, Sir, yours truly

Lux.

TREATMENT OF CORNS IN THE ARMY.

To the Editor of The Medical Press and Circular.

Sir,—I am glad to learn from your last issue that the treatment of corns is to be carried out in the Army.

It is little known what intense suffering is caused by corns among working people and soldiers whose boots come out of a ready-made stock—indeed, not these alone, but vast numbers of well-to-do people are "voluntary" sufferers from corns, inasmuch as they are slaves to a fashion of tight, and pointed, and high-heeled boots.

On one occasion, after amputating a leg, necessitated by a compound fracture, the first words of the patient on recovering from the chloroform were, "Which leg, sir, have you cut off?" I informed him that it was the right leg, and his reply was, "Thank God, my corns are gone." I examined the foot, and certainly there was cause for his thankfulness—five or six corns on the sole of the foot, some of them nearly an inch across. This poor fellow said he "sweated with pain from morn till night."

Well, corns don't kill people, but they are the cause of a life-long suffering, and as medical men don't give much consideration to them, it is not surprising that people place themselves under the care of corn-cutters, some of whom become corn quacks and extortioners.

Well, the treatment of corns is not *corn cutting*, but eradication, and if the operation is limited to corn cutting, it had better be avoided altogether. Corn eradication is an operation in which selected members of the Medical Staff Corps, who in intelligence are the pick of the private soldier, could very soon become skilled. For the operation the instruments required are a sharp dissecting knife, a sharp and pointed pair of small scissors, and sharp-pointed forceps. The foot should be soaked in warm water for half an hour, or, in cases of very large corns on the sole of the foot, for an hour; then the delineation between the corn and healthy tissue becomes clear. The edge of the corn is to be lifted with the forceps, and the knife or scissors delicately used to sever the connection of the corn with the healthy tissue. The cutting should be rather towards the corn than towards the healthy tissue, and under no circumstances should there be any bleeding whatever. If there should be bleeding, it is better to desist and do the operation another day, and with greater care.

A corn once removed in this manner may never recur. Any sign of recurrence should be quickly removed, and I distinctly assert corns are curable by this operation.

I do not know the name of the Army surgeon who has suggested that the treatment of corns should be taken up by the bearer companies, but certainly the suggestion is worthy of great praise.

Further, I am inclined to suggest that if practical instruction in the treatment of corns, such as I have described, were given in ambulance lectures, much agony among the poor might be prevented.

I am, Sir, yours truly,

A. T. Norton.

MOTOR-CARS FOR MEDICAL MEN.

To the Editor of The Medical Press and Circular.

Sir,—In reply to a letter from "M.D." on the subject of a small motor-car suitable for a country practitioner, it is very difficult to answer the first part of his letter. The broad lines of selection may be stated thus:—

A car by a well-known manufacturer, with an agent, who knows something about it, not too far off—*i.e.*, in Dublin (I am writing in Ireland), short-wheel base in any case, and a two-seater for choice; this reduces prime cost and up-keep materially, for, if a car is overloaded, it ruins the tyres very quickly, and if you have only two seats, this prevents overloading. Also, in some districts, if the roads are not mended with limestone, these cars can be run without non-skids. The number of cylinders is a matter of choice; obviously, four are better than one, but four need a little more attention. For country work a magneto should be fitted, in conjunction with the ordinary battery and coil, but this refinement is expensive, as it is not a standard on these small cars. A glass screen and hood add much to the comfort of the passengers. It will be seen that it is necessary to spend about £250. Less capital expenditure than this cannot be advised if 5,000 miles per annum are to be covered, and the car expected to wade through mud and against wind. For fine-weather work a smaller expenditure is possible, but, in the end, the smaller car will cost more in repairs, and the saving will not be what it might be expected. In reply to the second portion of the letter:—I ran a small 6½-h.p. car for 2½ years, with an outlay averaging £45 per annum, but this was an immature car, and needed too many repairs. By that I mean some parts were not up to their work, and so wore out quickly; also they were not protected from mud. N.B.—That car is running still in the hands of a friend of mine.

For the last year I have run a 15-h.p. five-seated car, often overloaded, including a tour of 1,000 miles, and my expenses for 5,000 miles are as follows, not including shillings:—Tyres, £53; petrol, £20; repairs, £5; oil, etc., £5; insurance, £13; total, £96. Taking expenses at £100, and mileage 5,000 (this is taken with a milometer), the average cost is 4·8d. per mile.

My tyre bill is too heavy, owing to two circumstances—first, a 300-mile trip at Easter, over new-laid stones, often with five up; and, secondly, an unnoticed puncture, which ruined a tyre and tube. Weight of car, 24 cwt., including all extras.

From the above, it is evident that a car of 10-h.p., with two seats, could easily be run for £50:—Tyres, £20; petrol, £12; oil, £3; repairs, £5; insurance, £8; total, £48.

I will be happy, if "M.D." is going to buy a car, to give him any advice and assistance if he will write direct to me.

I am, Sir, yours truly,

Lex.

February 1st, 1908.

THE "STAR" AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—When I wrote that it seemed not necessary to continue this controversy in your pages I had in view your professional readers alone. These had, I was sure, read enough to make plain the deplorable, bitter prejudice towards the medical profession displayed by the editor of the *Star*, and to estimate his claim to speak with authority on the subjects under discussion. He shows himself unacquainted with coarse facts essential to the formation of a sound opinion, and he gives no evidence whatever that he possesses the rudimentary knowledge needed even for the understanding of the scientific problems involved. His prejudice is again displayed to-day, when a charge of inhumanity alleged against two practitioners is put forth as though, if true, it should disparage the whole profession. One wonders whether the editor fully realises his responsibility in these matters, whether he bears in mind the fact that his paper forms the sole literary pabulum for thousands of poor and ignorant readers, who accept his utterances as their gospel; whether he has considered what the cost in suffering and misery may be if he beguile his simple readers into neglect of the help in preventing, relieving, and curing disease which medical and surgical art now so surely offers in many directions; and whether he has considered the harm that is being done to the poor and ignorant in driving them into the hands of the cruel quacks whose advertisements crowd the pages of so many newspapers. To point out all the misconcepitons which the editor's letters suggest he labours under would occupy pages of your space. The fact that he writes to you again shows, at any rate, that his mind is not closed; and, if you will allow me, I will point to one or two directions in which, if he desire enlightenment, he may inquire and gain it. In the first place, he seems not to be aware that a considerable section of the profession, not only in these islands, but throughout the civilised world, are not called upon, during the whole of their careers in their special departments of practice, to perform the operation of vaccination. These include many thousands engaged only in scientific work, and it is impossible to find one in a thousand among all these experts of experts who does not have his own children vaccinated. Does the editor of the *Star* insist that these men err through ignorance? Does he suggest any sordid motive for their conduct? Does he believe that they would uphold vaccination by their personal testimony if not convinced that it was at once necessary and harmless? We all know the danger of blindly accepting authority in matters of opinion; but in matters of scientific experiment we accept as true the testimony of an army of separate independent investigators, who state that the experiment is always followed by the same result, for we know that we can verify the statement by making the experiment for ourselves. The vaccination experiment has been made by tens of thousands of qualified observers, and its efficiency for its purpose and its harmlessness have been demonstrated millions of times since Jenner's discovery. Then, does the editor really know anything at all about the scientific aspect of the case, especially as viewed in the light of the new bacteriological knowledge of the present day? Does he suggest any scientific facts going to show the possibility of the convection of disease through vaccine lymph taken from the calf? Does he suggest that diseases like syphilis or tuberculosis could be so conveyed? And does he suggest that, if this were possible, the evidence would not be overwhelming, and that cases would not present themselves to observation in numbers every day? The fact is that the anti-vaccination propaganda is based almost entirely upon falsehood and gross, vulgar superstition. The evidence is of the crudest and most barbaric *post hoc propter hoc* variety. The vulgar ignorant are told that the operation is harmful, and they are ready to ascribe to it every complaint or disease to which a child is liable. The baby was vaccinated, and later on developed, for example, tubercular gland disease or syphilis, clearly inherited from the parents, and the vaccination must have formed the cause! In the very few cases, during half a century, in which an inquest has been held on an infant, the death of which has been ascribed to vaccination, it has been very rarely possible, after the most careful investigation, to trace any connection whatever between the alleged cause and the result. Will not the editor of the *Star*, for the sake of his ignorant readers, agree to remain neutral in these questions until he has mastered the necessary knowledge he now clearly lacks?

I am, Sir, yours truly,

January 29th, 1908. A SURREY DOCTOR.

CHRISTIAN SCIENCE AGAIN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Dixon denies that Christian Science is either unscientific or blasphemous. He calls your statement "a colossal generalisation," as though the "size" of a generalisation had anything to do with its truth. This phraseology is a good example of the tall talk that serves as Christian Science literature, and is worth passing notice on that score. As to the blasphemy, with which, by your leave, I would like to deal briefly first, I would point out that if to lower Divine Providence, the Omnipotent and Omniscient, to the level of an African fetish, constitutes blasphemy, then Christian Science is certainly blasphemous, and blasphemous in the eyes not only of Christendom, but of Judaism, Buddhism, Shintoism, and every elevated religion which worships a real God and not an artificial idol of its own manufacture. We cannot explain the mystery of human suffering, but we know that disease and pain exist, and have always existed for countless generations, not only in Christian lands, but among the myriads who have never heard, and cannot in our time hear, of the name of Christ. We are told by the Christian Scientists that pain and anguish can be done away with by belief in certain dogmas or creeds, and by performance of certain rites prescribed by their special ritual; and we are thus also told that the Omnipotent allows the vast mass of human misery due to disease to continue unchecked, and dispenses His mitigating favours only to those who know how to gain His ear and propitiate Him by their ceremonies and prayers. No other word than blasphemous can properly characterise such a cult. As to the science of it, the phenomena of disease are the outward show of solid concrete facts, the results of the action and reaction of matter and force. To profess, for example, to eliminate disease, due to the reception of solid, tangible doses of specific poisons into the system, by the induction of a certain form of religious emotion within the patient, and by the prayers of ministers of the cult, is to profess to work miracles. It is not unscientific; it is non-scientific; it is pernicious nonsense.

I am, Sir, yours truly,

January 30th, 1908. HENRY SEWILL.

TRYPSIN AND CANCER—THE QUESTION OF PRIORITY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—By universal consent, there are two crucial points that establish scientific priority These are—(1) priority of publication, and (2) priority of practice, and Dr. Saleeby, in his letter of January 29th, has conceded both these points to me with regard to the treatment of cancer by trypsin.

I fail, however, to comprehend how Dr. Saleeby can reconcile the statement in his letter to the effect that "there has never been any question as to Dr. Shaw-Mackenzie's claim" with the following expression of opinion which appears in his book, p. 68—viz., "Only a few weeks after Dr. Beard's lecture, Dr. Shaw-Mackenzie began the hypodermic use of trypsin in cancer, and to him undoubtedly must be awarded the credit of being the first physician to employ the new treatment," while, in addition, in the preface to his book he refers to "the new mode of attack indicated and initiated by Dr. Beard."

The obvious and only interpretation to be placed on these statements and on Dr. Saleeby's reservation of "priority of idea," is, that the trypsin treatment of cancer is due to Dr. Beard, whereas it was introduced by myself (*Lancet*, February 11th, 1905), based on a pancreatic theory published by me (*Lancet*, January 14th, 1905)—in continuation of my own work and question in this direction, previously published—and absolutely independently of any other investigator.

In view, therefore, of the contradictory statements to which I have referred above, I do not feel myself called upon to discuss the further points which Dr. Saleeby has raised in his letter.

I am, Sir, yours truly,

J. A. SHAW-MACKENZIE, M.D. (Lond.).

London, January 31st, 1908.

OBITUARY.

DR. ANTONY ROCHE.

WE regret to announce the death of Dr. Antony Roche, which occurred on Wednesday, the 29th ult., at his residence, 60, Lower Baggot Street. Dr. Roche for many years has been a well-known figure in medical circles, and has done much by his energy as a popular lecturer to improve the general hygiene of the city. He took the diploma of the King's and Queen's Colleges of Physicians in 1871, after a distinguished career as a student, and, on the death of Professor McSwiney, was appointed to the Chair of Medical Jurisprudence and Hygiene in the Cecilia Street School of Medicine. He has also been for many years Examiner in Public Health in the Royal University. Dr. Roche was a most determined advocate of improved housing of the working classes, and, by persistent agitation through letters in the press and popular lectures, did much to prevail on the municipal authorities to remedy the evil of overcrowding in the city. His efforts in this direction also tended to inaugurate the main drainage scheme. For many years Dr. Roche has bestowed much attention on the tuberculosis problem, and, long before the present anti-tuberculous crusade, his voice was raised in commending isolation and notification. In addition to his other appointments, he filled the position of Lecturer on Hygiene to St. Patrick's College, Maynooth. Dr. Roche's sterling qualities endeared him alike to his colleagues and his students, and his name will long be honoured, not only in Cecilia Street, but by the poor of Dublin. He has left a widow and five children to deplore his loss. At a specially convened meeting of the Medical Faculty of the Catholic University, the following resolution was passed unanimously:—"The Faculty of Medicine of the Catholic University desire to place on record their sense of the great loss which the School has sustained by the death of their esteemed colleague, Professor Antony Roche. An old student of the school, whose career was marked by the highest distinctions in all his classes, he has filled the Chair of Hygiene and Medical Jurisprudence in a manner to merit professional and public respect, and to earn the gratitude of the pupils, in whom he inspired a thorough devotion to scientific progress. The Faculty mourn the untimely demise of an honourable colleague, a professor of exceptional ability, a warm-hearted friend, and a strenuous advocate of the educational claims of the Irish people. They tender to his bereaved family a sincere expression of condolence in their affliction."

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons in Ireland.—Annual Dinner.

On Saturday the annual dinner of the Royal College of Surgeons took place in the dining hall of the College, Stephen's Green. The President, Sir H. R. Swanzy, occupied the chair. There was a large attendance. After dinner and the toast of "The King," the Vice-President, Dr. Lentaigne, proposed "The Guests." The Very Rev. the Dean of St. Patrick's, the Hon. the Recorder, and the President of the Royal College of Physicians responded.

Dr. J. Magee Finney, President of the Royal Academy of Medicine, proposed the toast of "The College of Surgeons." The toast was warmly received.

The President, in responding, said that their college had unquestionably had a distinguished record. Many of its members in the past had become most eminently distinguished. But what was more important in this work-a-day world was that the vast army of the rank and file had gone forth well-equipped for the battle of life, and had carried with them over the face of the earth the healing art and the good name of that college of which they were proud. In a few days the Royal College of Surgeons would have reached the end of its one hundred and twenty-fourth year. One hundred and twenty-four years was not, after all, a great age for a college—as the lives of colleges and universities were reckoned. Yet in that country, where they saw colleges and universities springing up, as he might say, in the night—or even in the course of a Parliamentary debate—and spending so short a life that one had really hardly time to get a nodding acquaintance with them—one hundred and twenty-four years was really quite a respectable span of life. Within the last eight or ten years there had been very important achievements and improvements in that college, and in the school they had provided many improved facilities for the teaching of bacteriology and of physiology, and they had also done a great deal to promote the comfort of the students.

Professor William Carter, of Liverpool.

There was a large and enthusiastic gathering at the Adelphi Hotel, Liverpool, on the 25th ult., on the occasion of a public dinner that had been accorded Dr. Carter on his leaving that city. The occasion was also taken advantage of for the presentation of a portrait in oils, painted by Mr. F. T. Copnall. The chair at the dinner was taken by the Lord Mayor, Dr. Caton. In proposing the toast of the evening, "Our Guest," his lordship referred in felicitous and sympathetic terms to his 40 years' friendship with the guest of the evening, and expressed his deep personal regret that he was leaving Liverpool. He well remembered when Dr. Carter first came to Liverpool (and so also does the present writer) being impressed with the fact that he was not only a medical man, but a graduate in law. He remembered, too, how his professional brethren soon learned to esteem Dr. Carter and to recognise his great learning, and his great ability as a physician. Dr. Carter had worked hard for the Medical School for 40 years. He also referred to his long association with the Royal Southern Hospital as physician; to his work as city magistrate; his labours on behalf of temperance, and his close association with the School of Tropical Medicine in Liverpool. Not many knew how generous he had been, but some of them knew how open his purse had been to every call of poverty, sickness and want.

The Bishop, who spoke to the toast, thought that the words of Hamlet as applied to his father were also applicable to Dr. Carter—"He was a man, take him for all in all, we shall not look upon his like again."

Dr. Wm. Alexander also supported the toast, and his words bore the greater weight as he had for 20 years been Dr. Carter's colleague at the Royal Southern, and had, as a matter of fact, been his surgeon, and Dr. Carter had been his physician. As showing his colleague's open mind, he mentioned that, although Dr. Carter held such strong opinions in regard to alcoholic drinks, he recognised the value of alcohol in the treatment of diseases, and used it where necessary.

Dr. Carter, in returning thanks, mentioned some particulars of his career. Until a fortnight ago he said he had been supposed to be an Irishman. He had taken the Fellowship of the Royal College of Surgeons in Ireland, and had married an Irish wife. Dr. Carter, as most of his friends are aware, was born at Newbury, Berks, being the son of a medical practitioner there, so that for him the science of medicine has claims by way of heredity. Of his career it would be superfluous to speak. We wish him a happy and green old age in his retirement, and we feel sure that, with his books, his garden, and his botany, of which he has always been an enthusiastic lover, he will find plenty to occupy his time and his thoughts.

Libel Actions by Dr. Hebert settled out of Court.

We have been asked to insert the following statement as to Dr. Hebert's libel actions:—In consequence of certain reports which appeared in the Press in relation to the Versailles affair, Dr. Hebert issued writs against the following newspapers, viz.:—The *Daily News*, the *Daily Mirror*, the *Daily Mail*, the *Evening News*, the *Pall Mall Gazette*, the *Evening Standard*, the *Daily Express*, the *Westminster Gazette*, the *Manchester Courier*, the *Glasgow Evening Times*, and the *Liverpool Echo*, for publishing libellous articles sent out by the Exchange Telegraph Company, Limited, referring to Dr. Hebert in connection with a charge at Versailles against the woman Pesnel, *alias* Cesbron, and the case was settled out of Court by the payment to Dr. Hebert of the sum of £1,000 for damages and costs, and the undertaking, on the part of the said newspapers, to publish an apology of a form agreed upon, and which has already appeared in the *Daily Mirror* of January 10th last.

University of Durham.—Faculty of Medicine.—Alteration of Dates of Professional Examinations.

The attention of candidates is directed to the fact that the examinations in Medicine, Surgery and Hygiene will, in future, be held in March and July, instead of April and September, as hitherto. For particulars as to dates of forthcoming examinations see advertisement.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

The following candidates have passed the Third Professional Examination, January, 1908:—P. N. Allman, H. Gray, E. A. Gregg, J. T. Heffernan, L. Hynes, T. J. Lyons, J. Marmion, T. McDonald, H. G. Miles, A. E. Moore, W. P. H. Parker, J. Patton, P. M. Power.

Special Examination for the Diploma in Public Health.—E. E. B. Landon, M.R.C.S., L.R.C.P.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

The Contents of Irreducible Inguinal Herniæ in Female Subjects, and True Hermaphroditism.—Corner (*Brit. Med. Journ.*, Jan. 4th, 1908) states that the contents of irreducible inguinal herniæ in females differ in the most marked manner when found in adults and when found in children. In children some of the female internal genitalia are practically always found in the hernial sac. The author has tabulated 20 cases of these herniæ in female infants up to 13 months old. Ninety-five per cent. of these contained ovaries or tubes, or both. In 15 per cent. bowel was present as well. When irreducible, the hernia of a female child will be felt to contain a small rounded body about the size of a small pea, which is freely movable upon its pedicle. It is the ovary. When strangulated, there is a non-translucent mass over the external abdominal ring through which it protrudes. There need be no sickness, and the bowels will act. The lump gets larger and larger, but may cause the infant very little inconvenience. The diagnosis is easy. When the hernia is simply irreducible the ovary and tube can be readily felt. When the hernia is strangulated and has no impulse on crying, the diagnosis is not difficult to make on account of the non-translucence of the swelling, and the association of it with no more symptoms than perhaps some slight irregularity of the bowels and the digestion. The hernia is of truly congenital origin, but may not appear till shortly after birth. The irreducibility to some extent depends on the difficulty that there may be in manipulating a small movable body through a small hole. Very occasionally these organs undergo spontaneous reduction. Operation is the only treatment, the gland being returned to the abdomen, and the sac removed. The use of the truss is contraindicated on account of the injury it may do to the gland. If left *in situ* the ovary is very liable to torsion of its pedicle, causing inflammation and destruction of the gland, or to the prevention of full maturition and development at puberty. In some cases, if the glands are removed and examined microscopically, they will be found to be immature testicles, not ovaries. When this is so the case is truly hermaphrodite—male generative glands and female generative organs. In 49 cases of irreducible inguinal herniæ in females between the ages of 15 and 91 years, four only contained internal generative organs, while 65 per cent. contained bowel. S.

The Treatment of Tuberculous Arthritis.—Primrose (*Canadian Journal of Med. and Surg.*, January, 1908) in general advocates conservative non-operative treatment in tuberculous arthritis, but recognises that operative measures are not infrequently indicated where the conditions are becoming rapidly worse, in spite of efficient conservative treatment. In tuberculous abscesses the great point is to avoid mixed infection by avoiding the drainage tube. Abscesses occasionally disappear spontaneously. When the abscess is enlarging progressively it should be incised by cutting into the cavity at a point which is not dependent, the incision being so placed that a considerable thickness of tissue is cut through before the cavity is reached, and not where the abscess approaches the skin. After evacuation of the contents the wall is thoroughly curetted, then rubbed with iodoform gauze and curetted again, the process being repeated till a smooth firm wall remains. The cavity is then flushed out with sterile water and carefully stitched up again without drainage. Occasionally the cavity fills up, and leakage occurs, the line of incision breaking down. The same process should be repeated a second time. Even a third operation may be necessary; but if a culture from the cavity shows pyogenic organisms, it is useless to persist. Excision of joints or less extensive operations are sometimes called for, as where serious destruction of a joint is threatened, or where constitutional symptoms become grave. Also in long-standing cases where septic sinuses exist amputation may be necessary. In cases of definitely localised areas of disease it is often possible to remove these foci without opening the articular cavity. The author removed diseased bone from the femoral neck by tunnelling through the great trochanter. S.

Appendicitis due to the Presence of Oxyuris Vermicularis.—Thrush (*Medical Record*, December 28th, 1907) describes a case presenting the usual classical symptoms of acute appendicitis. As medical treatment failed the appendix was removed by Dr. Wharton. It presented the characteristic appearances of acute infection, the only peculiar feature being a bulb-like expansion of the tip into a mass about one inch long and about double the calibre of the remainder of the organ. On dividing the appendix a thick mucoid substance was found, with a constriction above it, separating it from the rest of the appendicular canal. The mass contained a large number of worms moving around freely. There were about one hundred of these in various stages of development. Microscopically the diagnosis of oxyuris vermicularis was confirmed. Rectal examination showed an abundance of these worms. Evidently they had spread up from the rectum, and some of the ova becoming imprisoned in the appendix had developed and caused the attack of appendicitis. S.

Inoperable Sarcoma of the Neck Treated Successfully with Coley's Toxins.—Oliver (*Lancet-Clinic*, January 11th, 1908) reports the following case. The patient, æt. 52, had a tumour in the neck for 11 years, when it commenced to grow rapidly, and was removed. It proved microscopically to be a myxo-fibro-chondrosarcoma. New tumours appeared, and grew more rapidly than the original ones. They were situated at the angles of the jaw and along each carotid sheath. The right tonsil and side of the pharynx were pressed inwards by these masses, seriously encroaching on the lumen of the throat, and causing difficulty in swallowing. The right tonsil was indurated, ulcerated, and had the appearance of a malignant growth. An attempt was made to remove one of the tumours for diagnostic purposes, but it was so friable, vascular, and intimately united to the lower jaw that it was found impossible to remove the entire mass. A microscopic section of part of the removed mass showed chronic adenitis, but the subsequent history proved the malignant nature of the case. Coley's serum was injected from October, 1905, to March, 1906, about every other day. This was followed by marked local reddening of the skin over the masses, and also by a general reaction. During part of this period X-rays were also employed. In March there was scarcely a remnant of the original growth. Two months after leaving hospital the patient developed, apparently spontaneously, a severe attack of facial erysipelas, which quickly recovered under treatment. The tumours disappeared entirely, and remained away until November, 1907, when there was a recurrence in the right parotid region. He is again under treatment. The author used this treatment in three cases of tuberculous cervical adenitis. The reaction was not well marked, and no good results were obtained in this class of case. The author considers that about 10 per cent. of sarcoma cases are saved by Coley's treatment. S.

Modifications of the Movements of the Knee-Joint Directly Consequent on Injury.—Sir Wm. Bennett (*Brit. Med. Journ.*, Jan. 4th, 1908) divides these cases into two types—(*a*) those in which the joint is completely locked; and (*b*) those in which flexion to a limited degree is possible. The commonest causes of complete locking in patients under 35 are displaced semilunar cartilages. After that age it is usually due to hypertrophied synovial fungus, especially in osteo-arthritis. Some cases in young patients are due to an abnormal flap of synovial membrane which is sometimes found dependent from the patella. These occasionally become caught between the bones of the joint. Rarely, locking is due to a piece of bone broken off one of the condyles. The author does not consider that a displaced tendon of popliteus muscle is a possible cause. Locking in the absence of an anæsthetic may be caused by muscular spasm, secondary to pain. Restriction of movement in the joint may be due to small foreign bodies acting as a wedge in certain positions of the joint only. A fairly common cause is ruptured conical ligaments following a violent forcing backwards at the knee-joint. The commonest causes of restriction of movement are extra-articular, as rupture of the inner head of the gastrocnemius, thrombosis from injury to a vein, and formation or rapid increase of a popliteal bursa in osteo-arthritic subjects. If extension is free, the question of foreign bodies between the bones may be for practical purposes set aside. S.

Acute Suppuration in Thyroid Adenoma.—T. Legg (*Lancet*, January 25, 1908) reports the case of an Italian, æt. 26. He was suffering from typhoid fever, which ran an ordinary course, but at the end of five weeks his temperature, instead of dropping, began to rise again, and a tender swelling was discovered in the right lobe of the thyroid. The gland had been enlarged for at least two years, presenting the appearance during this time of an ordinary goitre. In four days' time the swelling had become much larger, the whole of the right lobe being globular and elastic. The evening temperature was over 102°. An incision was made into this swelling, and about two ounces of pus were evacuated. The cavity was drained, and healed in the course of a couple of weeks. From the pus evacuated cultures of typhoid bacillus were obtained without any difficulty. The formation of an acute abscess in an enlarged thyroid gland is always a rare occurrence, but probably happens more often after typhoid fever than under any other conditions. Once a diagnosis of pus is made, the abscess should be opened at once, as otherwise it is liable to penetrate the capsule of the gland and lead to a diffuse cellulitis of the neck and mediastinum, or may open into the trachea or pharynx. Whichever of these occurs the result will in all probability be fatal. G.

Anastomosis of the Ureter.—Leguen (*Le Progrès Médical*, August, 1907) thinks that the causes of failure in many cases of ureteral anastomosis are due primarily to a fault of union by primary intention. When this occurs, either immediate or remote failure is bound to ensue. It is well to remember that because a case clinically appears well, we cannot regard the ureteral anastomosis as successful until the ureter has been catheterised. The author mentions a case of ureteral implantation in the bladder. This operation was performed for a patient who was continually getting severe attacks of renal pain of an obstructive nature. This obstruction was proved to be due to the retraction and thickening of a ureter which had been previously injured. The operation was apparently quite successful, the renal crises all ceased, but three years later the patient died, and the post-mortem examination showed the anastomotic opening completely obliterated, and the kidney had become entirely obliterated. G.

Congenital Hydronephrosis.—H. Coffin (*Post Graduate*, January, 1908).—The congenital forms of hydronephrosis are rarely bilateral. The condition may result from abnormal position of the kidney, atresia of the ureter, abnormal valvular formations, phymosis, and abnormal entrance of the ureters into the bladder. The retained urine distends the ureter, extends to the pelvis of the kidney, then to the tubules, causing degeneration finally of the parenchyma of the kidney. The author reports two cases—a child, aged 23 days, died, after some convulsive attacks, and the passage of a small amount of blood-stained urine. P.M.—Acute parenchymatous nephritis, the ureters were distended to twice their natural size, both pelves were dilated, the right ureter was markedly constricted 4 c.cm. below the kidney, at its entrance into the bladder there was another constriction causing dilatation above. The left ureter was narrowed at its entrance into the bladder, and above this the tube was greatly dilated. The bladder was normal, and contained a little bloody urine. The second case was that of a child who only lived six weeks, and died of an acute pleurisy, P.M. —There was acute nephritis and hydronephrosis of the right kidney. The pelvis of the kidney was much dilated, five cm. below there was a tight constriction of the ureter. There was a second stricture of the right ureter at its entrance into the bladder. The bladder was normal. In neither case was there any stone in any part of the urinary organs which could possibly have caused the trouble. G.

Cocaine in Vomiting after Anæsthesia.—H. Freund (*Wien. Klin. Woch.*, November, 1907) believes that if the gastro-intestinal canal is completely anæsthetic, all reflex irritability must necessarily be abolished. Vomiting usually occurs after a general anæsthetic as soon as the patient regains consciousness, though its appearance may be delayed for some hours. No one method of combating this vomiting can succeed, as there are two varieties of it—central, due to irritation of the vomiting centre in the medulla oblongata, and peripheral vomiting, due to reflexes originating in gastric and intestinal irritations. The former occurs during the induction of anæsthesia as the stage of excitement is passing into that of narcosis, the latter depends partly on the irritation caused by saliva impregnated by the anæsthetic, and partly by the secretion of the anæsthetic by the gastric mucosa. The author treats post-anæsthetic vomiting in the following way: Half an hour before the administration of the anæsthetic 1-6th of a grain of morphia and 1-200th of a grain of scopolamine is given hypodermically, just before the operation is completed 1-3rd of a grain of cocaine is given hypodermically to the patient. Out of 110 cases so treated only 14 had any vomiting after the anæsthetic. G.

Six Cases of Congenital Word-blindness affecting Three Generations.—In the *Ophthalmoscope* of September 1, 1907, Sydney Stephenson relates the above experience. The symptoms of the case which came under observation, and which gave rise to an inquiry into her family history, were of the usual kind, and similar to those recorded by other observers. The young lady, aged 14, was well developed and strong, with good hearing and full visual acuity, with weak correcting glasses. Her education was commenced before she was seven years old, and after two years she could read her letters at sight. When ten she could read aloud with difficulty such short words as "dog," "cat." During the following two years considerable improvement took place in her reading. Although distinctly intelligent, the patient was two years older than the others in her class. There was, as usual in these cases, no difficulty with figures, arithmetic being her strong point. Good at geometry, and passed with honours three examinations in drawing. Although learning music for six years there was difficulty in reading the notes. The family history revealed that the maternal grandmother learned to read with difficulty, and was seldom seen to read to herself. The patient's mother (unaffected) was the eldest of eight children, four of whom showed symptoms of congenital word-blindness. Of these, Barbara, now aged 35, could read slowly when 14, seldom reads for pleasure, and is very musical. Charles, who died at 32 years, was educated and clever, but had more difficulty in reading than Barbara. A girl who died at 8 years had a difficulty in learning to read, and Bella was worse than Charles. A brother, aged 16, had no difficulty in learning to read. It will be noted that the condition was passed from the second to the third generation by a female, who herself was unaffected. M.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

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VETERAN NURSE.

At the age of 104 Mrs. Mary Nelson, formerly an Army nurse, who was with Miss Florence Nightingale's nursing staff in the Crimean war, and was an eye-witness of the charge of the Light Brigade, has died at Carrick-on-Shannon (Co. Leitrim).

Pes Anserinus.—We have looked into the matter to which our correspondent refers, and our information goes to show that his assumption is quite correct.

Dr. G. J. P.—We are sorry to have to hold your letter over owing to the crush this week.

THE LATE ATTORNEY-GENERAL.

The lamented death of Sir John Lawson Walton reminds us that he was counsel for the plaintiff in a case which attracted great attention in medical circles some years ago. It was the action brought against the late Dr. William Playfair by a patient for breach of professional confidence, viz., communicating information to his wife. The verdict went against him, and he had to pay £12,500 damages.

Laboratory Notes.—Under the above heading last week we inserted a notice of Messrs. Allen and Hanbury's preparation "Sauerin"—by a typographical error this was spelt "Sanerin." At the same time we should like to mention that although Professor Metchikoff's name is mentioned, he is in no way responsible for the preparation.

N. 3 Med. Journ.—We are glad to see you read this column, and should be still happier if you thought more of us when quoting.

"OPHTHALMIA" NEONATORUM.

Up-to-date Medical Student *(loquitur)*: "Please, sir, what is ophthalmia neonatorum?"

Elderly Ophthalmic Surgeon: "Inflammation of the conjunctiva of the infant."

U.-t.-d. M. S.: "Yes, sir, I know—but what is 'ophthalmia'?"

E. O. S.: "Well, it doesn't mean inflammation of the eye——"

U.-t.-d. M. S.: "Thank you. But what I want to know is—wouldn't it be more correct to say *conjunctivitis* neonatorum instead of *ophthalmia* neonatorum?"

E. O. S.: "Certainly not. Hippocrates used the word 'ophthalmia,' and later authors after him have done the same."

U.-t.-d. M. S.: "I'm so much obliged. I'll make a note of that."

C. A. M. B. (National Canine League).—Can you seriously expect us to publish a letter containing such an expression as yours begins with? We certainly refuse to give currency to such a story as you introduce, unless we are satisfied that it is literally true; that it took place in England within recent years; that no anæsthetic was administered; and that the case had been brought to the notice of the Inspector under the Experiments of Animals Act, and not dealt with by him. If we are satisfied as to these points, we should do more than merely publish it without comment. If it does not fall in with these conditions, it is no more in point than the horrors of the Inquisition.

Meetings of the Societies, Lectures, &c.

Wednesday, February 5th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. R. H. J. Swan: Malignant Cutaneous Tumours.

Thursday, February 6th.

The Throat Hospital (Golden Square, W.).—5.30 p.m.: Mr. Faulder: Lecture:—Surgical Anatomy of the Tympanum and Mastoid Process.

North-East London Clinical Society (Prince of Wales's General Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. R. Jones (Liverpool): The Present Position of Arthrodesis and Tendon Transplantation.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Syphilis: Papular (I., Miliary; II., Lenticular; III., Squamous; IV., Moist), Pustular and Tuberculous.

Friday, February 7th.

Royal Society of Medicine (Laryngological Section) (20, Hanover Square, W.).—5 p.m.: Dr. W. Williams, Sir Felix Semon, Dr. J. Donelan, Dr. St.Clair Thomson and Dr. J. Horne: Cases and Specimens.

West Kent Medico-Chirurgical Society (Miller Hospital, Greenwich, S.E.).—8.45 p.m.: Dr. F. E. Taylor: Uterine Hæmorrhage.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8 p.m.: Pathological Meeting. Specimens will be shown.

Society of Anæsthetists (20, Hanover Square, W.).—8.30 p.m.: Adjourned Discussion on Status Lymphaticus.

Royal Society of Arts (John Street, Adelphi, W.C.).—8 p.m.: Mr. W. Burton: The Hygiene of the Pottery Trade. (Shaw Lecture on Industrial Hygiene.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. C. E. Beevor: Diagnosis and Treatment of Hemiplegia.

Monday, February 10th.

Royal College of Surgeons of England (Lincoln's Inn Fields).—5 p.m.: Erasmus Wilson Lectures:—Mr. S. G. Shattock, F.R.C.S.: Ovarian Teratomata.

Appointments.

Cooper, A. J. Sisson, L.R.C.P. and S.Irel., Medical Officer and Public Vaccinator for the Fontmell District.

Friend, Gerald Edward, M.R.C.S., L.R.C.P.Lond., Superintendent and Resident Medical Officer at St. George's Hospital.

Glenny, Edward T., M.B., B.S.Lond., L.R.C.P.Lond., M.R.C.S., Medical Officer to the Bristol Dispensary.

McCandless, R., M.B., B.Ch.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Rathfriland District of the county of Down.

Morris, Leonard Newsom, L.R.C.P.Lond., M.R.C.S., Medical Officer to the Bristol Dispensary.

Phillips, Hugh R., M.D.Edin., Physician to Margaret Street Hospital for Diseases of the Chest.

Telling, W. H. Maxwell, M.D., B.S.Lond., M.R.C.P., Honorary Physician to the Cookridge Convalescent Hospital, near Leeds.

Vacancies.

Castlebar Union.—Medical Officer. Salary, £110 per annum. Applications to J. M. Quinn, Clerk of Union. (See Advt.)

Birkenhead Borough Hospital.—Senior Resident House Surgeon. Salary, £100 per annum and fees. Applications to the Hon. Secretary.

Parish of Lambeth.—Board of Guardians.—Third Resident Assistant Medical Officer. Salary, £125 per annum, with the usual residential allowances. Applications to the Medical Superintendent at the Infirmary, Brook Street, Kennington Road, S.E.

County Borough of Great Yarmouth.—Assistant Medical Officer of Health. Salary, £200 per annum. Applications to W. Edgar Stephens, Town Clerk, Town Hall, Great Yarmouth.

Drogheda Union.—Medical Officer. Salary, £110 a year. Applications to Thomas Dowdall, Clerk of Union. (See Advt.)

Births.

Buchanan.—On Jan. 30th, at Kirkgate, Thirsk, the wife of Walter J. Buchanan, M.B., of a son.

Edwards.—On Feb. 2nd, at Granville House, Bridport, the wife of Charles Edwards, M.R.C.S., of a son (stillborn).

Marriages.

Reynolds—Romer.—On Feb. 1st, at Holy Trinity Church, Tulse hill, London, Russell John Reynolds, M.B., B.S. (Lond.), L.R.C.P., M.R.C.S., only son of John Reynolds, M.D., F.R.G.S., of 11, Brixton-hill, London, to Anna Thekla Henrietta Römer (Annie), only daughter of Adolph Römer, of "Brynbella," Tulse-hill, London.

Deaths.

Green.—On Feb. 1st, at Greyroofs, Wimbledon Hill, London, Mowbray Vincent, only son of Dr. and Mrs. Vincent Green, in his 6th year.

Holland.—On Jan. 31st, Charlotte Elizabeth Holland, dearly beloved wife of Dr. Edmund Holland.

Marley.—On Jan. 26th, at Mellingey, St. Issey, Cornwall (late of Padstow), Henry Frederick Marley, L.R.C.P.Lond., M.R.C.S.E., last surviving son of the late M. P. W. J. Marley, F.R.C.S., of Burlington Gardens, London, W., aged 76.

Pettigrew.—On Jan. 30th, at The Swallowgate, St. Andrews, James Bell Pettigrew, M.D., LL.D., F.R.S., F.R.C.P., Chandos Professor of Medicine and Anatomy in the University of St. Andrews.

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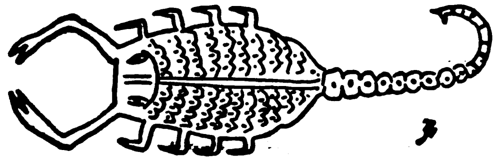

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NOTES AND COMMENTS.

More Light. A nation which deliberately neglects the resources placed by Nature at its disposal must not seek sympathy if it suffers in health or pocket by its policy. The gospel of fresh air, imported from Nordrach, has—the gospel, that is, not the fresh air—captured thousands, and the gospel of light, imported from Denmark, has conquered its tens of thousands. Stuffiness and darkness are beginning to be recognised as unnatural conditions of life for *homo sapiens*, and there is no doubt these are very healthful notions. Electricity or incandescent gas have not the reputation of sunlight, either as agents for good or as bactericides, and yet civilised man deliberately prefers literally to turn night into day rather than endure the minor discomforts of getting up a little earlier in the morning and going to bed a little earlier at night. A gentleman named Mr. William Willett recently devised a plan for cheating us of our laziness without our knowing it; something like the "drink cures" which are put into the drunkard's cup to deprive him of his relish for strong liquor. Mr. Willett's proposal was that all public clocks during the Sundays of the month of April should be put forward twenty minutes, so that during the summer we should have an hour and twenty minutes more daylight during waking hours. Similarly during the month of September the Sunday time should undergo a complemental retrograde movement, so that by October we should be in the same position as we would have been if the scheme had not been in operation.

And Old Age Pensions. Public attention has been called to the matter by the introduction of a Bill into Parliament "to promote the early use of light in certain months of the year"; Mr. Robert Pearce, the member for Leek, being the agent who wishes thus to do us all good by stealth. This gentleman has had to undergo a good deal of good-natured chaff by his unimaginative fellow-legislators, and we should be surprised if so novel a measure found its way to the Statute Book in the course of the next few sessions. But, looked at fairly and squarely, we confess we like the scheme very much, and when hygienic crusades are taking place on all sides it is not for medical reformers to throw cold water on so suitable and elegant a plan for giving health to the people. From every point of view, sunlight is the prime agent of good to man. It supplies him with energy, it tinctures his blood with hæmoglobin, it slays the insidious microbe, and it relieves the strain on his eyes; so much we know, and what good influences lie in its actinic rays we are beginning to find out. Opposition is sure to be forthcoming from gas and electric light companies, whose shareholders, like Demetrius, would be alarmed for the gains of their occupation did the plan look like succeeding; but that would be all the more reason why citizens with no axe to grind should adhere to the other side. It is calculated that the nation would save £2,000,000 yearly by this simple dodge, and if, grateful for the support of the profession, they would use that sum for the supply of old age pensions for medical men over the age of 60, we may assure the promoters that our support would be none the less hearty.

Mrs. Harris à la mode. Even those who are most dissatisfied with the present system of training and "supervising" midwives agree that poor women should have the advantage of being able to secure in their confinements, the services of a person who has had some education in the responsibilities attendant on the practice of the art of obstetrics. The worst of education, however, is that it has a knack of making Jack as good as his master, and despise the daily round and common task which in his unregenerate condition he performed without demur. The old-fashioned Gamp, with all her dirt, and superstition, and ignorance, when she attended a confinement, was not above doing the housework, cooking the husband's dinner, and slapping the children, what time her patron was unable to carry out those necessities of civilised existence. The registered madam of to-day, now that her eyes are opened to the difference between good and evil, considers herself a professional lady, and the position of a domestic drudge is not one which she fancies. At least, so it would appear from a claim made by one Clara Tyte in the Temple Cloud County Court recently. The lady in question sought to recover from a farm labourer the sum of 5s., the balance of the amount alleged to be due to her for attending the defendant's wife in her confinement. The stipulated fee was 10s., but the plaintiff, after attending for three days, was taken ill and had to secure the services of a fellow-midwife, who, like herself was duly certified, to complete the job. The substitute bore the suggestive name of Mrs. Harris, but, unlike her renowned prototype, she was visible in the flesh when duty called. The defendants were not pleased with either of the midwives, and refused to pay Mrs. Tyte for Mrs. Harris's services, alleging neglect on the part of both ladies. These ladies, however, replied that their duties did not include household work, and eventually obtained judgment for 4s. and costs. Surely the old order is changing, but is the new quite Utopian?

The Brown Dog in Parliament. The brown dog has founds its way into Parliament. The Home Secretary was quizzed last week as to the cost of guarding the memorial, and apart from emergency arrangements, it seems that six members of the Metropolitan Police are told off for the sole purpose of watching the statue. Indeed, Buckingham Palace, in all its glory, is not more efficiently cared for, for two sentry boxes have been erected for the accommodation of the policemen on guard, and a sleepless vigil is kept up. The suggestion was made that the cost of these measures should be borne by the Battersea Borough Council, and there seems to be every reason in common sense why they should be. That sapient body have had every opportunity of making reparation for the insult and of withdrawing the obnoxious inscription, but although a temperately-worded motion for this purpose was presented by one of their members and well supported by the more statesmanlike members, the majority would not listen to it, and the proposal was rejected by a large majority. If the Council as a whole, then, consider the inscription worth preserving, they probably will see no reason why it is not worth paying for, and they would probably render themselves very popular with their constituents if they proposed to cast a burden of £700 a year on the rates to gratify their favourite whim of posing as humanitarians and stultifying that honourable title. As things stand, the next move, it seems to us, lies clearly with the Council of University College, who have the public courts open to them, and who should not hesitate to have recourse to them to justify the good name of their institution. Everyone knows ths risks of the law, the chance of a composition of a jury, and the predispositions of the parties engaged, but the accusation is sufficiently specific and definite to afford ground for action, and the College should not fear to attempt victory because of the risks to be taken in achieving it.

Royal Commission on Vivisection. After all it is necessary to remember that the anti-vivisectionists form a very small proportion of the community, although by the noise they create they may be mistaken for a lusty crowd. As a matter of fact, a great deal of the shouting done by them is analogous to that of a child in the dark who makes a noise to show he is not afraid. The influence of the various cliques which run good-hearted people into mistakes and misapprehensions as to experiments on animals is likely to be seriously undermined, we venture to predict, when the report of the Royal Commission on Vivisection comes out. That body has now retired to draft its report, which is likely to be presented in April or May, and seeing the class of people who gave evidence on the anti-vivisection side, their mental calibre, and their general muddleheadedness, we cannot see how the Commissioners can attach any weight to their evidence. The Hon. Stephen Coleridge, with his wild accusations and ingenious methods of treating "facts," cut a particularly pitiable figure when faced with such an impartial judge of evidence and procedure as Lord Selby, before whom bluster and pompous posturing are not calculated to score, as they do on the annual platform of "my" society. We are prepared to see an increase in the inspectorate recommended, for the simple reason that the bulk of the work carried on now is vastly greater than it was thirty years ago, and also as a guarantee to the public that every reasonable precaution is taken. We have no doubt, too, that various points in administration will be subjected to suggestion and criticism, but we shall be surprised if the report is not unanimous, considering the line taken by the various members in examining witnesses.

Indecent Advertisements. We should be glad to know if it has come to the knowledge of any of our readers whether any of their lady patients who have been recently confined, have received obscene advertisements from certain traders. In a case under notice, among the many legitimate advertisements of perambulators and baby requisites which flood the letter-box of parents of a child whose birth has been announced in the daily papers, a particularly offensive circular was received addressed to the wife and marked "Private." Among the announcements of certain trumpery goods purveyed by the firm is contained descriptions of aphrodisiac medicines and preventive pessaries, together with the usual insult to the effect that this sort of thing is supported and prescribed by the medical profession. It is disgusting enough that every dealer in pornographic literature and other filth should advertise "medical specialities" as a description of his prurient goods, but it is more than insulting when the lowest type of quack preparations are described as "recommended by the medical profession." How far the guttersnipe who send advertisements of this type to ladies recently confined are amenable to the law we are not aware, but the matter is certainly one for the police, and we should be glad to place evidence of this kind before them. Indecent advertisements can be no less of a scandal when sent direct to ladies than when published in "comic" papers, and the parties responsible for them should be held equally criminal.

LEADING ARTICLES.

ANOTHER UNITED HOSPITALS CONFERENCE.

MORE than a year has elapsed since the joint Conference of representatives of the medical charities of the United Kingdom met together at University College, London. Our views upon that event were freely expressed in a leading article of the MEDICAL PRESS AND CIRCULAR of December 12th, 1906. The main feature of the situation was a transparent attempt to fix upon the whole hospital system a set of principles framed by persons who, for the most part, were not in close touch with the general practitioner, in whose interests the Conference has been avowedly organised with a view of stemming the tide of hospital abuses. We pointed out that the chairman, although an eminent and a popular man, as an ex-President of the London Royal College of Physicians, represented a body that is absolutely autocratic and aloof from the faintest suspicion of modern democratic thought and progress. The chief resolution, again, was moved by Sir Henry Burdett, an amiable and well-intentioned philanthropist, but, so far as one can gather, without any solid claim to represent the general interests of medical men. The Conference of 1906 was asked to adopt out of hand a number of principles involving most complex and vital issues, and the delegates spoke their minds on these matters with no uncertain voice. They carried a resolution welcoming the further consideration of the principles drawn up by the joint Hospitals Committee of the British Medical Association; they advocated an annual conference; and they appointed a committee to act in conjunction with the Hospitals Committee to consult with medical charities generally and organise a Conference in 1907. The determination to hold a further meeting in 1907 has fallen through, but it is gratifying to find that the germ of energetic hopefulness indicated by the original attempt has been able to survive the perils of its nativity, and that another meeting is to be held in 1908. The composition of the committee entrusted with the organisation of the coming Conference is, we venture to say, hardly that which will secure the confidence of the general practitioner. Take the vexed question of payment by hospital patients, which is one of supreme importance in the relations of the medical charities to the profession. On the committee of fifteen are such ardent advocates of the pay system as Sir Henry Burdett and the Hon. Sydney Holland, not to mention others. Then, again, the lay portion of this united committee has an overwhelming element from the Metropolitant Hospital Funds. With all our admiration of those bodies, it is impossible to shut our eyes to their faults. The government of the King Edward's Fund, for instance, is absolutely autocratic, and the representative element is either absent or hopelessly curtailed. The policy of the Sunday and the King Edward's Funds is clearly to destroy the small hospitals, and their awarding or withholding of public money is determined upon *in camerâ*. There is no opportunity for an aggrieved hospital to appeal against a decision or to ascertain the reasons for a grant having been withheld. Under such circumstances the dispensation of money entrusted to the Funds for distribution is practically handed over to a kind of Twentieth Century Star Chamber, of which the administrators and defenders are amiable and benevolent elderly gentlemen whose only conceivable ulterior motive could be the somewhat meagre one of love of power and the thirst for social advancement. Now, if the United Kingdom Hospitals Conference Committee, as it is now called, wants to submit a vital issue at their meeting, let them bring forward the policy, the administration, and the control of the Metropolitan Hospital Funds. If these things be settled on a sound basis in London the rest of the kingdom will quickly follow suit. The Funds are claiming the right by the power over the purse to direct the affairs of the metropolitan hospitals. This assumption may, or may not, after due discussion, meet with general approval. But the public will demand a declaration of the principles which are adopted by the Funds. Are the Funds, for instance, in favour of the pay system by patients, or are they not? Do they uphold any system of restricting the number of patients seen by the honorary medical staff? Are they to be supported in their deliberate policy of crushing the small hospitals out of existence? Why should not the Funds seize the opportunity of this Conference, pregnant as it is with possibilities for the future progress of the cause of the medical charities, to declare their views upon each of the fundamental principles to be discussed at the Conference? Surely, if the Funds are to be the self-appointed mentors of the hospitals, their minds should be made up on all these points. If they are not so made up, how can the public and the medical profession and the medical charities look forward to consistency and justice in the allocation of money given by the charitable for the relief of the suffering poor? At present the policy of the Funds appears to be simply chaotic, and lies at the mercy of the caprice of irresponsible individuals or small groups of individuals. At the present moment there is a widespread feeling of discontent against the arbitrary actions of the King Edward's Fund, and we suggest that the Fund will do well to approach the Conference, and by that conciliatory step to avert the possibility of a coming storm. As regards the Conference itself, we have little doubt that the representatives will have the courage of their opinions in 1908 as they had in 1906, and that they will refuse to be guided by any but their own convictions. The issues are of importance, not only to the medical profession, but also to the public. Moreover, ultimate settlement can only be arrived at on sound and equitable principles, but the evolution of perfection in human affairs is often an extremely slow process. At any rate, whether we agree or otherwise with the views of the organisers of the original Conference, we thank them most heartily in the name of the medical profession for the attempt to arrive at some sort of solution to the many problems that vex the hospital world. That they should have survived the somewhat serious rebuff of 1906, and have presented a revised programme for discussion in 1908, furnishes a proof of tenacity of purpose that augurs well for the future. They have practically accepted the only sound basis of permanent rule, namely, government by consent or representation of the majority. If we mistake not, the real struggle to be fought out at the second Hospitals Conference is that between the autocratic and the representative government of hospital funds, of hospitals, and of the medical profession.

THE HEALTH OF DUBLIN.

Dublin is, as our readers are aware, the city with the highest death-rate in the kingdom. During the ten years 1895-1905 its average annual death-rate was 27 per 1,000, as contrasted with that of London, 17.7 per 1,000, and of Edinburgh, 16.7. During the past few weeks the mortality rate of the Dublin Registration Area, which contains several healthy suburbs as well as the City of Dublin, has reached to 30 and even 33 per 1,000 per annum, the city rate being presumably something higher. It will be seen, therefore, that Dublin has an unenviable eminence, not only in the United Kingdom, but throughout Europe. As a matter of fact, outside some of the cities of Russia, we can find no city in Europe whose average mortality is as high as that of Dublin. These facts are so notorious that one might hope that the Corporation of Dublin would have been forced by very fear to bestir themselves to do something to put the city in a more healthy condition. It will hardly be believed that Dublin, a city with over a quarter of a million inhabitants, and the appalling mortality we have mentioned, has not the advantages of the services of a whole-time medical officer of health. Such, however, is the case, and, moreover, in the health department there is not a single qualified assistant. In the year 1900 a Committee appointed on the suggestion of Earl Cadogan, then Lord Lieutenant of Ireland, to inquire into the causes of high mortality in Dublin, made in their report some eighteen recommendations. Of these, according to the report of Surgeon-Colonel Flinn to the Local Government Board a year ago, four have been followed. The excuse given for the neglect of most of the remainder is, that new legislation is necessary to carry them into effect. This requisite legislation the Dublin Corporation are now in a position to demand, as they are promoting an Omnibus (or Various Powers) Bill in the present session of Parliament. As first drafted and submitted to the House, this Bill contained clauses which would give the Corporation much valuable power to deal with matters affecting the public health. Provision is made therein for the compulsory notification of tuberculosis, for the establishment and maintenance of a bacteriological laboratory, for the better control of meat and milk exposed for food, and for the establishment of milk depôts. To our amazement, however, it is now proposed to drop these sections! Vested interests have apparently been too strong, and the Bill has been eviscerated. As a measure for the betterment of public health, it will not be worth the paper it is printed on, except for the solitary clause making it a penal offence to spit in a public place! We do not know how long the public of Dublin is going to tolerate this criminal contempt for their lives. If the Corporation of Dublin persist in the withdrawal of the public health clauses, they are taking on their heads the responsibility of postponing indefinitely the public health reforms so urgently required.

CURRENT TOPICS.

The Professional Income.

THE editors of some of the public newspapers have lately been exercised in mind as to the general prosperity of the medical profession. They have been set thinking by the fact that large numbers of highly-qualified men apply for any vacancy in a public post offering a salary of £500 a year. The idea of a man in the prime of life, who has spent several thousand pounds and devoted many years of his life to render himself competent in a learned profession striving for such a post as his *summum bonum,* may well make the average journalist pause. What moderately prosperous tradesman would launch his son on the journey of life with such a prospect as that before him? Yet the average medical practitioner would think himself lucky if he can made sure of an income of £500 after years of honourable and assiduous toil. The fact may be commended to Mr. John Burns and other legislators who appear to think that the State is entitled to demand gratuitous services from the medical profession. A close review of the situation, however, will serve to show the editors that they themselves have no small hand in straitening the medical income. Without newspaper advertising there would speedily be an end of the huge system of quackery which now defrauds the public and diverts them from the honourable services of State-qualified medical practitioners. The public suffer not only in health, but also by the injury inflicted upon their medical attendants—while the newspaper proprietors, and their advertising clients, prosper exceedingly.

Report on the Peterhead Typhoid Epidemic.

THE report on the recent epidemic of enteric fever at Peterhead has been presented by Professor Matthew Hay to the local Town Council. Some interesting points were brought forward. The sanitary arrangements of the town are clearly open to a good deal of improvement, especially in the provision of water closets and of sound drains. The origin of the epidemic, moreover, lay neither in the water supply nor in the defective drainage, although the water supply appears to be in need of rigorous remedial measures even more than the drainage system. It is exposed to risks of contamination at many points, and the catchment area of its origin contains various dairy farms manured with town refuse. So that if Peterhead has not been devastated by wholesale typhoid fever, it seems to be rather by good luck than by good management. The ultimate cause of the outbreak was an infected milk supply, and the later spread of the disease was for the most part due to personal contact. Peterhead has now had a formal warning, so to speak, to put its house in order, still it is somewhat disquieting to learn from Professor Hay that in the matter of defective drainage Peterhead is probably not worse than the majority of towns of similar size and age. Like all other reforms, that of sanitation makes but slow headway against the inertia of the established and conservative order of things.

Herbal Indignation.

THE Bradford and Halifax Branch of the National Association of Medical Herbalists, Limited, held a monthly meeting last week, to enjoy a scientific paper by a member on "The Evil of a Common Cold," but the lecturer being summoned suddenly away, presumably to attend some patient with whom his herbs were not agreeing, the members fell to politics as affecting their cult. Ultimately a number of resolutions were passed *nem. con.* The first urged the Council of the Association to take immediate steps to get some definite provision for *bonâ fide* medical herbalists under the Death Registration Act, "in order to avoid the worry and anxiety their patients are put to." The second was like unto it, namely, that a strong protest be laid before the Lord Chancellor against holding inquests on the patients of herbalists, except under extraordinary circumstances, and finally that the testimony of the herbalists themselves should be taken at inquests. The herbalists are beginning to take themselves very seriously, and their desire that the deaths of their patients shall not be made the subject of inquiry is very natural. The exposure attendant thereon must certainly be bad for trade.

The Local Government Board and Plural Appointments.

IN former years the general undesirability of plurality in public health appointments has been adversely criticised in our columns. It is only under the most exceptional circumstances that any single medical officer of health or analyst can do justice to more than one appointment, especially if it be of any great magnitude and importance. We are glad to see that the Local Government Board has taken up this point, because, after all said and done, the key to the situation has been ultimately in the hands of the central authorities at Whitehall. The immediate occasion of their interference was the proposal to appoint Dr. G. P. McCleary, Medical Officer of Health for Hampstead, to the post of Consulting Medical Officer of the Bedfordshire County Council. As the Local Government Board pay half this salary they have a right to withhold their consent, which they have done on the ground that under the terms of the present appointment he is bound to give the whole of his time to the service of the Hampstead Borough Council. It is to be hoped that this policy will be definitely established at Whitehall, for in some instances that could be cited the number of diverse posts held by individual health officers amounts to something approaching a public scandal. Amongst other serious objections to plurality of posts is that it tends to encourage underpayment of officers by local authorities, who regard the added posts as contributory sources of income which will ease their own legitimate burden.

The Viewing of Bodies.

THE English law is built upon tradition, and many of its survivals have long since become grotesque. Now and then, as in the case of the proclamation of the court usher, "O Yes, O Yes," there is a quaint reminder of ancient times that reconciles one to its want of latterday practicability. Undoubtedly, it appeals more forcibly to the imagination of the man in the street to call for his attention in corrupt Norman than in simple Anglo-Saxon. Other legal survivals, however, are injurious to the best interests of the subject, and should be relegated to the limbo of barbarous times. Among these objectionable things may be mentioned the "viewing" of the body by the Coroner's jury. In ancient times, somewhere about the Norman Conquest, the Coroner's jurisdiction gradually emerged into separate existence, and it has been with us ever since. In the early days when the general security of life and property was a plant of slender growth, it was undoubtedly necessary to ensure identification of a body found dead by every reasonable means at command. But it would be idle in the present day to say that the Coroner's jury are able materially to assist the cause of justice by personal inspection of the corpse. On the other hand, the process is sometimes dangerous and often revolting. A Bill will shortly be read a first time in the Commons, introduced by Mr. Higham, to dispense with the compulsory viewing of bodies by Coroners' juries. Under exceptional circumstances we imagine the right to compel viewing would probably be retained by the Coroner.

Fees of Medical Witnesses.

WHILE so much is heard nowadays about the hard case of the medical practitioner, it cannot be said that the authorities, great or small, neglect any opportunity of cutting down his income still further. On this principle the Lancashire County Council recently decided that after March 31st they will pay only one guinea per inquest to medical men giving evidence Mr. Coroner Brighouse, of South-West Lancashire, referring to the subject the other day at St. Helens, suggested that the doctors should protest most vigorously. No doubt this advice will be followed to the letter by the local medical societies. It is to be hoped that the matter will go further, and be taken up by the British Medical Association and by other medical journals, for this parsimony affects the whole profession. As a matter of fact, some unfortunate practitioner in Lancashire may find himself taken a long distance away from his patients and kept waiting two or three days to give evidence, for which he will be awarded the magnificent sum of one guinea. Well might Mr. Brighouse exclaim that if he were a medical man he would never dream, under the circumstances, of bringing his son up to the profession to which he belonged; he would rather make him a crossing sweeper! We trust his fervent wish will be realised, namely, that medical men will take steps to see they were remunerated in a manner that is more consistent with the knowledge they bring to bear on the execution of their duties.

PERSONAL.

DR. D. J. MORGAN, M.A., M.D. Cantab., D.P.H., has been appointed Medical Officer of Health for the Borough of Swansea.

SIR ALMROTH WRIGHT will deliver the Harveian Lecture on "Some Points in Connection with Therapeutic Immunisation."

SIR HENRY R. SWANZY, President of the Royal College of Surgeons of Ireland, took the chair at the annual dinner of that institution on February 1st.

DR. GLOVER LYON was elected President of the Life Assurance Medical Officers Association on February 6th, and delivered his Presidential Address.

MR. D'ARCY POWER has been elected President of the Harveian Society, Mr. Crisp English and Dr. Willcox being elected Honorary Secretaries.

DR. R. B. WILD has been unanimously elected Chairman of Convocation of the University of Manchester.

DR. WILFRED HARRIS has been appointed Physician-in-Charge of the new special department for nervous diseases at St. Mary's Hospital.

MR. W. J. M. ETTLES will give the annual Hunterian Oration to the Hunterian Society this evening. His subject is "The Renaissance of Ophthalmology during the Hunterian Period." Medical men are invited.

DR. W. CARTER has been appointed a Professor Emeritus, in recognition of his long and useful services to the Liverpool University College and the University.

ON February 18th Sir Dyce Duckworth will give a lecture in French to the Medical Faculty of Paris on "Les Diathèses, le Facteur Personnel dans les Maladies." Professor Landouzy will be in the chair.

DR. W. N. BARLOW, who was for six years Medical Officer of Bootle, and now holds a similar post under the Wallasey District Council, was the recipient of two handsome presentations from his old colleagues under the Health Committee of Bootle.

DR. CHARLES PYE OLIVER has been appointed by the Borough Council of Maidstone to carry out the medical inspection of school children. For services rendered in this connection his salary has been raised by £200 per annum.

THE Liverpool Council last week passed a special resolution of thanks to His Majesty for his gift of a plaster cast of his horse Persimmon to the Veterinary Department. The school is fortunate in the possession of the skeleton of his Majesty's horse Ambush II., presented some time ago, and also of the skeleton of the well-known steeplechaser Manifesto.

A CLINICAL LECTURE

ON

CANCER OF THE UTERUS. (a)

By CUTHBERT LOCKYER, M.D., B.S., F.R.C.S.,

Senior Out-Patient Physician, Samaritan Hospital for Women; Obstetric Physician in Charge of Out-Patients, Great Northern Hospital.

Gentlemen,—I have chosen to speak upon the somewhat melancholy subject of cancer of the uterus, because it is one which has occupied and engrossed my thoughts for many years, and because I am sure that no one who listens to what I have to say can dispute the fact that it is a subject of prime importance for us all. It is now a well-established fact that more women die of cancer of the womb than of cancer of any other part of the body. As Dr. Herbert Spencer reminded us in his admirable address at Exeter last July, nearly 4,000 adult women die of cancer of the uterus every year in England and Wales. This is an appalling fact; and in these days of surgical successes it behoves us to ask ourselves what can be the causes which lead to so sad a record.

The main reason is not far to seek. The women come to gynæcologists too late for operation. Then, again, many operators are themselves very pessimistic, and have as little to do with cancer of the uterus as possible. Dr. Spencer quotes Pozzi as saying he cannot speak of cure by operation, but only of "prolonged survivals"; but when we remember that there are many cases on record where women have remained well for twenty years after operation for cancer of the cervix, it is certainly not going too far to say that, under favourable conditions, this disease can be cured by operation. As an operating gynæcologist, I am convinced that if cases come to me early in the disease, I can honestly promise a fair measure of successes, and what I would like to insist on, to-day and for all time, is that we operators need the intelligent co-operation of our brethren, the general practitioners (to whom many of these sufferers from cancer first present themselves). An immediate examination should be insisted upon, and in cases of even doubtful malignancy a microscopical examination should be made of the suspicious cervix, and this can only be done for the poorer classes in an hospital.

From a careful record of every case of cancer of the uterus which has come under my observation, I have calculated that from the vaginal hysterectomy point of view, at least 80 per cent. were inoperable when first seen. For the last two and a half years I have abandoned this operation for the more radical method of abdominal pan-hysterectomy according to Wertheim's technique, thereby raising the percentage operability almost fourfold. Whilst mentioning this fact, I would fain point out my conviction that the improvement hoped for in dealing with cancer of the uterus is not to be sought so much in extended operative technique as in an hitherto un-made effort to get these cases in the initial stages of the disease. Strenuous attempts must be made to educate the patients, general practitioners, midwives, and all concerned in the signs and symptoms of incipient cancer; and the question arises—How is this to be done? Five years ago Winter published a paper entitled "Strife Against Uterine Cancer," in which he stated the results obtained from a pamphleteering crusade which he waged single-handed in East Prussia. In addition to soliciting the help of general practitioners, midwives, and irregular practitioners, he utilised the medium of the public Press, advertising far and wide the symptoms of early carcinoma of the womb.

Professor Strassmann, of Berlin, who was present at the discussion on the earlier recognition of cancer opened by Dr. Spencer at Exeter, laid on the table a specimen of the appeal issued by the Berlin Society of Obstetrics and Gynæcology to practitioners in that city, asking for their help in the campaign against cancer. He told us that the same Society issued pamphlets instructing midwives in the early symptoms of cancer, and Strassmann advised that popular lectures should be given to the public, even going so far as to advocate a demonstration to the laity of specimens such as we have before us to-day. The consensus of opinion at the Exeter meeting was in striking contrast to that expressed at the Leicester meeting of the British Medical Association in 1905. The idea of educating the public by any means whatever met only with derision two years ago, whereas at Exeter last July Dr. Thomas Wilson's amendment, "That the Council of the British Medical Association be requested to appoint a Committee to consider the best means of disseminating knowledge of the importance of the early recognition of uterine cancer," was carried *nem. con.*

We have a right to hope, therefore, that some sort of crusade will soon be started in England, and it is to be hoped that the Registrar-General's report of 4,000 deaths annually from cancer of the womb will be substantially reduced.

Whilst awaiting the inauguration of a scheme of crusade by the British Medical Association against cancer, it will not be amiss to pass in review the signs and symptoms by which we as doctors are to recognise the disease.

In the first place, let us remember that cancer of the womb varies greatly in degree of malignancy, according to whether it originates in the body or in the neck of that organ.

Cancer of the "body," whether it be the type known as malignant adenoma, or whether it be the diffuse adeno-carcinoma, is far less virulent than is any form of cancer affecting the cervix. Cancer of the body is a rarer disease than cancer of the cervix. It is generally found in elderly spinsters, or in elderly married women who have borne but few children.

It arises more commonly after the menopause than before the change of life.

Its connection with the lymphatics and blood-vascular system of the pelvis is less intimate and more remote than is the case where cancer starts in the neck of the womb. Consequently, there is far less risk of the growth trespassing beyond the confines of the uterus than is the case with carcinoma cervicis. This disease may be suspected when a sanious discharge makes its appearance after the menses have totally ceased, or where an inter-menstrual, blood-stained, watery discharge is noticed in a previously healthy woman about the time of the climacteric.

It may exist in a uterus which is atrophic from old age, and which gives a sound-measurement of less than 2½ inches. I have had three examples illustrating this fact, where the uteri were small and mobile, painless on contact by bi-manual examination, and where nothing wrong could be discovered, save the fact that the patient had a blood-stained discharge.

On the other hand, a corporeal cancerous growth may be rapid in its development, enlarging the uterine body to three or four times its normal size in a short time.

The treatment for these cases, in my opinion, is vaginal hysterectomy, but the abdominal route is the better if there is stenosis or contraction of the vagina.

I do not favour vagino-perineal section in these cases, for several reasons. First, because, even when the vagina and perineum have been split to give freer access, it frequently happens that, before the uterus can be removed, the organ has to be divided by mesial section, which leads to direct cancer implantation upon the newly-cut surfaces; and, secondly, in drawing down a uterus per vaginam, the cancerous material is very prone to ooze out through the external os, even when attempts have been made to close the canal by circular ligature. With plenty of room, however, we can remove a small uterus with cancer of the body, *per vias naturales*, with perfect safety. I have removed the uterus seven times for cancer of the body with one recurrence. One case dates back five years, and the woman has had no return of the disease. The recurrence occurred in my third case, and appeared within a few months of operation, the site of the secondary growth being the urethra. The body of the uterus was large, and I think the urethral orifice was abraded by the vaginal speculum.

(a) Post Graduate Lecture delivered at the Great Northern Central Hospital, Jan. 31, 1908.

To pass to the more important question of cancer of the cervix, let us first note that this commoner and more fatal disease is prone to affect the mothers of large families. In Lewer's statistics, he proves that women who have borne five children are more liable to become the subjects of this malady than those whose families are smaller. As regards the age incidence, cancer of the cervix is commonest between 35 and 50 years, but is by no means confined to these limits, so that the age question must not be allowed to weigh in the least against the diagnosis of cancer of the cervix. Heredity is thought to play a not unimportant *rôle* by some, but my own experience leaves this an open question.

Among the early symptoms, *bleeding* is the most important indication; in fact, for some time it may constitute the only sign. In some of my cases the bleeding has amounted to a flooding or floodings, but, as a rule, a pinkish *discharge* and hæmorrhage of slight degree, only noticed on coitus, constituted the earliest symptom. The early hæmorrhage is often preceded or accompanied by a muco-purulent discharge, the latter being streaked with blood, and at first not offensive. Later on, *pain* is added to the above cardinal signs, and, unfortunately, the patient often postpones her visit to the family doctor until this late symptom has driven her to seek advice. The pain is often associated with fœtor from necrosis and decomposition of the growth.

The pain may be due to extension of the growth into the cellular tissues which embrace the cervix, or it may be caused by distension of the cavity of the uterus by discharges which cannot escape because the cervical growth has completely blocked the cervical canal. The physical signs of cervix carcinoma are worthy of careful study, and in this connection I would state that, whilst some cases could not be missed by a novice provided he made vaginal examination, others are extremely difficult of diagnosis in the early stages, and in these the microscope is often necessary to settle the question.

When cancer of the cervix presents as a prominent excrescence or overgrowth, or where it takes the form of an excavating ulcer which bleeds profusely on digital examination, there can be no doubt about the nature of the case. It is with what are termed intra-cervical growths that a difficulty may arise. Here there may be no abrasion of the vaginal surface of the cervix, but only a circumferential enlargement of the collum or an induration or thickening of one or other lip. In such a case it is well to pass a sound into the cervical canal to see if there is any bleeding, for the external surface of the cervix will not bleed on contact. In such cases the os is usually patulous, the canal bleeds readily on passing a sound, and the cervix is thickened.

Again, a simple erosion may take on malignant activity, and for this reason erosions should not be ignored, but carefully treated and examined until healing is secured.

My plan in dealing with erosions of the cervix is to pass a Fergusson's speculum, mop away all discharge with a solution of bicarbonate of soda, then swab the surface with iodised-phenol, remove the excess, and insert a tampon soaked in 10 per cent. ichthyol in glycerine. This I do every week until the lesion is healed.

If the erosion shows any signs of spreading, or is sluggish under treatment, I remove a portion for microscopical examination. This is done under anæsthesia, when the nature of the tissue can be better studied, and at the same time I apply the actual cautery to the so-called ulcerated area.

These are the precautions which I should like to feel were becoming generalised, for I am sure many lives would be saved, for, speaking generally, it may be said that it is only in the early stages that cancer of the cervix is difficult of diagnosis, and it is equally true that only in the early cases can we feel any degree of certainty as to permanent cure by operation.

There are but few affections of the cervix which can be confused with cancer upon making a thorough vaginal examination. The most likely condition is primary tuberculosis. A colleague of mine sent me a case which he considered might be tuberculosis, but which proved to be cancer. I have seen two or three examples of tuberculous cervix after removal, but have never met with a case in the ordinary course of vaginal examination. Again, the microscope will tell us with which of the two diseases we have to deal.

The danger of cancer of the cervix is twofold: The disease soon spreads by continuity of tissue to the surrounding parts; it is also prone to cause early infection of the lymph glands of the pelvis.

A point of practical importance is that, whereas under anæsthesia we can, with some degree of accuracy, estimate the freedom or otherwise of the parametric tissues, such as the bases of the broad ligaments and the utero-sacral folds, it is extremely difficult to feel the cancerous glands which run along the great iliac vessels, and which lie deep in the fossa ovarica. Only once have I been able to feel these glands, and in this case a well-known Colonial gynæcologist thought the palpable mass was an enlarged ovary.

The frequent gland-involvement, and the more frequent infection of the parametric tissues, even in cases of comparatively small malignant growths of the cervix, have an important bearing upon the question of operative technique, and, to my mind, render any hope to secure a large percentage of permanent cures by vaginal hysterectomy quite abortive. In the year 1902 I expressed my doubts, at a meeting of the Obstetrical Society of London, on the utility of vaginal hysterectomy as a radical operation for cancer of the cervix. My objections to this operation are not theoretical, but based upon personal experience—an experience which I have published *in extenso* in the *British Medical Journal.* Vaginal hysterectomy opens up the enormous risk of implantation of cancer cells on the surfaces which are severed during operation, so that in a large number of the cases so treated this growth returns locally in the vaginal vault. Moreover, it is impossible to remove the parametric tissues which surround the cervix when operating per vaginam, whilst, of course, the high-lying cancerous glands are not discoverable, and, if they were, could not be removed. It seems high time that we should adopt a more heroic technique in dealing with this fatal disease, and science, as well as humanity, demands a more determined effort to cope with cancer of the cervix on the lines of modern surgery, such as is exemplified in dealing with malignancy in other parts of the body. We see the general surgeon attacking cancer of the breast by following the lymphatics on to the abdominal wall, into the axilla, and even beneath the clavicle and up the neck; and yet English gynæcologists have been content to palliate with cancer of the cervix by leaving the infected adjacent tissues behind. The reason for this seems to me to be the fact that there are admittedly some cases—although few—in which the patients have remained well after amputation of the cervix and vaginal hysterectomy for eight, twelve, and even twenty years; but it cannot be denied that these are the fortunate exceptions which prove the rule—the rule of almost complete and total failure. I abandoned the vaginal operation in 1905. I had performed hysterectomy per vaginam for 14 cases of cancer of the cervix. In nine cases the patients died of recurrence, and one has been lost sight of, so that only four can be proved to have benefited by my exertions.

Whilst despairing of getting any satisfactory results by vaginal hysterectomy, I had the good fortune to meet Professor Wertheim, and to learn from him his method of abdominal pan-hysterectomy. Wertheim was generous enough to operate, with my assistance, upon a case of my own in London, and subsequently I studied his method by watching his technique in Vienna, and I am sufficiently impressed by its superiority over every other method of dealing with cancer of the cervix to have decided to burn my boats behind me as far as the vaginal operation is concerned, and throw my lot in with Wertheim for the future.

An outline of Wertheim's technique is as follows:—The patient is prepared for abdominal section. She is then placed in the lithotomy position, and, without an anæsthetic, the growth is scraped away as thoroughly as possible, and the bleeding surface then treated with the actual or Paquelin's cautery. The vagina is then plugged with tampons soaked in a 2 per cent. formalin solution, and carrying strings by which they can be withdrawn during the operation at the time desired. Next the patient is anæsthetised by a general anæsthetic, or partial anæsthesia is secured by lumbar puncture, and the introduction of stovain into the canal of the spinal cord. The high pelvic posture is used, and two assistants are employed. The abdominal incision is at least five or six inches long, and extends to the bony symphysis. The parietal peritoneum is divided down to the fundus of the bladder. No retractors are employed; the second assistant retracts by both hands; no gloves are used. The fundus uteri is drawn up as far as possible and inclined over the anterior pelvic brim, where it is held by a vulsellum. The posterior fold of the broad ligament on the side opposite the operator is seized by dissecting forceps, and opened about 1½ in. below the Fallopian tube. By closed blunt scissors the two folds are separated from one another, and the ureter sought, as it lies in close apposition to the posterior fold. It is then followed back to its point of crossing the pelvic brim, and forwards to its entrance into a fibrous canal by the side of the cervix. The index finger of the hand corresponding to the side operated upon is then introduced into this canal, and the later dilated, whilst the finger is made to come out of the canal at a point anterior to the cervix. To expose the finger-tip it is now necessary to strip off the anterior fold of the broad ligaments which obscures it from view, and at the same time—if it has not been previously done—the infundibulo-pelvic fold must be tied off, the meso-salpinx divided, and the round ligaments tied and cut. This enables the operator to see the structures which lie upon his finger as the latter passes through the ureteric canal. They are the uterine artery and veins. These are hooked up by the finger, and a ligature is now passed beneath them, and they are tied far out against the pelvic wall.

When this is done the ureter lies exposed as far as within an inch or so of its entry into the bladder. The latter is now freed from contact with the uterus and vaginal wall, and by a little dissection the ureter can be exposed right up to its entrance at the corner of the trigone. The same procedure is carried out on the opposite side, and then the peritoneum and rectum are stripped from off the posterior wall of the cervix and vagina. Next the ureters are held well aside whilst the utero-sacral, parametric, and para-vaginal tissues are clamped. The tampons are removed from the vagina after the latter has been dissected out far enough to apply the clamps beyond the cervical growth. This done, the vagina itself is cut across beyond the clamps. The uterus, with the collar of dissected vagina, securely clamped beyond the growth, is then removed. The edges of the vagina are held open by a series of long silk sutures; the canal is cleansed by swabbing, the edges ligatured, and finally all clamps are replaced by ligature. Glands are now sought for. and, if found, removed. Before closing off the deep raw surfaces by peritoneum, Wertheim packs them fairly firmly with gauze, the end of which passes into the open vagina. No abdominal drain is ever used. I have modified many details in this technique to suit my own ends. I do not use gauze, but leave the tissues to drain of themselves. I do not scrape the growth without an anæsthetic, but carry out this procedure a week before I remove the uterus. I prefer to keep my patients in bed for ten days or a fortnight on strychnine prior to the final operation. In drawing up the uterus I free the round ligaments, meso-salpinges, and infundibulo-pelvic folds before looking for the ureter. In cases of old pelvic inflammation, where the tubes and ovaries are diseased, if the ureter is not easily found behind the uterus I endeavour to discover it first in front.

I pass a sound into the uterine body at the time of scraping and cauterising the growth in order to determine the presence or absence of a pyometra. I sew the peritoneum to the skin all around the parietal wound in order to shut off raw surfaces and protect the cavum Retzii. I wear gloves, employ but one assistant, and use my own automatic retractor. For the rest I use Wertheim's special instruments—his parametric forceps and vaginal clamps.

In July I reported 12 cases in which I had performed this operation. All save two were too far advanced for vaginal hysterectomy. My primary mortality was four, and two cases have died of recurrence. Since July I have performed the operation three times, and all the cases did well.

There is a higher primary mortality with this operation than is obtained by the old vaginal method, but against this must be placed the fact that four times as many cases can be dealt with by abdominal pan-hysterectomy than by the vaginal route.

Speed in operating and a thorough knowledge of the deep pelvic structures are most essential factors to success. I have every reason to believe that my high initial mortality will not continue, as the practice gained of experience makes every operation more easy of performance. In conclusion, gentlemen, let me say that I hope much from this operation of Wertheim's, since Wertheim's own statistics are better than those of any other operator which have hitherto been published.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by J. Dundon, M.B., F.R.C.S. Eng. and Irel., Surgeon, Mercy Hospital, Cork, Senior Assistant Surgeon, North City and County Infirmary, Cork. Subject: "Diagnosis of Injuries above the Shoulder."*

ORIGINAL PAPERS.

A SHORT SUMMARY OF LITERATURE OF

LUMBAR PUNCTURE IN OPTIC NEURITIS.

By SYDNEY STEPHENSON, M.B., C.M.,
Ophthalmic Surgeon North-Eastern Hospital for Children, London, etc., etc.

BABINSKI and CHAILLOUS.—The therapeutic results of lumbar puncture in optic neuritis of intra-cranial origin. (Résultats thérapeutiques de la ponction lombaire dans les névrites optiques d'origine intra-cranienne.)

Bull. et Mém. de la Société Française d'ophtalmologie. XIV., 1907, p. 302.

Babinski and Chaillous preface an important communication on the therapeutic results of lumbar puncture in optic neuritis by a brief reference to the work done by Druault, de Lapersonne, Aubineau, Moissonnier, and Abadie respectively in this direction. The authors next relate seven cases where improvement followed the operation,. In abstract, the leading facts of these cases are as follows:

CASE NO. 1.—*Disturbances of sight after a fall on the head. Lumbar puncture. Cure.*

Five weeks after a fall upon the head, an accident followed at once by unconsciousness and emesis and later by violent headache, the patient found that his sight had failed (R.E., 12 opt.; L.E., 9 opt.).

The failure of the sight was due to intra-cranial pressure. After the removal of 15 c.cm. of cerebro-spinal fluid by lumbar puncture, the headaches almost disappeared, and the sight of the left eye rose to 11 opts. The optic discs, moreover, had become almost normal. Somewhat later, the patient, apparently cured, was able to resume his occupation, that of a lithographer.

Case No. 2.—*Bilateral optic neuritis. Paralysis of the right external rectus. Lumbar puncture. Cure.*

A married woman, æt. 23, suffered from headache, paralysis of one external rectus muscle, and bad sight due to bilateral papillitis. Lumbar puncture was followed in seven days by some modification for the better in the ophthalmoscopic appearances. A second and third operation were succeeded by disappearance of diplopia, and eventually by cure. Other treatment included seven or eight intra-muscular injections of calomel.

Case No. 3.—*Bilateral œdematous neuritis with considerable diminution in the sight of the left eye and blindness of the right eye. Lumbar puncture. Rapid improvement.*

A man, æt. 19, admitted for intense frontal headache, vertigo, asthenia, vomiting, constipation. After lumbar puncture, headache completely disappeared, and the other symptoms became attenuated. Three days after the little operation, however, the man complained that he had suddenly become blind in his right eye, and that the vision of the left eye was dim. There was intense optic papillitis. A second lumbar puncture, together with mercurial treatment, was slowly followed by considerable improvement in sight. The optic discs, however, became pale. When seen nine months after admission, vision had risen to 0.7.

Case No. 4.—*Bilateral optic neuritis. Paralysis of the left external rectus muscle. Syphilitic meningitis probable. Lumbar punctures. Rapid disappearance of the papillitis.*

A woman, æt. 24, who had probably acquired syphilis, was received suffering from defective sight, vertigo, and gastric disturbances. On examination, bilateral papillitis and paralysis of the left external rectus muscle. Visual acuity and visual fields normal. Marked lymphocytosis in cerebro-spinal fluid obtained by lumbar puncture. The operation was followed by diminution in the vertigo and definite improvement in the state of the optic discs. The woman, however, had also received a daily injection of mercury biniodide. Another puncture was succeeded by further improvement in the neuritis and disappearance of the diplopia, although by careful examination with a coloured glass, the external rectus was found to be still paralysed. The latter, however, disappeared a week later. In the further history of the case the patient developed hemiplegia, without premonitory symptoms.

Case No. 5.—*Bilateral œdematous neuritis. Paralysis of the left external rectus muscle. Lumbar puncture. Rapid improvement in sight and visual field. Reduction in the symptoms of intra-cranial pressure.*

A man, æt. 20, was admitted on account of severe headaches, vomiting, vertigo, delirium, diplopia, and defective sight. The family history suggested syphilis. On examination, frontal headache, especially at night, obstinate constipation, marked asthenia, emaniation, and paralysis of the left external rectus muscle. Bilateral optic neuritis. R.V., 1.50–50; L.V., 5–30. Ten minutes after the withdrawal of 25 c.cm. of cerebro-spinal fluid, R.V. 5–15 and L.V. 2.50–50, while the visual field in each eye had increased in size by 10° (average). Iodide and mercury were then administered. The treatment was followed by eventual disappearance of the optic neuritis and diplopia and by vision of 5–30. A relapse took place in the course of about six months, and the man, who had meanwhile enlisted, was lost sight of soon afterwards. The last note of sight was 5–15.

Case No. 6.—*Bilateral optic neuritis. Lumbar puncture. Considerable but transitory improvement.*

A female, admitted on account of headache, accompanied by disturbance of sight and of hearing. Double optic neuritis, V. 5–10. A week's treatment by injections of calomel having failed to improve matters, lumbar puncture was resorted to. Abundant lymphocytosis. Sight tested immediately after the operation had risen to R. 8–10 and L. 9–10. About a month after operation a note was made to the effect that the optic discs were also normal in appearance. But despite calomel injections, the vision fell again, the right trigeminal nerve became affected, and the patient was lost sight of some four months after she was admitted.

Case No. 7.—*Hydrocephalus. Lumbar punctures. Arrest of the symptoms of compression.*

A child, æt. 1, brought on account of hydrocephalus. Optic neuritis had been found in the child eight months previously. On examination, post-papillitic atrophy of both optic discs. Four lumbar punctures were made in the course of three months. No lymphocytosis. In the result, ocular and general condition of the child improved.

Case No. 8.—*Cerebral tumour. Bilateral optic neuritis. Arrest lasting for several months.*

In May, 1904, one of the authors was consulted by a patient on account of right hemiparesis, complicated with disturbance of speech, believed at the time to be due to softening (*ramollissement*) of the psycho-motor area of the left cortex and of Broca's convolution. During the next three months, Jacksonian epilepsy involving the right side (face, upper and lower extremity). Mercurial treatment adopted. By the following December the patient's condition had become worse. Surgical measures not adopted since the absence of headache, vomiting, and optic neuritis was thought to tell against the existence of a cerebral neoplasm. The mercurial treatment was continued. But in October, 1905, double optic neuritis was found to be present. Between that month and May, 1906, seven or eight lumbar punctures were practised, the fluid on each occasion being normal. On the whole, the ocular symptoms improved during this period. In May, 1906, the optic neuritis became more pronounced and the sight suffered. In the following month (June) the patient was trephined, and a tumour, weighing 310 grammes, was excochliated from the motor area. The patient unfortunately died in syncope as soon as the operation was completed.

Babinski and Chaillous advise that in performing Quincke's operation, the following precautions be observed:—(1) The patient should be recumbent; (2) the cerebro-spinal fluid should be evacuated slowly, drop by drop, and a maximum of 8–10 c.cm. should at the most be removed; (3) after the operation the patient should be kept in bed for several days. They conclude that lumbar puncture may be considered as a curative method in optic neuritis due to intra-cranial effusion. On the other hand, it is merely palliative in neuritis due to intra-cranial tumour. The operation, under any circumstances, should be performed with care, and the amount of liquid evacuated should be in inverse proportion to the severity of the symptoms of compression. It is better to renew the puncture as often as necessary rather than to do too much at one time.

RECENT INVESTIGATIONS ON DYSENTERY.

By R. KRUSE, M.D.,
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[Specially Reported for this Journal.]

As has always been shown, the dysentery that is met with in Germany is almost exclusively the bacillary form, not the amœbic. Of the former, two groups are to be distinguished, the true and pseudo-dysentery. The bacillus of the first group, generally known as the Shiga-Kruse bacillus, is found over almost the whole earth. I have selected the name pseudo-dysentery for a double reason—first, because the bacillus of it agrees in all essential particulars with that of the true bacillus, and can be only distinguished from it by the specific reaction in the blood serum of patients suffering from the disease, and that of immunised animals; and, secondly, because the diseases set up by it do not show such typical symptoms as true dysentery. It is owing to this that, since the time of Widerhofer, enteritis follicularis, which is nothing else than a pseudo-dysentery, has been distinguished from true dysentery. The less well-marked symptoms of dysentery seem to correspond to the fact that pseudo-dysentery affords a distinctly better prognosis. Its dissemination is very considerable. The disease has been met with in the most varied regions of Germany, in Austria, Holland, Constantinople, Ceylon and China. It does not appear in such great epidemics, but more in the form of small epidemics, and especially also in the sporadic form, but very frequently, and extended over a large area. The frequency of pseudo-dysentery in asylums for the insane is very striking; in these places it is quite endemic. They afford a good nutrient soil for the infection, and when it has once got in in any way it is very difficult to get it out again. Here it can often be proved to be an infectious disease, as it does not spare even the attendants and medical officers. Outside of institutions it is often very difficult to ascertain the source of the infection and the manner of its dissemination.

It has already been stated that the properties of the bacilli of dysentery, as well as those of the pseudo-dysentery, possibly permit of their remaining alive for months outside the patient's body. Practically it is nearer the mark to assume that there are bacillus carriers or go-betweens in dysentery and pseudo-dysentery; such have been met with in both forms of the disease.

Whether the suspicion expressed by Jehle and Charleton that pseudo-dysentery is communicated by food that has gone bad is correct as regards the majority of cases must remain undecided. An explanation of the origins of outbreaks of pseudo-dysentery is rendered very difficult by the fact that there are various forms of it; and, secondly, for the reason that a bacteriological determination of the disease is no small matter. Still, a number of different types of isolated bacilli have been distinguished. The agglutination test has proved the most certain. The following genera have been distinguished amongst the pseudo-dysenteric bacilli (Abarten or Typen).

1. Pseudo-dysentery A, or the first chief race.—The bacilli attack neither milk, nor malt, nor cane sugar to any great extent, and they are agglutinated by the serum of almost all the other kinds almost as strongly as the "homologous" stems, B H. Inversely the serum of this genus acts on bacilli B almost as much as its own bacilli, C usually the same, D and E frequently the same, but usually more feebly; the others but little or not at all. It seems to be the type most frequently met with in Germany.

2. Pseudo-dysentery B is distinguished from A only in that it decomposes milk sugar with the formation of an acid, and does not saturate agglutinine A (whilst A saturates that of B). As regards immune serum the behaviour of both is the same.

3. Pseudo-dysentery C embraces only two cultures. The one acidifies maltose, the other not; as regards serum, the behaviour of both is the same; they do not saturate any other serum.

4. Pseudo-dysentery D, or the second chief genus.—Of 15 stems, only two acidify malt sugar. They are more or less influenced in serum A, B, and C, only slightly in the rest. Serum D agglutinates A and B alike, the other genera only slightly. Mutual saturation does not take place with other kinds.

5. Pseudo-dysentery E.—Acidify malt and milk sugar and curdle milk in 8 to 14 days; can be very sharply agglutinated by serums A C, and inversely influence these stems in their own serums. Mutual saturation is not possible. Active immunity for A, D and E only applies to their respective genera.

6. Pseudo-dysentery G, H, etc., are terms applied to a number of genera that cannot be classed in the previous groups, and which mostly differ amongst themselves. Some attack milk sugar, others all three kinds of sugar.

Compared with the many-visaged image presented by the pseudo-dysenteries, that of true dysentery is very uniform and distinct. First of all, the manuit and indol tests are always negative. Then the true bacilli are agglutinated but little or not at all by the pseudo-serums. Active immunity only applies to the kinds affected. Sub-divisions of true dysentery could not be established, although attempts were made in that direction with stems from all parts of the world. The occurrence of different genera in true dysentery is, however, by no means impossible.

Doubt is no longer possible as to the causative significance of the bacilli of the two chief genera of pseudo-dysentery, for the reason that they are found so frequently, and always with the same characteristics. The behaviour as regards agglutination in the serum of dysentery cases, and, lastly, a case of laboratory infection recently observed (genus A), are in favour of this. The different divisions of each genus differ only little from each other, and have preserved their characteristics for years unchanged. Further, in the same person only strains of the same genus have been met with. Finally, the cases of dysentery of the same epidemic have in general belonged to the same type. Exceptions have, it is true, been met with, but they have been explained as infections from other sources, and not as variations of the same virus, that therefore the different genera must be considered as essentially constant—*i.e.*, in the somewhat limited sense, as with all other bacteria.

The diagnosis of the forms of dysentery is easy when the bacilli can be cultivated with the aid of Würtz's milk sugar, litmus agar, or gelatine painted plates, from the evacuations. The suspected colonies are dipped into sugar agar, mannite agar, milk or bouillon, and are best taken, not from the plates, but from the bouillon culture for the purpose of being tested with the immune serums for agglutination. Unfortunately, it is not always possible to get hold of the bacilli, and failures are not infrequent when the evacuations are not fresh or are not typical. When there is no result, by the help of the agglutination test in the disease serum, we can solve the question with great probability as to whether the case is one of true dysentery or not. The diagnosis of pseudo-dysentery and its varieties is more difficult, as, unfortunately, the blood serum of healthy people—and even that of new-born infants—frequently agglutinates these bacilli to a sufficient extent, whilst that of patients often fails.

With these difficulties of investigation it is not to be wondered at that the diagnosis remains doubtful in unfavourable circumstances, and that many investigators have drawn the conclusion that, besides the bacilli of dysentery and pseudo-dysentery, there are still other excitors of the disease. This notion may not be rejected summarily.

Moreover, every dysentery must not be looked on as an infectious disease; there are hæmorrhagic and dysenteric catarrhs of the large intestine of purely toxic origin. Mercurial poisoning is a well-known example. The possibility may also not be denied that from various injurious causes, such as a cold drink, the use of unripe fruit, a chill, etc., although these may not set up dysentery, yet the germs that inhabit these parts in greater or lesser numbers may become virulent, and dysentery be set up by self-infection. It is very probable that many intestinal diseases, especially in infants, are nothing more than such self-infections. When the effect is restricted to the large intestine, we have a condition of dysentery. The experiments of C. O. Jensen on new-born calves that have placed our knowledge on a firmer foundation have shown that self-infection and capability of transmission are not excluded. The bacteria once become virulent, set up the same disease in healthy calves. Even in the above-named intestinal diseases of infants, the capacity for infection is general. Possibly in these cases the bacilli are those of pseudo-dysentery.

The attempts to produce in animals a disease having the essential characteristics of human dysentery have, as in earlier times, been unsuccessful. On the other hand, we have learned to understand better the toxic effects of the bacilli of dysentery. After carefully testing the communications of Conradi, Vaillard, and Dopter, Neisser, Shiga, Rosenthal and others, we reach the following conclusions:—The bacilli of dysentery produce a poison which, introduced into rabbits even in small quantities, generally kills them with symptoms of a peculiar progressive paresis and convulsions. The simplest way of producing the poison solution is to wash the germs freshly grown on agar in a saline solution, keep them at a temperature of 60° C. for two hours, and then separate it from the bodies of the bacilli by centrifugation. Heating above 80° to 100° C. almost completely deprives the poison of its power. The intestinal changes have only rarely been seen in rabbits, and then only to a slight extent. The hæmorrhagic enteritis in dogs, on the other hand, is often limited, as in dysentery, to the lower part of the intestines, and not seldom developed in the duodenum and colon only. Experiments with other bacteria showed that in the dog all possible kinds of bacteria poison set up a hæmorrhagic enteritis, frequently similar to dysentery. The different kinds tested were the prodigiosus, the bacilli of typhus and paratyphus, the bacillus coli, and staphylococci. There is, therefore, no question of a specific dysentery poison, but of an effect common to all bacteria, a bacteria protein action.

From these experiments we can conclude, first, that the bacilli of dysentery have a specific and powerful action on rabbits, and that, besides this, they form at least one other poison that is less powerful and characteristic in the case of guinea-pigs and dogs. In applying these results to the human subject we must be very cautious. The symptoms of poisoning that are rarely absent in dysentery, as in other infectious diseases, are not by any means to be compared with those of rabbits, and may be explained by the effects of the guinea-pig poison. The possibility that the human subject may be susceptible as regards the rabbit poison cannot at first be denied.

The experiences gained with the dysentery poison are important in other respects also. There is, first, the result of the experiments with dogs, then the varying failure of those with rabbits; further, the extraordinary unequal susceptibility of the usual laboratory animals, for dysentery poison is perhaps due to the want of a suitable animal for experiment when we are so little fortunate in being able to procure the specific poisons of other infections—typhoid and cholera, for example.

Along with the intoxicant, the so-called "aggressive" actions of the excitors of infection have come more to the front, after remaining neglected to some extent during the fourteen or fifteen years that have elapsed since I first brought them forward. R. Pfeiffer and Friedberger associated the side chain theory with the aggressine (lysine) hypothesis. Bail believes that the aggressines manifested themselves in the locality into which they were brought—*i.e.*, in the living animal in which they developed The aggressines are supposed to be the substance through which the resistance of the body to growth is overcome. Bail believes, indeed, that he has found the specific aggressines in the most varied exudations. It is possible that may be so, for some cases—anthrax, for instance—but in others it has been shown that the matter is not so simple. The explanation of this probably lies in the fact that the aggressines become too readily combined at their place of origin, and that free aggressines, therefore, are no longer to be met with in the exudations. For the purpose of producing the aggressive action, it will be well, wherever possible, to make use of the bacteria cultures. The facts that have been brought to light in this respect have not yet been exhausted by experiment, so far. The culture aggressines that have been prepared out of the bacilli of dysentery are a proof of this. In the case of guinea-pigs the extract is so aggressive that the thousandth part of the usual minimum fatal dose develops, so that in the course of a few hours the peritoneum and blood are flooded. It is probable that anti-bacteriological and anti-opsonic effects come into play, as specific diphtheria serum has the power of neutralising aggressine. Naturally, one would desire that the aggressine should act specifically, and, in fact, it appears to do so, but to a certain extent only. Streptococci are apparently not affected at all; staphylococci and cholera bacilli somewhat; pseudo-dysentery and coli form strongly, but not so much as the bacilli of dysentery. The importance of mixed infection in the dysenteric intestine is known to every inquirer. As work is still in progress, nothing more need be said at present.

In regard to the further study of the more important questions of immunity, I was obliged to study anew the doctrines of infection, as by the peritoneum, the blood, the lungs, etc. I was able thus to confirm the statement of Werigo as to the astonishing power of consumption of the endothelial vessels, and especially those of the liver, on which the immunity of animals in blood infections plainly rests. The great importance of phagocytosis has also been made manifest. We must accustom ourselves to the thought that in infection a real struggle takes place, the outcome of which depends not only on the forces brought into action on both sides, but also on the new forces developed within.

All the forces that have been shown to exist in the juices are present in a united form in the serum of dysentery—bactericide, opsonic, and also antitoxic. The antitoxic—to mention this first—appears to act in a somewhat capricious manner. The serum I have used for the last five years has always been prepared in the same way from fresh dead agar cultivations at 60°; the procedure unites in itself all the advantages that can be expected theoretically, and the immunisation is more readily effected when the bacilli bodies are not removed. The importance of the pure antitoxic serums is over-estimated. We are not justified in calling upon diphtheria serum, the action of which cannot depend exclusively on neutralisation of the poison. We observe under its influence, however, a cessation of the diphtheria infection—*i.e.*, an aggressive action, not alone a removal of the symptoms. It is very probable that, whenever the antitoxic influence of the serum of diphtheria comes into play in the human subject, the bactericide and opsonic action which I have proved to exist participates in the effect produced. In any case, favourable results have almost always been obtained in the treatment of diphtheria by serum. Hitherto these results have not been improved upon by the employment of living dysenteric bacilli for purposes of immunisation, as asses and horses even highly immunised are very susceptible to the administration of living bacilli, an indication that we have in living bacteria still further toxic substances which we have not yet got hold of.

As regards successes in the use of the serum of pseudo-dysentery, no report can be made, as the animals used in the experiments have all died through repeated accidents. A limited influencing of pseudo-dysentery by the serum of true dysentery, and *vice versâ*, and of pseudo-dysentery of one kind by the serum of another kind, is, judging from test-tube experiments, within the range of possibility; especially the serums prepared from races A and B appear to react mutually on each other.

The London Fever Hospital.

Two new wards containing 27 beds were opened recently by Lady Balfour of Burleigh, who with Lord Balfour made a tour of inspection of the wards, accompanied by members of the staff. His Lordship said that although one of his medical friends had remarked that the present occasion would be the only opportunity for at least fifty years for the average member of the community to come into the building with complete safety, he himself believed that with all the modern devices for disinfection and sterilising germs, this hospital was a more healthy and safe place for people to live in than walking about the streets of London with the chance of being run over. The institution could look back on a useful career of more than one hundred years. Dr. Sidney Phillips, senior physician, having obtained permission from Lady Balfour to name the new ward the "Lady Balfour Burleigh Ward," the proceedings closed with a hearty vote of thanks to Lord and Lady Balfour.

THE annual dinner of the Royal Medical Society of Edinburgh was held in the hall of the Society in Edinburgh on February 5th, Dr. A. C. B. M'Murtrie, senior president, in the chair. The guest of the evening was Mr. Jonathan Hutchinson, F.R.C.S., LL.D.

ECTOPIC GESTATION. (a)

BY HENRY BRIGGS, M.B.ED., F.R.C.S., ENG.,
Professor Midwifery, Liverpool University, etc.

THIS paper on the diagnosis and treatment of ectopic gestation, mainly founded upon a clinical study of 124 cases of interrupted early gestation marked by physical signs and symptoms, at, or before, the end of the second month; deducted from an inclusive total of 139 cases, all of them treated by operation, the 124 cases left 15 others, nine at two to six months, two at six months, three about full term, and one nine years after the full term, not included in the paper. The earliest disturbances amongst the 124 early ectopic gestation sacs occurred after intervals of six, ten and eighteen days beyond the cessation of a previous normal and regular menstruation. For the group of clinical symptoms and signs, indicative of these disturbances, Dr. Briggs, fifteen years ago, had instituted and since adopted the term *peritoneal crisis*. The symptoms and signs of sudden onset were often moderate or mild, and that even trivial, locally recurrent pains, together with slight, irregular menstrual and intermenstrual blood-loss, were not to be construed as harmless or insignificant until the physical signs had been closely watched or waited for. A more prompt appreciation of their significance and of what may lie before the patient would lead to earlier and easier and safer operations, and to the more frequent recognition (with the Trendelenburg position for operation) of "unruptured tubes," and a little free intra-peritoneal blood, even in cases where the acute peritoneal crisis had been recent and severe.

To postpone operation is to incur adhesions and hæmatocele sacs in their various forms. The peritubal (Sänger and Taylor) and the para-tubal (Sampson Handley) hæmatocele sacs, for their intact removal, must be in a suitable physical condition; earlier and later in their course the physical conditions may defy intact removal. Intact removal is not indispensable, but the handling of organised and organising tissues, especially of adherent blood clots, or simply draining them, does not diminish the post-operative risks. Localised hæmatocele sacs as intra-peritoneal formations, subsequent to originally free intra-peritoneal hæmorrhages, possess a stage at which there is both free and localised blood; the free blood outside the hæmatocele sac in process of absorption may be accepted as evidence of secondary rupture of the tubal or hæmatocele sac.

The older statistics of the prevalence of tubal rupture are probably inaccurate in consequence of the frequency with which gestation sacs were torn or ruptured by the fingers of the operator. In the future the continued use of the Trendelenburg posture, lending sight and light to the lower abdomen, would show, as it had shown in his more recent experience, that gestation sacs before operation are rarely ruptured.

Werth and Taylor and Bland-Sutton have established their respective contributions to the process of tubal abortion. An examination of various old gestation sacs, nine years old downwards, demonstrates which may remain in a latent or active form in the patient after apparently successful expectant treatment. During the first ten years up to the end of 1897, one vaginal and 20 abdominal sections, compared with the second ten years 17 vaginal and 101 abdominal sections, denoted a change from expectant to operative methods in the author's practice. Nine of the cases show bilateral lesions, on one side a tubal gestation sac and on the other a pyosalpinx once, a small ovarian cyst twice, and old, adherent inflamed tubes six times, masking the diagnosis of ectopic gestation from the symptoms. A three years old and a recent tubal pregnancy on opposite sides co-existed in one case. A second tubal pregnancy on the opposite side had been treated by a second operation in three of his patients.

Dr. Briggs referred to a paper he himself read in 1897, in which he had produced evidence that intraperitoneal hæmorrhage and hæmatocele were occasionally associated with lesions other than those of ectopic pregnancy. The very rare rapid fatalities associated with tubal rupture form a very small class of their own; operative treatment, if at hand, is almost excluded by the brief space of time available. "To operate," says Dr. Champneys, "during the state of shock is, in many cases, to kill the patient." Dr. Briggs said he had invariably acted on this principle, and he showed a series of ectopic sacs successfully removed from patients after they had recovered partically or wholly from a peritoneal crisis. The severity of a peritoneal crisis was no certain measure of the amount of hæmorrhage. He was of opinion that, with this exception, delay in the operative treatment of ectopic gestation increased its dangers.

There were two deaths following operative treatment amongst his 124 cases, (*a*) after an unusually troublesome and risky operation amidst dense adhesions in a patient who had refused operation for appendage disease three months previously, and (*b*) after the operation for abdominal drainage of a very large hæmatocele in a very anæmic woman; death resulted from anæmia.

(a) Abstract of paper read before the Liverpool Medico-Chirurgical Society, January 30th, 1908.

THE SYMPTOMS AND ETIOLOGY OF MANIA. (a)

BY LEWIS BRUCE, M.D.Ed., F.R.C.P.Ed.,
Superintendent of Murthly Asylum.

THE lecturer first referred to the inadequacy of the psychological path of inquiry to elucidate the nature of mental disease; if our knowledge of the intricate mass of symptoms called insanity was ever to be advanced, it must be by attacking the problem from the physical side. The subject to be discussed in these lectures was the physical symptoms to be observed in the class of mental disease known as acute mania. Mania constitutes between 50 and 60 per cent. of all admissions to asylums, and is a disease of adolescence, or early adult life; the two main types are mania will confusion, and manic-depression, insanity in which depression alternates with exultation, but there is little or no confusion. Confusional mania is liable to become chronic, and pass into delusional insanity and ultimately dementia. Dr. Bruce went on to say that the causes of all insanities, particularly mania, were physical. The emotional crises, so often regarded as causal, were symptoms of an unstable brain, just as alcoholism was more often a symptom than a cause. The most generally predisposing cause was heredity, which included not only mental disease in the parents, but alcoholism, tubercle, hysteria, criminality, etc., or any weaknesses in the body defences against toxic and bacterial invasion. As to the exciting causes, Dr. Bruce believed they were toxins of bacterial nature, and that the bacteria was allied to the *micrococcus rheumaticus*. Though he had not found a specific organism in every case, there was always evidence of a specific bacterial invasion. Second, he had produced evidences of lesions in the nervous system of rabbits, showing that the bacterial toxins attack nerve tissues. Third, in using vaccines made from organisms isolated from cases of mania, a marked exacerbation of the symptoms occurred if the doses were too large. Fourth, the blood serum of infected rabbits shows the same changes as those in man; and fifth, a pure culture of the organism has been obtained from infected rabbits. In working at the opsonic indices of insane persons, it has been found that their serums often agglutinated the normal red corpuscles, but did not agglutinate the corpuscles of other cases of mania; this was observed in over 90 per cent. of the cases of mania investigated. Further work on persons who were sane, and either otherwise healthy, or suffering from known bacterial invasions, showed that about 50 per cent. of normal persons, and a large number of bacterially infected, gave the reaction—that is, did not agglutinate in the presence of serum of mania, in other words, were immune to the agglutinating substance. He had been able to produce a similar reaction experimentally, by inoculating rabbits with various organisms, isolated from cases of mania, and with Ford-Robertson's *B. paralyticans*. The serum of the infected animals agglutinated a control rabbit's corpuscles, but not the corpuscles of other infected animals. From this it is inferred that when a patient's serum agglutinates the corpuscles of a healthy person, the person from whom the serum is derived is probably suffering from a coccal infection. But as the sane and insane both show evidence of bacterial toxæmias, there must be differences in the two. The brain of the insane is hereditarily unstable, and there is probably also a constitutional weakness of the bodily defences. In mania, the leucocyte counts show a marked abnormality. Even though the temperature remains normal, there is constantly a very definite polymorphous leucocytosis. Among other physical symptoms, are disorders of the alimentary tract, particularly septic conditions of the mouth, the saliva of which teems with bacteria. The digestive and bactericidal power of the gastric juices are also poor. One of the most remarkable changes, however, is the alteration in the flora of the fæces. Culture from the fæces of acutely maniacal patients very often do not show the great numbers of b. coli found in health, but instead yield streptococci. Sometimes the streptococci alone are present, b. coli being absent. The pulse is rapid, and the blood pressure low, except at the onset of acute excitement. The metabolism of mania resembles that of a febrile condition: during the acute stage the urinary nitrogen exceeds that of the food, then there is a period of balance, and afterwards, during convalescence a stage of nitrogen retention and gain in weight to make up for the early loss. All these signs—the agglutinating property of the blood, the leucocytosis, the disorders of digestion, the organisms in the fæces, or the nitrogenous output, go to show that mania is due to an infectious process.

(a) Abstract of Morison Lectures on Insanity, delivered in the Royal College of Physicians, Edinburgh, on January 27th, 29th and 31st, 1908.

The normal blood serum agglutinates staphylococci, and may also contain other agglutinins the result of disease—*e.g.*, typhoid, etc. Specific agglutinins may be found indicating that a patient is suffering from a particular microbic invasion. In persons suffering from mania, Dr. Bruce had been able to detect agglutinating substances in many streptococci: these are rarely present in health, or in other forms of mental disease. In all, some five strains of streptococci have been isolated from patients suffering from mania, and these are agglutinated by the serums of nearly every case of mania; using as controls the *personnel* of the asylum, and non-maniacal patients, only 15 per cent. agglutinate these streptococci. Conversely, the normal agglutinating power against staphylococcus aureus, is very much less frequent in mania than in health. Dr. Bruce then shortly recapitulated his already published observations on the leucocytes in acute mania, the leading feature being the very marked hyper-leucocytosis of polymorphs, which is found in the blood during the acute stage, irrespective in many cases of any coincident rise in temperature.

Turning again to his investigations as to the causal organism of mania, the lecturer described in some detail his methods of isolating it from the intestines and urine. In a large proportion of urines of cases of mania, collected with antiseptic precautions, various strains of streptococci were found. In health, the same organism was met with, though less commonly. The method of examining the fæces was to make stroke cultures on six successive agar tubes. Normally, the growth of b. coli is so luxuriant, as to crowd out all other organisms, but in cases of mania streptococci are very common. Slides were shown, illustrating an almost pure culture of the latter, with very few colonies of b. coli. This peculiarity was met with in 15 out of 27 cases examined. The presence of streptococci in the urine was probably due to their entering the blood stream or lymphatics from the alimentary tract (which showed gross pathological changes in almost all cases examined post mortem), and ultimately being excreted by the kidneys. Attempts were made to produce an antiserum to these organisms by injecting them into goats, but without success. The study of the opsonic index in mania to these strains of streptococci showed several points of interest. For the controls, pooled sera were used, and the normal index was taken as between .8 and 1.2. In mania the opsonic index showed variations very much wider than any obtained in healthy persons. Vaccines of these organisms were prepared, and produced a negative phase, followed by a positive phase in the usual way. During the negative phase, or when the opsonic index was low, the patients suffered from excitement; during the positive phase, or high index, the symptoms abated. It is well known to all asylum attendants that patients with mania had good days and bad days, and that their symptoms tended to remit. Repeated observations on the opsonic index showed that the index was low when the symptoms were acute, high during the remissions. To illustrate the similarity to the micrococcus rheumaticus, charts were shown giving analogous results on the injection of vaccines of that organism into persons suffering from rheumatism. It was impossible by means of vaccines to maintain the opsonic index at a high level for any length of time. Dr. Bruce's theory of the cause of mania is, that it is a bacterial poison formed in the intestinal tract. Owing to the lowering of the bacterial defences of the body, certain organisms flourish unduly in the intestines, where they elaborate toxins which are all absorbed into the blood. These poisons have an affinity for the nerve elements, and when absorbed in sufficient quantity, they produce brain intoxication and an attack of mania. The defences of the body are stimulated to action by the presence of these poisons, and antitoxins are formed, which temporarily neutralise the toxins, and apparent recovery ensues. The infecting organisms, however, being in the intestines, are not affected by the protective substances, so that any lowering of the general health may be and frequently is followed by another poisoning of the brain, and further attacks of mania.

A NOTE ON THE

VOMITING OF ANÆSTHESIA. (a)

By L. G. GUNN, M.D.,

Assistant Surgeon to the Adelaide Hospital, Dublin,

THE medical man who makes anæsthetics his special study, knows, as a rule, comparatively little about the vomiting which so frequently follows their administration.

The patient may be sick once, or perhaps twice, before he leaves the anæsthetist's hands, but he is still unconscious, and does not complain. The surgeon who has to see the patient later on during the day realises more fully the misery caused by this post-operative vomiting, the nurse who sits for hours beside the patient's bed could probably write an astonishingly strong article on the subject, while, if the patient were asked to place his ideas on post-anæsthetc vomiting on paper, I fear in most cases the communication would not be fit for publication.

There is no need for me to attempt to prove that, quite apart from the misery entailed on the patient, vomiting after an operation is often a real danger to the success of the operation, not only in general surgery but also in many of its special branches; that such is the case is generally accepted by the medical profession. Why then is so little done to stop this post-anæsthetic vomiting? Because I think it has come to be looked upon as a necessary evil. Our forefathers looked for and expected laudable pus as the natural sequela of any operation, and were seldom disappointed. We know better now, but are we not inclined to take up to-day somewhat the same position in regard to the vomiting which follows the administration of a general anæsthetic?

There are three unpleasant sequelæ to anæsthesia, headache, pain in the back, and vomiting. I only wish to deal with the last and greatest of these this evening, but would remark in passing that the loin pain is probably due to a direct irritation of the kidneys, a fair proportion of cases, whose urine was normal before the administration of the anæsthetic, show traces of albumin and hyaline tube casts in the urine for several days afterwards. I have found such a condition present in about 20 per cent. of the cases I have so tested, but I have done little work on this particular subject, and observers with large experience put the percentage much higher than this.

At the Adelaide Hospital year by year we average well over 600 anæsthetics, and for several years I now have had the benefit of this material at my disposal for observation on post-anæsthetic vomiting. I am not going to give you any figures, but merely the conclusions I have formed on this subject, nor are these conclusions in any sense my own; probably all have been advanced time and again before now. I believe, however, that they are correct.

1. The careful preparation of a patient before an anæsthetic is of some importance, but not of very great moment. Preparation can easily be overdone, *i.e.*, a patient starved too long a time before the anæsthetic is likely to have more vomiting than one who had received no preparation at all.

2. The vomiting is in no way dependent on the anæsthetic administered. I have only experience of three varieties, chloroform alone, chloroform followed by ether, and gas followed by ether; sickness follows each of these three forms equally.

3. The vomiting does not depend on the amount or duration of the anæsthetic. A short anæsthetic may be followed by as severe vomiting as one that may have lasted for a couple of hours.

4. The part of the body operated on does make a considerable difference. Abdominal operations, and especially those on the generative organs, are specially liable to be followed by severe vomiting. For this reason the gynæcologists see probably more troublesome post-operative vomiting than any other class of operator.

5. Sex is not a factor. Men suffer equally with women, but children, as a rule, suffer less; they probably have a smaller proportion of abdominal operations performed, and almost never have severe operations on their generative organs.

From time to time drugs in some shape or form have been recommended for the prevention of post-operative vomiting. I have tried many; none have been to any degree successful. To enumerate these methods would be useless.

Some months ago Dr. Bewley drew my attention to an article by Dr. MacArthur, of Winnipeg, in the *Montreal Medical Journal* of June, 1907. He gives the following explanation of the vomiting which we are considering to-night:—"The patient receives little or nothing in the way of food for twelve hours before the anæsthetic is administered; consequently, the stomach is empty. During the administration the saliva becomes surcharged with the anæsthetic, and trickles down the gullet into the stomach, where, in its concentrated form, it attacks the mucous membrane and causes gastritis; the vomiting naturally follows on this inflammation. When the stomach is full of water, the anæsthetised mucus swallowed mixes with it, and is absorbed in such a diluted form that it does not irritate the mucous membrane of the stomach." Acting on this assumption, MacArthur prepares his patients in the following way. After midnight, on the day of the operation, the patient is given four ounces of fresh cold water to drink; this is repeated every fourth hour, until two hours before the operation, when about ten ounces of water is given, and this is repeated just half-an-hour before the anæsthetic begins. In this way you fill up the tissues that have been depleted by purging, as well as put the stomach to its full capacity. Out of 35 cases treated by MacArthur in this way, only four had any trouble from post-operative vomiting.

This method appealed to me, as being harmless, simple to carry out, and likely to make the patient more comfortable before, if not after, the operation. With Dr. MacArthur's reasoning I cannot entirely agree. I cannot think that once the patient is fully under the anæsthetic that any saliva is swallowed; also he is wrong in thinking that at the time of operation the stomach remains full of water, for I tried palpating the stomach in several cases of operation on the upper part of the abdomen performed on patients who had been given this water treatment. In each case the stomach was nearly empty, so that now I have modified this method to this extent—that the last drink of ten ounces of water is given just as the patient leaves for the anæsthetic room.

I have tried this plan now on about 40 cases; in nine of these there has been no vomiting whatever after the anæsthetic, in 12 of these cases vomiting came on in the usual way, and I could not satisfy myself that the administration of the water had in these cases really made any difference. The remaining 19 were all improved, some being only sick once, and that very slightly. Several of these patients had had an anæsthetic before, and all remarked that it had been much less unpleasant on this occasion than the first time.

When this water treatment succeeds, there is marked absence of headache, thirst, and retching. The odour of the anæsthetic is quickly eliminated from the system, and the patient is able to take and enjoy nourishment in from six to eight hours after the operation. I do not for a moment suppose that this method is either new or that it has solved the problem of post-anæsthetic vomiting, but I do think that it is sufficiently simple and successful to be worth a trial. What I feel most strongly is, that it is an effort in the right direction, and along correct lines, which may in time lead us to a method of giving anæsthetics in which there is no risk of vomiting following.

(a) **Paper read before the Surgical Section of the Royal Academy of Medicine in Ireland.**

I have avoided the question of spinal and local anæsthesia. Their disadvantages seem to me to be greater in many cases than their advantages, and certainly they are by no means free from danger. The surgeon is responsible for the preparation of the patient for his anæsthetic; surely the treatment and prevention of post-anæsthetic vomiting lie more in our domain than in that of the anæsthetist.

The possibilities in these aseptic days, which are opened up for rapid healing, freedom from pain, and delicacy of technique, could we but be certain that no straining would follow the anæsthetic, calls for great effort on our part to attain to this end. I would be ungrateful indeed did I not in closing express my indebtedness to the anæsthetists for the high state of excellence to which they have brought their art.

It is no small comfort to the surgeon to know that in the hands of the Dublin anæsthetists the risks to a patient of a general anæsthetic become almost inffinitesimal.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

FRACTURED PATELLA.—MR. WILLMOTT EVANS operated on a woman, æt. 39, who had been admitted suffering from injury to the left knee. She had slipped down seven steps, and her left knee went under her; she was picked up, but was unable to stand. She was taken home, and remained in bed five days; with some difficulty she got about for the following days, and then came to the hospital. On admission there was much swelling and bruising round the left knee, extending upwards to the junction of the middle and lower thirds of the thigh. On palpation a fractured patella was found, the fracture being horizontal, the upper fragment forming only a fourth of the whole bone; the fragments were separated more than one inch. The leg was put on a back splint, and lead lotion applied to the affected area. Four days later the operation was performed. The patient having been anæsthetised a horse-shoe shaped incision was made from a little above the inner condyle passing downwards to immediately above the tubercle of the tibia, and then upwards to a corresponding point on the outer side. A flap composed of skin and subcutaneous tissue was turned upwards, and the fragments of the patella exposed; it was seen that the capsule of the joint was torn on both sides of the patella in a line with the fracture. A large quantity of clotted blood filled the joint cavity; this was removed, special care being taken to cleanse the fractured surfaces; the torn periosteum projecting from the edges of the patella was cut off. By means of an awl two holes were drilled in each fragment, commencing on the anterior surface and ending on the fractured surface. A piece of silver wire was passed through the inner and outer holes, and the two fragments drawn together. The wires were twisted twice, the excess cut off, and the ends hammered into the bone. The joint was then irrigated with normal saline solution at a temperature of about 103°. The torn capsule was united by silk sutures, both at the inner and outer sides of the patella. The skin edges were brought together by interrupted sutures, and the wound dressed. Mr. Evans remarked that at the present day the best treatment for an average case of transverse fracture of the patella was suturing. In the first place it might be mentioned that, although a majority of cases of transverse fracture of the patella were due to muscular action, yet in a not small proportion direct violence may cause a transverse fracture. Not only is this shown by the history, but often, as in this case, a large amount of local bruising makes it almost certain that direct violence had been responsible for the fracture. The injury to the soft tissues makes them a little more susceptible to septic influences, and therefore, in suturing such cases of fracture, the surgeon has to be extra cautious not to permit the introduction of micro-organisms. The best incision for this operation, he considered, was the horse-shoe, but the convexity of it may be either upwards or downwards to suit the operator's fancy. One great merit of this open operation, he thought, was that the blood effused into the joint can be removed, and this is not possible if any subcutaneous method of wiring was adopted. Bony union was also furthered by removing the fibrous tags of the torn periosteum which interpose themselves between the two fragments, but unless extreme care be employed, the risks of suppuration of the joint are by no means small. As to the method of union of the fragments, wire, he said, was usually employed, and does extremely well, and even fairly fine wire was quite sufficient to keep the fragments in apposition. Several surgeons, however, have used silk or catgut with good effect, for it must not be forgotten that, after the first few hours the force tending to separate the fragments was very small, and therefore somewhat slight sutures were quite sufficient. He regarded as desirable that the sutures, whatever their nature, should not encroach on the articular surface of the patella, as, should they do so, they must interfere, if only to a slight extent, with the movements of the joint. It was desirable, he pointed out, but not essential, to suture the torn capsule. No drainage was required if the surgeon was satisfied that the most strict precautions had been taken as to asepsis of the operation. A question arose as to when these operations should be performed—immediately or after a certain interval? His opinion was that in those cases in which the fracture was due to muscular action, no time was better than the second or third day after the injury, and no reason existed for further delay. The case, however, was somewhat different when direct violence had caused the breaking of the bone, for the tissues around the joint, and the skin over it, would certainly be damaged, bruised and œdematous, and therefore less suited for aseptic operations. In such cases as these a delay of a week or ten days was, in his opinion, useful, as it would enable the tissues to recover their normal condition, and therefore to be in a better state for operation. A splint for the first week after operation was, he thought, convenient, but by no means essential.

The further progress of the case was eminently satisfactory. The wound healed by first intention, the stitches were removed on the ninth day, and the patient left the hospital on the twenty-second day, walking well, with free movement of the joint. During the last week of her stay in hospital passive movement was employed.

A SERIOUS outbreak of typhoid fever has occurred at Workington. Since the beginning of the year 77 cases have been notified, and of these 52 have been reported during the present month. The Town Council are taking every practicable measure for dealing with the epidemic.

TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

THERAPEUTICAL AND PHARMACOLOGICAL SECTION.

MEETING HELD TUESDAY, JANUARY 28TH, 1908.

The President, Dr. T. E. BURTON BROWN, C.I.E., in the Chair.

THE minutes of the previous meeting were read and confirmed.

The following gentlemen were elected to the membership of the Section:—John McDonald Brown, M.D., F.R.C.S.; Frederick William Higgs, M.B., B.S., M.R.C.P.

Professor W. E. DIXON announced that he had given evidence before the Royal Commission on Vivisection, as the representative of the Section.

Dr. BURTON BROWN proposed a vote of thanks to Professor Dixon for having done so. Dr. GRAY DUNCANSON seconded, and this was carried unanimously.

Professor CUSHNY gave an address on "Nutmeg Poisoning." He referred to the scanty recognition of this in English medical literature, and noted the work of his former assistant, Dr. Wallace, in America, who found that cases of poisoning occurred exclusively from the use of the crude nutmeg or mace. In many instances it had been used as an abortifacient, although it does not appear to have this action. As far back as 1576, Lobelius relates a case in which a woman was rendered delirious by nutmeg. The symptoms are drowsiness, stupor, diplopia, delirium frequently is present, and sometimes the first symptom is burning pain in the stomach, præcordial anxiety or giddiness. One case of death in a boy occurred after eating two nutmegs. The symptoms resemble those of cannabis indica. Professor Cushny showed how the powerful poison was contained in the oil of nutmeg, and it was the fraction which came over at 150° C., 14 mm. Hg. From this several bodies have been isolated—*e.g.*, myristicin. From experimental work Professor Cushny came to the conclusion that the symptoms are to be attributed to action on the central nervous system, which is depressed, but exhibits some indications of stimulation in the form of restlessness, slight convulsive movements and tremor. The oil also has a marked local irritant action, whether given by the mouth or hypodermically. The stomach wall is found red and injected; the urine often contains albumin.

Dr. POWER (introduced by Professor Cushny) said that he had been working on the chemistry of oil of nutmeg, which he found a very complex mixture. He had isolated large quantities of myristicin, which did not conform in its features with the substance described by Semmler under that name. He drew attention to the very small amount of myristicin contained in the quantity of nutmeg necessary to induce poisoning, this suggesting a doubt to his mind whether the symptoms were entirely due to this body.

Dr. J. GRAY DUNCANSON mentioned the case of a woman who aborted, after taking, amongst other things, a ground nutmeg in gin; she displayed the symptoms described.

Professor CUSHNY replied.

The PRESIDENT moved a vote of thanks to Professor Cushny for his valuable and instructive paper. This was seconded by Professor DIXON, and carried.

Professor W. E. DIXON dealt with arterio-sclerosis and its causation. He referred to two theories of causation—(*a*) raising of blood pressure; (*b*) toxic influences; and showed that it had been established conclusively by experiment that arterio-sclerosis could be produced in the lower animals by simply compressing the abdominal aorta for one minute once or twice a day for a comparatively short period. The changes consisted in a drawing out of the elastic fibres and degeneration of the muscular coat, plaques of calcareous material being formed. He explained how this might be brought about in man owing to violent exercise, and more especially was this likely to occur as man grew older, as the rise of blood pressure was then greater after exertion than in youth. Dr. Dixon also spoke of the effect of nicotine on the blood pressure, comparing the sudden high rise in the young nonsmoker, after his first cigar, with the slight rise in the moderate smoker, and the absence of effect in the habitual smoker. He concluded by stating that man produced a ferment, probably in his liver, which counteracted the effect of nicotine.

Professor CUSHNY hoped that the study of this subject might lead to some advance in treatment. He did not think that the raising of blood pressure in man, by the administration, for example, of digitalis, would give rise to these changes.

Dr. SAVILLE stated that he was surprised to hear that the compression of the abdominal aorta for such short periods in small animals should give rise to so serious changes in the aortic arch, as had been described by Professor Dixon.

Mr. MABEN spoke also.

The PRESIDENT proposed, and Dr. GRAY DUNCANSON seconded, a vote of thanks to Professor Dixon for the account he had given of the results of the valuable work he had done on this difficult and important subject.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FEBRUARY 5TH, 1908.

The Vice-President, Dr. HUNTER, in the Chair.

MR. F. M. CAIRD showed (1) patient after removal of a sub-maxillary gland, and (2) patient after removal of half the tongue and the floor of the mouth for epithelioma.

Mr. A. A. SCOT SKIRVING showed a large pedunculated fibroid, uterus, and adnexa removed by abdominal hysterectomy from a patient, æt. 70, in which a complete twist of the uterus had occurred, causing strangulation of the uterus, and symptoms of acute intestinal obstruction.

Dr. DAWSON TURNER read a paper on

ELECTROLYSIS IN MEDICINE AND SURGERY.

After referring to the earlier methods, he turned to the present day applications of electrolysis, in particular to the process of cataphoresis, or introducing medicines through the skin by means of the galvanic current. Solutions which conducted electric currents were known as electrolytes, and only such solutions could be introduced percutaneously. The electrolytic properties of a solution depended on the fact that the molecules dissolved in it—*e.g.*, sodium chloride—did not exist as sodium chloride, but were dissociated into ions—an Na-ion and the Cl-ion. The metallic ion was known as the kation and the chlorine ion as the anion—the former was positively charged with electricity, the latter negatively. The positive ions of an electrolyte are conveyed through the skin by the positive electrode, the negative ions by the negative electrode. This has been shown experimentally in the following way. If two rabbits be placed side by side so that a constant current can be passed through their bodies, the right-hand rabbit being in contact with the positive pole-anode, and the left-hand rabbit in contact with the negative pole-cathode, and if the two electrodes be kept wet with a solution of strychnine hydrochloride, the rabbit attached to the anode will be poisoned, and the other will escape. The anode drives in the strychnine kations, while at the cathode the hydrochlorine anions accumulate. When, however, we replace the strychnine by a solution of potassium cyanide, the rabbit attached to the negative pole-cathode is killed, as the poisonous cyanogen ion enters its body, and the inert-potassium ion that of the other rabbit at the positive pole. This method of administering drugs had, of course, many advantages; when it was desired to produce a total effect, *e.g.*, on a stiff rheumatic joint, we could introduce the remedy directly, without having to impregnate the whole body in order that the one part should benefit. On the other hand, only those drugs which are electrolytes can be made use of, so that cataphoresis is limited in this direction. Cataphoresis may be employed in a variety of affections. Dr. Turner had tried introducing the salicylic ion in cases of rheumatism, but his results had not been so satisfactory as those of several other observers. In rodent ulcer it was very serviceable. A solution of zinc chloride was used, several layers of lint being soaked in it and laid upon the ulcer, and the cathode applied over it. A current of from 10 to 40 m.a. was required. After two sittings, in some cases, the ulcer was markedly benefited. A number of other cases were referred to, and photographs were shown to illustrate the improvement brought about by cataphoresis. The chlorine ion had proved serviceable in various conditions of sclerosis and ankylosis, *e.g.*, Dupuytren's contraction. Tic doloureux was also very amenable to cataphoresis. It was suggested that some part of the benefit of the constant current in a number of chronic nervous affections was probably due to the action of the chlorine ion on fibrous tissue.

The paper was discussed by Dr. **Webster**, the **President**, and Mr. **Wallace**, who referred to cupric electrolysis in the treatment of ozæna. Dr. **Turner** said that the best method of applying cupric electrolysis would be, instead of using a copper electrode introduced below the nasal mucous membrane, to fill the nasal cavity with a copper solution and pass in the copper ions, using a copper cathode.

Dr. A. E. **Morison** read a paper on

ONE HUNDRED CONSECUTIVE CASES OF EMPYEMA.

He first drew attention to some points concerning the physics of pleural effusions. The intra-pleural pressure is positive in pleural effusion; in normal conditions the pressure is negative. Effusion into the pleural cavity first shows itself as an area of dulness—(*a*) just below the angle of the scapula; (*b*) in the left axilla, between the fifth and eighth ribs; (*c*) in obliteration of Traube's semilunar tympanitic space; (*d*) in the right front near the angle made by the cardiac and hepatic dulness. Disappearing effusion is last manifest in the axillary line between the fifth and eighth ribs. The root of the lung is its fixed point, and with increasing effusion the lung becomes compressed round it. The re-expanding lung last touches the chest-wall at a point diagonally furthest from its fixed point—*i.e.*, in the axilla about the fifth interspace. The lung does not tend to collapse on its fixed point when air is admitted into the pleural cavity. Turning to the causes of empyema in his series of cases, in the enormous majority the empyema followed pleuro-pneumonia, there being evidence of this in 91 per cent. Pleurisy was a cause in 4; this confirmed the experience of others that serous effusions rarely turned purulent unless they were infected accidentally. Tubercle was the cause of 3 cases; septic disease of the abdomen of 1; and general streptococcic infection of 1. The diagnosis of empyema rested partly on the history and partly on the physical signs. The patient had a pneumonia, and after the crisis there was not the usually expected improvement; the chest did not clear up properly, there was a febrile temperature, loss of flesh, night sweats, vomiting, fitful appetite, and cough. On examination of the chest one side would be found to expand badly; the ribs were usually approximated except in cases in which the effusion developed very rapidly; on percussion there was dulness over the affected region, with diminished vocal fremitus and resonance. The breath sounds were usually absent; in some cases (especially children) bronchial breathing was heard. The position of the heart was altered in effusions of any size, particularly those which were left-sided. On exploring with the needle pus was found. Dr. Morison urged the need for repeated puncture, if necessary, and said he had never seen any bad results whatever from this. The prognosis in uncomplicated empyema was good, the mortality in this series of cases being only 3 per cent. Absorption of pus undoubtedly occurred in some cases; this had been observed in one of the patients comprised in the series. In two cases cure followed spontaneous evacuation of the pus through a bronchus. Discharge of pus into organs adjacent to the pleura was another possible mode of termination, but no such condition had come under the speaker's notice. Empyema necessitatis, or spontaneous evacuation through the chest wall, occurred in 5 cases, subsequent operation being required. Surgical treatment offered the best results, immediate and remote. In ordinary acute empyema cured by drainage, there was complete return to health, and if the chest were examined a month or two after operation, it was impossible to say, except from the scar, which side had been affected. Although now and again aspiration was curative, it was only really advisable as a temporary expedient, as when dyspnœa is great, or some complication renders operative interference inadvisable. In adult patients the chest could often be drained under local anæsthesia; in children a general anæsthetic was required. The patient ought never to be turned over on the unaffected side; this could easily be avoided by drawing the patient well to one side of the table. It was always advisable to explore the chest so as to make sure of the situation of the pus immediately before operating. The site of election was in the fifth interspace in the posterior axillary line. In ordinary cases it was not essential to remove a rib. Simple incision with the insertion of a stout-walled drainage tube was enough. The pleural cavity ought not to be irrigated. As a rule the tube could be removed in about three weeks' time. Estlander's operation had been required in several of the cases. Dr. Morison illustrated his remarks by quoting the details of several of the more instructive cases in his series.

Dr. **Affleck** said that sometimes the odour of the pus showed its origin, and quoted a case of fœtid empyema arising from an appendicular abscess as an instance of this.

Dr. **Russell** was glad to hear that simple incision was sufficient treatment for so many cases. Formerly this had been the practice, but now surgeons always resected a portion of rib. He also spoke of the aid which was derived from the leucocyte count in the diagnosis of pus in the chest, and of the difficulty which exists in diagnosing deeply-seated diaphragmatic foci of suppuration. These latter were liable to terminate by evacuation into a bronchus. He doubted whether bronchial breathing ever occurred over effusion; it probably only was audible over the compressed lung near an effusion.

Mr. **Caird** agreed that incision was sometimes adequate, but thought that the advantage of resection was in enabling the surgeon to remove tough masses of lymph, and to ascertain the degree to which the lung was compressed. For resection a general anæsthetic was required.

Dr. **Goodall** referred to Professor Macewen's observations on the factors determining the absence of collapse of the lung when the chest wall was incised.

Dr. **James** said that in acute uncomplicated empyema incision was sufficient; in other cases it was better to resect. The reason why the pressure was positive in empyema was that the lung was bound down by adhesions and the pus gathered behind these.

Dr. **Morison** replied.

LIVERPOOL MEDICAL INSTITUTION.

Seventh Meeting of the Session, held Jan. 16th, 1908.

The President, Mr. **Thomas Bickerton**, in the Chair.

Dr. T. **Bradshaw** read a paper on "The Physics of the Mitral Regurgitant Murmur. Especially with Regard to its Audibility at the Heart's Apex." He assumed the correctness of the views held by George Balfour, Chaveau, Marey and others, that murmurs are due to the vibrations of the fluid veins formed in the space beyond the narrowing. The difficulty in explaining the mitral regurgitant murmur on this theory was that it was heard at a point (the apex) in the opposite direction to the fluid vein, which was directed towards the auricle. No explanation quite satisfactory had ever been offered. The writer's explanation was that the sonorous fluid vein lay between the two curtains of the mitral valve, and that its vibrations, transmitted to the cone of blood, passed through the thin walls without damping, and set up vibrations in the ventricle. The vibrations were heard best at the apex, because the walls of the ventricles were thinned at this spot, and this spot was most accessible to auscultation. He showed an apparatus constructed to show that sonorous vibrations could under similar conditions be conducted in a retrograde manner.

The paper was discussed by the President, Sir James Barr, Prof. Wilberforce, Drs. Lloyd Roberts and Buchanan, and Dr. Bradshaw replied.

EIGHTH MEETING OF THE SESSION, HELD JAN. 30TH, 1908.

The President, Mr. THOMAS BICKERTON, in the Chair.

Mr. ROBERT JONES described his operation for the production of pseudo-arthrosis at the hip-joint without disarticulation of the femoral head. The great trochanter was first separated from the shaft by a broad osteotome, and the neck of the femur either divided or removed, and the trochanter was screwed on to the head of the femur, which lay in the acetabulum. The operation might be employed in all varieties of bony ankylosis, but was eminently suited for old people with malum coxæ senilis where the shock of disarticulation was serious.

Mr. ROBERT JONES also described his procedure in the treatment of Volkmann's ischæmic paralysis, and his operation in paralytic calcaneo cavus.

The communication was discussed by the President, Messrs. Thomas and Newbolt and Dr. Abram, and Mr. Jones replied.

Dr. BRIGGS read a paper on

ECTOPIC GESTATION,

an abstract of which will be found on page 178 of the present issue.

The paper was discussed by the President, Drs. Grimsdale and Gemmel, and Dr. Briggs replied.

ULSTER MEDICAL SOCIETY.

MEETING HELD THURSDAY, FEBRUARY 6TH, 1908.

The President, Dr. JOHN MCCAW, in the Chair.

DR. W. B. MCQUITTY showed a case of juvenile general paralysis of the insane. The patient was a boy of 11.

Captain ARCHER, R.A.M.C., showed a patient suffering from paralysis of one arm, the result of a fall on the elbow. The diagnosis lay between an injury to the brachial plexus and a hæmorrhage into the cord, the general opinion being in favour of the former.

Mr. ANDREW FULLERTON showed a case of halux rigidus.

Mr. ROBERT CAMPBELL showed a case of longitudinal fracture of the styloid process of the radius (Chauffeur's fracture).

Dr. HICKS read a paper on "Some Cases of Extra-Uterine Fœtation." The paper was based on six cases in which Dr. Hicks had operated. All were in the early months of gestation. One was an example of repeated tubal gestation, the others were single ectopic gestations. In five of the six cases, or 83 per cent., there was a history of gonorrhœa previously. Two had pyosalpinx on the opposite side. One was complicated by an ovarian cyst and pyosalpinx on one side, and a ruptured tubal gestation into the pouch of Douglas on the other. Five of the six cases recovered. The connection between gonorrhœa and cases of this sort was first suggested by Lawson Tait, but he thought that the ciliated epithelium was injured by gonorrhœal catarrh. It is now known that the cilia are not destroyed, and that, moreover, their action is downwards from the tube to the cervix. American and German authors still look on gonorrhœa as the chief cause of extra-uterine fœtations, probably by producing interstitial changes in the wall of the tube, or peritoneal adhesions causing constrictions. Bland-Sutton and other English authorities teach that fœtation may take place in the healthy tube, but so far as Dr. Hicks' cases went, they certainly supported the other view.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 9th, 1908.

CUTANEOUS EPITHELIOMA.

THE treatment of epithelioma of the skin is either surgical or medical. The thermo-cautery or the X-rays represent the former, while the chemical or potential cautery forms the medical treatment. The surgical treatment has given good results, but is ordinarily not within the reach of the country practitioner. On the other hand, many pusillanimous patients refuse the actual cautery, consequently some more anodyne treatment must be employed.

Numerous were the agents proposed for cauterising superficial cancer of the skin. Bulroth used to say that he did not know of any agent that had not been employed for this purpose—nitrate of silver, proof spirit, tincture of iodine, acetic acid, arsenic, phosphorus, turpentine, etc. One of the most ancient drugs was arsenic, but in inexperienced hands the treatment produced disastrous effects.

It remained for Cerny and Truneck, of Prague, to rehabilitate this caustic by giving a formula free from all danger and radical in its cure.

They employed arsenious acid, which they used at first dissolved in glycerine, but had to renounce the preparation, as it produced such a thick crust or eschar that a second application was impossible. They changed, consequently, their formula for the following, which has been used with so much success by dermatologists:—

Arsenious acid, 15 gr.
Ethylic spirit, }
Water, } āā ℥ijss.

The seat of the neoplasm must be well cleansed and rubbed rather roughly, so as to provoke the issue of a few drops of blood. The mixture is then shaken and applied over the raw surface of the cancer by means of a brush. The solution is allowed to evaporate, and no dressing is required. The patient experiences for a few hours following the application some pain, but nothing excessive. The next day the neoplasm is completely covered with a crust produced by the action of the arsenious acid. Each day the solution is applied over the crust, which, yellow at the outset, becomes gradually brown, and finally black.

The first day the crust is firmly attached to the subjacent tissue. It is thin, but gets thicker each day until it invades all the surface of the cancer. At the end of a certain time the edges begin to rise and the separation increases each day, while a whitish serosity oozes from the ulcer.

The treatment is continued regularly until the crust is almost detached, held only by a few filaments that may be cut with the scissors. The raw surface is once more painted over with the arsenical solution, and if on the following day only a slight yellowish crust, easily detached, is observed, the ulcer will heal of itself, as all carcinomatous tissue has been destroyed. If, on the other hand, the crust is brown, resisting and adherent, the treatment must be continued until all cancerous elements have retroceded. At that period the wound commences to granulate and to heal. It must then be treated as a simple ulcer—that is to say, cleaned every day with a solution of boric acid or oxygen water, and dressed with some non-irritant powder, such as:—

Iodoform, }
Cinchona powder, }
Benzoin powder, }
Carbonate of magnesia, } 3 oz.
Ess. of eucalyptus, 2 dr.

It is remarkable that arsenious acid appears to have an elective action on cancerous elements, for, applied to simple ulcers, no crust is produced, and also after all the cancerous cells are destroyed, proving that the cure is complete

TREATMENT OF VASCULAR NÆVI.

There is good news in store for those persons, somewhat numerous, who are afflicted from their birth with vascular nævi, otherwise called wine spots or mother's mark. These stigmates, as every one knows, were always considered indelible.

Drs. Wickham, of the St. Lazare Hospital, and Degrais, of the St. Louis Hospital, presented to the Académie de Médecine a series of aquarelles of different types of these nævi, which were rendered completely colourless by the action of radium. Some belonged to adults, others to infants.

All these spots were effaced by the simple application of plane apparatus coated with a varnish in which radium was incorporated. The radiations emitted from the apparatus were dosed in such a manner that it was easy to vary the action according to the duration and number of applications.

Certain nævi can be cured by weak doses frequently repeated without producing the slightest reaction. However, in many cases where the nævi were extensive and profound, it was necessary to provoke a certain reaction. In these cases the new tissue was supple, smooth, and colourless, presenting an excellent æsthetic appearance.

The applications produce no pain, and for this reason, large surfaces can be treated and even children during sleep.

M. Wickham declared that radium can be utilised with advantage in all forms of mother's mark, even those generally considered as incurable, and the most amenable to cure are those which are most coloured and raised above the skin.

WARM BATHS FOR PNEUMONIA.

Hydrotherapy is at present employed in the treatment of acute maladies of the lung according to two methods: Cold baths and warm baths. Each of them has its partisans and its adversaries.

Hippocrates recommended warm baths in his treatise on acute affections, and Celsus advised them for all fevers.

The practice, says Dr. Dufour, fell into disuse until the beginning of the 18th century, when it was employed by empirics. But Rilliet extolled the benefits drawn from warm baths, as a sedative in bronchopneumonia accompanied with fever and delirium. D'Espine employed them systematically in bronchitis and pneumonia.

The wonderful results obtained by cold baths in the different forms of pyrexia, according to the Brandt method, caused warm hydrotherapy to be forgotten for a time. However, some ten years ago Renaut, of Lyons, rehabilitated this treatment, concurrently with Prof. Lemoine, of Lille.

There is nothing very particular in the method of administering these baths; the physician is guided as regards the number, temperature, and duration of the baths, by the general condition of the patient, the fever, the extent of the pulmonary lesions, and their more or less resistance to treatment. In average cases, a temperature of 102° to 104° F. is sufficient, the baths repeated every eight hours, each lasting fifteen minutes.

Where the general phenomena are intense with great nervous excitement, the baths should be repeated every four hours; where the pulmonary lesions are extensive as in pneumonia or in bilateral pulmonary congestion, accompanied with high fever and considerable dyspnœa, the baths should be given every four hours at 105° F. Mustard might be mixed in the morning and evening baths; one pound of ordinary mustard mixed with cold water and thrown into the bath before the hot water is poured in. While the patient is in the bath cold applications should made to the head, and a little champagne or or grog administered once or twice during the sojourn in the bath.

OPHTHALMO-REACTION.

Referring to the subject of opthalmo-reaction, it may be useful to know that Dr. Montagnon, of St. Etienne, has just published a series of cases in which the ophthalmo-reaction was abnormal. Although clearly positive in the majority of cases of well-established tuberculosis, it fails in patients suffering from bacillary cachexia, those who have reached the third stage of pulmonary phthisis, and those affected with tuberculous peritonitis.

On the other hand, the reaction is almost constant in patients suffering from typhoid fever, but entirely exempt from the bacilli of Koch. Two cases of hysteria, one of Basedow's disease, and one case of chorea responded to the same reaction.

Dr. Montagnon explains these anomalies by the fact that tuberculin is a vaso-dilator toxin, whose action is revealed under certain conditions, and it is possible that a particular condition of the vaso-motor system, or a certain degree of erethism of the nervous system, favours the appearance of these phenomena.

Oculo-reaction can, consequently, be observed in certain injections which seem to stimulate the vaso-dilator action of the tuberculin.

The phenomena resulting from oculo-reaction are complex in their nature, and are accompanied by exceptions which may be explained later on, scientifically, but for the moment one should be very prudent in their clinical interpretation.

The important practical question is: Are all patients who present reaction to the tuberculin really tuberculous? A positive affirmative in doubtful cases would be of the greatest value. Such, however, cannot be given up to the present; yet it is an acquired fact that in cases where there is little doubt on their tuberculous nature, the reaction is almost constant (85 per cent.).

A certain number of tuberculous patients present no reaction, while certain nervous and infectious conditions (typhoid fever) give a positive reaction outside all tuberculous taint.

GERMANY.

Berlin, Feb. 9th, 1908.

AT the Verein für Innere Medizin, Hr. Jul. Citron spoke on

THE SCIENTIFIC AND PRACTICAL IMPORTANCE OF OPHTHALMIC (CONJUNCTIVAL) REACTION IN TUBERCULOSIS.

He said that he had already spoken and written so much on the subject that he would only discuss certain points on which he did not agree with Hr. Stadelmann, who introduced the subject at the meeting of the Society on the 6th inst. As regarded the skin reaction, he did not attribute the importance to it that Stadelmann did. A method of reaction that, according to Pirquet, gave a positive result in 30 per cent. of healthy children of from three to five years of age, could not be of much value as regarded diagnosis in the adult. A certain value could not be denied as regarded prognosis, in so far as a negative result had any prognostic value at all. With a more delicate dosage better results might perhaps be arrived at.

The Conjunctival Reaction.—This had a close connection with that of the skin, as prompted by Pirquet's address. Wolff-Eisner introduced a drop of a 10 per cent. solution of tuberculin on to the eye-ball. Shortly after this, in the Académie des Sciences, Vallet reported the negative results of cutaneous inoculation in cattle, and Calmette the same as regarded ophthalmic inoculation. It was not worth while to discuss priority. Wolff-Eisner, from a diagnostic point of view, had unfavourable results at first, as the 10 per cent. solution used by them was too strong. The speaker had dropped in a 1 per cent. solution which gave a result that was of diagnostic value. Calmette also used a 1 per cent. solution, which, however, as it contained 1 per cent. of dry tuberculin, was ten times too strong. It was the same with the preparation obtained from the Höchst establishment. Not only must the right preparation be used, but the instillation must be done in the right way—*i.e.*, so that the drop remained in the eye, and it must be looked after at the right time, not too soon before the reaction could be begun nor too late, when it had passed off. From his observations the test was specific for most cases of tuberculosis. The result was positive in 80 to 90 per cent. of tuberculous cases, in 70 to 80 per cent. of suspected cases, and in 0 per cent., or only very rarely, in people who were not tuberculous. Not infrequently the 1 per cent. solution was not strong enough to set up the reaction, and a 2 per cent. or 4 per cent. solution was necessary. If, however, the result was not satisfactory, and a repeated application to the one eye was not advisable, he had helped things on by applying a 2 or 4 per cent. solution to the other eye. The speaker mentioned shortly the positive results that had been observed by some authors in typhoid, acute rheumatism, and syphilis. The contra-indications were of two groups, the absolute and the relative. One absolute contra-indication was disease of the eye; even if only one eye was affected, on account of the possibility of sympathetic disease. Very severe inflammations of the eye might be set up by the reaction. Scrofula was a relative contra-indication, as scrofulous people reacted with great violence. He had often seen a phlyctenular conjunctivitis after the use of the drops in such cases. Residence in a locality where trachoma was prevalent was also a relative contra-indication. In any case the individual on whom the test was made must be kept isolated for a time. The effect of tuberculin injection, after applying the test to the eye in lighting up again the inflammation that had taken place there, the speaker explained according to the views of the Wassermann school on the formation of antibodies and antigen.

Hr. L. Pick had examined the histological structure of the late papules in five cases of skin reaction. In three cases he found nothing but round-celled infiltration; in one case peculiar cells in the subcutaneous fatty tissue; and in one case typical giant cells. On a further search dead tubercle bacilli were found in the tuberculin, the giant cells being the result of their incorporation.

Hr. Noeggerath did not think that any prognostic conclusions could be drawn from the negative result of the test in severe cases of tuberculosis. In nine cases, not severe, the Pirquet test was negative, whilst subcutaneous injection gave a positive result.

Hr. S. Cohn mentioned 66 cases of typhoid (12 of his own) in which the reaction was tested with a positive result in 34 cases. Typhoid fever possibly had some relation to tuberculous susceptibility; perhaps tubercle was already present. He found no reaction in cases of diphtheria and pneumonia. He then tried whether typhoid cases reacted to non-specific extracts, and found that a positive result followed the injection of extract of bacterium coli. He had met with the same results in non-infectious cases.

Hr. Max Wolff had not met with such favourable results as other reporters. Of 19 tuberculous cases in the first and second stages, the result was positive in 12; in 18 cases of conjunctival testing the result was positive in 12. In animal inoculations he had not had one success. In 85 scrofulous children and adults, a positive result was obtained in 44 only. X-ray examination gave more frequent results as regarded tuberculosis. He had also made comparative experiments with subcutaneous injection, and the latter was far more reliable from a diagnostic point of view. After the ophthalmic reaction he had seen severe conjunctivitis.

THE CLINICAL VALUE OF WASSERMANN'S SERUM DIAGNOSIS IN SYPHILIS.

A paper on this subject appeared in the *D. Med. Wochensch.*, 52/07, by Drs. Fischer and Meier, of the Rudolf Virchow Krankenhaus, Berlin. They state that Wassermann's syphilis reaction is specific, that it has not been met with in any but syphilitic cases. If the result is a positive one, it agrees in all points with the clinical symptoms and the history. The reaction admits of a constitutional but not of an "organ" diagnosis—*i.e.*, it says only that the system is infected with the disease, but it does not say that any particular pathological process in any particular organ is syphilis. A positive result, also, only is decisive. No conclusion can be drawn from a negative result, neither as to any syphilis possibly present, nor as regards a final recovery. Treatment does not appear to influence the reaction in any way.

AUSTRIA.

Vienna, Feb. 9th, 1908.

LYMPHO-SARCOMA.

HORNER showed preparations taken from one of Schwarz's cases who died from compression and stenosis of the superior vena cava. The sarcoma lay in the anterior mediastinum region at the hilus of the lungs sending roots behind, while a portion of the growth ensheathed the vena cava producing the stenosis.

Schwarz said that a few months before death he had treated the patient with the Röntgen rays, which acted very favourably at first in reducing the size of the morbid growth. Two days after the first application the tumour went down 2½ centimetres in diameter, which apparently removed the stenosis of both the bronchi and the blood vessels, as shown by the relief to the swelling in the neck and distended jugular veins.

Later the growth had shrunk from 17 centimetres in diameter to 8 centimetres. After a pause it began slowly to increase again, but it never exceeded 10 centimetres, and remained stationary with no return of the dyspnœa and congestion of the vessels till a tooth had to be extracted, which injured the jaw, followed by infectious fever and a sudden change in the whole condition that precipitated the end.

Chiari remarked that lympho-sarcoma possessed the property of receding for a time after an operation or after an attack of fever, erysipelas, and cauterisation. He thought the Röntgen rays acted in the same way by giving a shock to the morbid growth.

ERYTHRODERMIA.

Ehrmann presented a patient who had been ill for the last nine months with erythrodermia, or what others might term pseudo-leukæmia, pityriasis rubra, etc. The physical signs were a constant, diffuse, general redness over the whole body, but less pronounced on the palmar and plantar surface and absent altogether over the genitals. The skin is œdematous and swollen. The breast and back surface are quite distended and tense with a glistening appearance. The inner surfaces of the thighs, axillæ, and elbows are greatly enlarged as with fat, and marked with a mosaic colouring combined with an irregular surface which gives it the appearance of crocodile skin. The glands of the groin, axilla, elbow, and supra-clavicular region were very tender. Nothing abnormal could be found with any of the internal organs. Injections with old tuberculin 0.01 gram., as well as the reactions of Calmette and Pirquet, failed to give any information.

The blood at the end of October gave 3,900,000 red blood corpuscles and 21,000 white; Fleischl 85 of hæmoglobin. The polynuclear and neutrophile leucocytes were 72 per cent.; eosinophile, 9 per cent.; basophile, 3 per cent.; and mononuclear eosinophile, 16 per cent.

At the end of December the red blood corpuscles were 2,800,000; white, 20,450; polynuclear neutrophile leucocytes, 55 per cent.; eosinophile, 32 per cent.; lymphocytes, 11 per cent.; while the large mononuclear leucocytes were 7.7 per cent.

Withal the pathology of this disease appears very doubtful—whether it is leukæmia or pseudo-leukæmia? Hebra was wont to group a number of these cases under the title of tubercle, but these tests all failed in the case exhibited. There is another group of cases with circumscribed patches of reddening and desquamation, which we do not place as tubercle, but which may be placed as leucocytosis. It is quite possible to confound pseudo-leukæmia and leucocytosis, as in the case brought forward, where the proportion of large and eosinophile cells preponderate. He was inclined to believe this case to be one of mycosis fungoides.

Lang said he had shown similar cases to the Society under the name of dermatitis exfoliata, although he was aware the French termed it "erythrodermie." At the beginning of this disease it is difficult to distinguish it from eczema, while at a later stage it is hard to say whether it is psoriasis or pemphigus foliacea. He could not believe, however, that it ever was associated with mycosis fungoides.

PULSATING DIVERTICULA IN ŒSOPHAGUS.

Hajek gave the history of a diverticulum in the œsophagus and the difficulty of diagnosis when pulsating. What confirmed his opinion was the passing sometimes of a small bougie into the stomach, while a large one was resisted, but sometimes would pass. The œsophagoscope and radioscope confirmed this at a later stage.

Robinsohn, who used the Röntgen rays, said a modification of the usual methods was necessary in this case. As a rule, all fluids and solids tend to enter these diverticula, but more especially the latter. With this object a capsule of bismuth, 1½ centimetres in diameter, was swallowed and subsequently observed in the sac. To guide him with the œsophagoscope he attached a thread to the capsule and measured the length of the teeth for the exact position of the instrument in order to observe the size of the opening into the sac.

HUNGARY.

Budapest, Feb. 9th, 1908.

At the recent meeting of the Budapest Royal Medical Society Dr. Stern read a paper on

Traumatic Lesions of the Skull.

In his paper he presented the following summary: 1. Injuries of the skull and brain may be classed under two heads, those of impact and those of momentum, either of which may be occasioned directly or indirectly. 2. Injuries of impact, however extensive, offer a better immediate and remote prognosis, but must be treated with as little delay as possible, and almost always surgically. 3. Injuries of momentum show graver probabilities both in their immediate and remote effects. 4. In injuries of momentum lesions through *contre coup* are more apt to occur, with extensive damage to brain structures, and often without fracture of the skull or external wound. 5. After trauma to the skull and brain, the immediate necessity is free drainage and avoidance of intracranial pressure. 6. The possibility of fracture should ever be kept in view after injuries to the head, the scalp wound should, if necessary, be freely enlarged to determine the wisdom of further operative interference. 7. Progressive coma, after momentum injuries, is a strict indication for operation.

The Complications of Polyarticular Rheumatism.

Dr. Harasfi has analysed a large number of cases, and found that about 2.2 per cent. of all hospital cases are admitted for articular rheumatism. The greatest frequency is noticed between 16 and 20 years, and the sexes are affected about equally. In 26 per cent. an angina preceded the attack, and recurrences were noticed in 39.7 per cent. Complications were noticed in 57 per cent., but more frequently among women than men. The great majority of complications (51.7 per cent.) were cardiac, and mitral insufficiency was the most frequent lesion observed. Pericarditis was observed in 1.7 per cent.; less frequently, erythema nodosum, pneumonia, chorea minor, psychical disturbances, and nephritis. The mortality was 1.7 per cent., the cause of death being pneumonia and nephritis, secondary to loss of compensation.

The Treatment of Diabetes Insipidus.

In a typical severe case of diabetes insipidus, Dr. Stein has tried a number of different therapeutic measures, with the following results:—Change in diet did not increase the amount of urine, while it made the patient very uncomfortable. Decreasing the amount of fluid ingested was also a failure, since severe nausea, vertigo, and weak pulse were the result, and the amount of urine dropped only from 10 to 8 litres. Cold baths were refreshing, but warm water, applied in the hopes of stimulating diaphoresis, was not borne well. Preparations of valerian, large doses of antipyrin, the bromides, arsenic, sodium kakodylate, mercury, and the iodides did not make a lasting impression upon the disease; but good results were finally seen from small, gradually increasing doses of strychnine, injected subcutaneously. Polyuria and polydipsia disappeared in three weeks, and the patient rapidly gained in weight.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Workmen's Compensation and Surgical Operations.—An important judgment was delivered last week by a Court of seven judges in the second division on a stated case under the Workmen's Compensation Act. A workman whose hand had been injured in the course of his employment, and who was in consequence incapacitated, received compensation under the Act. Three out of four doctors who examined him advised that the second finger of the hand should be removed, and at the same time a painful nodule in the palm. The Sheriff, holding that these were not serious operations, and that they would probably relieve the man and fit him for work, ended the compensation as the man refused to undergo them. The Court of Session upheld the Sheriff's decision. The majority of the judges were of the opinion that the workman, like any prudent and reasonable patient, who wished to be restored to health, was bound to submit to the operation, which was reasonable, and not attended by serious risk. This decision seems eminently just, and agreeable to commonsense. It is surely ridiculous to suppose that a man who will not adopt ordinary treatment to render himself self-supporting again should be allowed to receive compensation for an indefinite period.

Edinburgh University Honorary Degrees.—Among those who have been offered the degree of LL.D. by the University of Edinburgh in anticipation of the forthcoming spring graduation, are two members of our own profession, Dr. J. O. Affleck, Edinburgh, and Dr. Caton, Liverpool. Dr. Affleck is one of the best known and most highly respected medical man in Edinburgh, and has occupied very many important public positions. He is equally esteemed as a teacher, a physician, and a man, and his many friends and admirers will feel that the honour which his Alma Mater is now about to confer upon him, has never been more appropriately bestowed. The high estimation in which Dr. Caton is held by his fellow citizens is best shown by the fact that he is now chief magistrate of Liverpool—the Right Worshipful Richard Caton, M.D., Lord Mayor of Liverpool. Among other recipients of the same degree are Sir Norman Lockyer, K.C.B.; Sir James Balfour Paul, Lyon King-at-Arms; and the Rt. Hon. Thomas Shaw, M.P., Lord Advocate.

Royal Medical Society Dinner.—The annual dinner was held in the Hall of the Society on the evening of February 5th, Dr. A. C. B. McMurtrie, Senior President, in the chair. A large company gathered to meet the principal guest of the evening, Mr. Jonathan Hutchinson, London, who, after replying to the toast of his health, gave "The Royal Medical Society." In the course of his speech Mr. Hutchinson reiterated his well-known views on examinations—insisting that he would leave nothing to the caprice or individual predilections of an examiner, but would prepare lists of questions which would be put beforehand into the hands of those about to be examined. Examiners would be clumsy in their work if they could not defeat the cramming which his method might engender. Lord Salvesen and the Moderator of the Church of Scotland replied to the toasts of the sister professions, and Professors Chiene, Simpson, and Harvey Littlejohn for the University and Colleges.

Foot and Mouth Disease in Edinburgh.—A serious outbreak of foot and mouth disease was discovered in Edinburgh this week, about 80 cattle of a herd of 110 being affected. The farm is one just on the outskirts of the city, and very active measures have been necessitated. It is announced that altogether 200 cattle will be slaughtered forthwith, their carcases being disposed of by burial in the immediate neighbourhood. Meanwhile, the provisions of the Contagious Diseases (Animals) Act have been put into operation, and no movements of stock within a large district of the country are permitted. The disease has not occurred in Scotland for nearly twenty years. The present outbreak has been traced to a consignment of Dutch straw lately imported. So far, no cases of stomatitis referable to infected milk have been reported. The infected farm was in an industrial quarter of the town, from which many of the patients attending the various hospitals are drawn, but no cases suggestive of foot and mouth disease in man have been seen at the dispensary of the Children's Hospital.

Ruchill Hospital Inquiry.—The Commissioners investigating the affairs of the Ruchill Hospital brought their inquiry to a close this week. Their sittings were public, and the evidence given has been published at great length in the daily Press. Pending the appearance of the Report of the Commission, comment on the evidence (which was conflicting on several minor points) is inadmissible. On one matter, however, a word may be said. That great overcrowding of the wards was a common occurrence is admitted, and it does not seem to us that the gravity of this is sufficiently appreciated. One of the witnesses expressed the opinion that, after all, the children (for the overcrowding chiefly took place in the measles and whooping-cough wards) were better off as regards nursing, etc., than they would have been at home. Now this is very questionable. There is no doubt whatver that in diseases like measles and whooping-cough particularly, the risk of secondary infection with pneumonia and diarrhœa are very serious—so much so that in many hospitals it is the practice to isolate these diseases from uncomplicated measles. When one reads of cots so closely placed that it was difficult for the nurses to get between them, of 70 patients in wards intended for less than half the number, it is difficult to agree with the opinion that the patients did not run very grave risks indeed. But, apart from this general question, we refrain from commenting on what is *sub judice*.

BELFAST.

THE UNIVERSITY QUESTION.—A meeting of the Education Reform Association was held last week in Belfast for the purpose of demolishing, in advance, Mr. Birrell's new scheme, or rather what the members of the Association conclude the scheme will be. A group of resolutions, much too long to give here, but full of "protests," "menaces," "viewing with alarm," "outrages," "betrayals," "ecclesiastical domination," "depriving of civil and religious liberty," and such somewhat time-worn phrases, was moved by Mr. R. J. McMordie, a solicitor who was much associated with the late Dr. McKeown in educational matters. Dr. R. W. Leslie seconded, and, speaking with the knowledge of a senator of the Royal University, he said that the present state of things was absolutely deplorable. He recognised the growing strength of the feeling in favour of an Ulster University, but set himself to stem the tide by attributing its rise to a secret agitation, a faked demand, etc. The speech of the evening was made by Mr. F. Hugh O'Donnell, who supported the resolutions in a long and vigorous address. He spoke as a Roman Catholic layman, and it was exceedingly funny to hear him refer to his spiritual masters, and specially to the Jesuits, in terms which would warm the heart of the most ignorant and intolerant Orangeman in Ulster. Truly the absurdities of Irish politics surpass all belief.

PUBLIC HEALTH.—The death-rate continues high, having been 26.5 from all causes last month, including 10.4 from chest affections and 3.7 from zymotic diseases. The mortality from the latter cause was almost entirely due to measles and whooping-cough. Cerebro-spinal meningitis is apparently increasing again, though, so far, not to any alarming extent.

LETTERS TO THE EDITOR.

CHRISTIAN SCIENCE PUBLICATION COMMITTEE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am in no way anxious to start a controversy in your columns; indeed, I simply wrote in the first instance to ask to be allowed to make clear certain points which the abbreviated reports of the recent inquest had confused. I am, however, going to ask you now to permit me to reply quite briefly to Dr. Sewill.

May I say to him at once that no case was ever yet strengthened by ostentatious discourtesy. The truth about the religion of Christian Scientists is known today to too many millions of people to make gibes of the nature he employs in any way effective. Such language can only reflect on the critics who employ it.

There is in the Westminster Library a copy of "Science and Health," the fly-leaf of which is endorsed in the handwriting of one of the Abbey's great deans, as presented by Arthur Stanley. Now, no doubt, Dean Stanley knew, quite as well as Dr. Sewill, that the teaching of that book was not in conformity with the teaching of the Church of England, but I think he knew something else, which Dr. Sewill is in danger of forgetting—that you cannot define Christianity in a dogma, and that the great apostle to the Gentiles knew what he was talking about when he wrote the thirteenth chapter of the First Epistle to the Corinthians:—"Though I speak with the tongues of men and of angels, and have not love, I am become as sounding brass, or a tinkling cymbal." "And now abideth faith, hope, love, these three; but the greatest of these is love."

If Dr. Sewill believes that God is conscious of all the sufferings of humanity, ought he not to pray, and teach the patient to pray to God to remove this suffering, for, as James writes, "the prayer of faith shall save the sick," and ought he not to discountenance the ministrations (I am writing this absolutely without a thought of offence) of every doctor who is not a Christian? On his own showing, what could be more blasphemous than to call in an agnostic to destroy a disease of which God was conscious, and which He had not been prayed to destroy, or, having been prayed to destroy, had permitted to remain.

As for Dr. Sewill's objection to the term science, it is frankly amazing. The word science has a specific meaning which can be discovered by consulting a dictionary, and the use of it in the term Christian Science is absolutely justified by every philologic law.

Dr. Sewill first begs the question by assuming that disease is purely material in its origin, and so brushes aside the entire structure of idealism, as it exists quite apart from Christian Science; and then he assumes a theory of Christian Science treatment which, honestly, is quite ludicrous in its perversion of what that treatment is. There is nothing in the whole teaching of Christian Science which can be tortured into a justification of the statement "that pain and anguish can be done away with by belief in certain dogmas or creeds, and by performance of certain rites prescribed by their special ritual"; the last of these statements, indeed, is the production of undiluted imagination. Nor has any Christian Scientist ever suggested that poison could be expelled from the system by religious emotion. What they have insisted on is that when emotion comes in Christian Science disappears.

So far from Christian Scientists being blasphemous, they are attempting to show that, because Jesus was the way, the healing of what Whittier termed the seamless dress is as possible to-day as it was in His lifetime; to show that there is an answer as practical as it is beautiful to that wonderful question of Palgrave's—

"Ah, sense bound heart and blind!
Is nought but what we see?
Can time undo what once was true?
Can we not follow thee?"

It is because time does not alter truth that Christian Science, which is the effort to demonstrate truth practically, is scientific. Dr. Sewill may infer, as others have, that science is confined to the elucidation of secondary causes, and that primary causes are in "the realm of the unknowable," but the inference will never get beyond just what it is, a simple begging of the question. Christian Scientists will go on steadily and patiently, never attacking those from whom they differ, but seeking for understanding with which to demonstrate the truth of their theology, confident that Jesus was the way, and that they can follow Him.

I am, Sir, yours truly,
FREDERICK DIXON.

23 and 24, Clun House, Surrey Street, Strand, W.C.,
February 8th, 1908.

"A SURREY DOCTOR" AND VACCINATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Through a recent issue of THE MEDICAL PRESS AND CIRCULAR, a correspondent signing himself "A Surrey Doctor" put the following queries to the Editor of the *Star*. He says:—"I wish to ask him how he accounts for the fact that, with the exception, perhaps, of the extremely rare instances in which a medical man is an anti-vaccinationist, the whole of the profession take care that their own children are vaccinated? Does he believe that a man, when he becomes a doctor, is converted into an anti-human monster, capable of sacrificing his own children in a vile conspiracy for paltry, sordid gain? Does he not see that if the profession—not only in these islands, but throughout the civilised world—have the operation carried out on those they love, it must be because they, as an army of skilled witnesses, are satisfied that at least vaccination is a perfectly harmless process."

Now, it is not a fact, as here insinuated, that the instances are extremely rare in which a medical man is an anti-vaccinationist. Indeed, it can be safely said that all those members of the profession who have ever studied the subject—and they are now legion—oppose the practice of vaccination. But, even if it be assumed, just for the nonce, that the "Surrey Doctor's" interrogatories embody the facts, it tells nothing in favour of vaccination that doctors practice it on their own children; for when their infallible remedies were the now admittedly false ones of bleeding, blistering, salivating, small-pox inoculating, etc., did they not also carry these out on those they loved? They knew no better then, and, apparently, they know no better now, thus clearly showing their ineptitude for learning from past mistakes and failures.

But how medical men can still claim that to be "a perfectly harmless process" which, according to their own certifications, has killed thousands, and which even a packed Commission admitted to be inseparable from danger, is inexplicable.

I am, Sir, yours truly,
J. West.
Bradford-on-Avon, February 4th, 1908

"PRINTERS' ERRORS."

To the Editor of The Medical Press and Circular.

Sir,—You say, in your issue of February 5th, "the sole consolation we have is that the misprinted copies only reached medical men, who must have observed that there was something wrong."

Your latter assumption is no doubt right, and I, for one, at once took my pen and corrected the obvious misprint in my copy of The Medical Press and Circular, to which, from week to week, I look forward.

But in the former you are wrong, for in the work and detail which devolve on the editor, reader, and printer, and in view of the consideration you have asked for the latter two, you, Sir, may be assured of our appreciation and sympathy, not only for them, but for yourselves.

I am, Sir, yours truly,
Subscriber.

TREATMENT OF CORNS IN THE ARMY!

To the Editor of The Medical Press and Circular.

Sir,—In the letter on above subject in last issue Medical Press and Circular, the writer seems to consider that corns are altogether due to ill-fitting boots. "Five or six corns on the sole of the foot" could hardly be due to that cause? We have also heard of "corn in the ear," surely not attributable to tight boots? It is certainly novel to learn that corns on the sole of the foot act as a diaphoretic!—perhaps not the sole reason? We presume that the infantry soldier (if particular in getting his boots to fit) will have no corns whatever—the cavalryman supplied with plenty. It will certainly be altered times for Tommy Atkins when he can have his "soul" looked after both by the Army chaplain and the chiropodist, and his teeth treated as well. The writer of the letter says nothing about bunions, which are quite as likely to be caused by ill-fitting boots as corns, and have before now produced a "pilgrim's progress"!

I am, Sir, yours truly,
Observer.

MOTOR CARS FOR MEDICAL MEN.

To the Editor of The Medical Press and Circular.

Sir,—In reply to "M.D.'s" letter in your issue of January 29th last, I have been working my dispensary and private practice since February, 1906, with an 8-h.p. car, whose name I shall be glad to give privately to "M.D.," and have driven it about 11,000 miles over roads which must be about the worst in Ireland. This car is very easily driven and managed, all the vital parts are most accessible, and it is most reliable; it is very strongly made.

The seating arrangement is rather novel, three bucket seats being arranged in front in the form of a shamrock, and it can be converted into a two-seater in about ten minutes. The extra weight of the third seat is very little, which makes it much less expensive to run than if it were of the tonneau or side entrance type. The firm also fit their cars with four seats. The running expenses are well under £50 yearly. The record of these cars in the Irish and Scotch Reliability Trials has been wonderfully good.

I may say that I have no interest whatever in the firm which builds these cars.

I am, Sir, yours truly,
Gerard J. Pierse, M.D.

THE FACIAL MUSCLES IN ACHONDROPLASIA.

To the Editor of The Medical Press and Circular.

Sir,—I have recently had an opportunity of dissecting two cases of achondroplasia, and have been much impressed by the remarkable development of the muscles of the face and scalp. The individual muscles were not only strongly marked, but they formed an almost continuous stratum, by the fusion of their edges, and through obliquely-running interlacing bundles of muscle fibres. In each case the increased development was also well seen in the extrinsic muscles of the pinna and in the platysma.

The condition found in these two subjects—one male and the other female—and observations made on a living example of the disease, lead me to believe that hypertrophy of the facial muscles may possibly be a characteristic of achondroplasia. It would be interesting to learn whether other observers, clinically or in the post-mortem room, have noted a similar condition in this disease.

I am, Sir, yours truly,
A. Francis Dixon.
Medical School, Trinity College, Dublin,
February 5th, 1908.

OBITUARY.

G. M. CLOWES, M.R.C.S., L.R.C.P.

We regret to announce the death of Dr. G. M. Clowes, aged 29, a son of Major Clowes, of Ilford. He had been acting as locum tenens for a medical man at Southend, and came to London with the view of taking a house appointment at the London Hospital. Some time after midnight he was found lying upon the pavement in Spital Square, Bishopsgate, unconscious, and dying from suffocation. He expired almost immediately, and at the inquest at Stepney evidence was given that death was due to suffocation by a piece of apple having lodged in the trachea. Several apples were found in one of his pockets. A verdict of "Death from accidental suffocation" was returned. Dr. Clowes had distinguished himself at the London Hospital in the junior appointments, and much sympathy is felt for his bereaved friends.

WILLIAM ALLINGHAM, F.R.C.S.

We regret to announce the death of Mr. William Allingham, who died on February 4th at his residence at Worthing, at the age of 78. Mr. Allingham became a member of the Royal College of Surgeons, England, in 1855, and a Fellow by examination in 1857, and had served on the Council of the College. He had been a tutor, demonstrator of anatomy, and surgical registrar at St. Thomas's Hospital, and Senior Surgeon of St. Mark's Hospital for Fistula, and Surgeon of the Great Northern Hospital. He was also Consulting Surgeon to the Farringdon General Dispensary and the Surgical Aid Society. He was well-known as an authority on rectal surgery, and enjoyed an extensive practice in that special line. His well-known book on "The Surgery of the Rectum," ran into five editions.

J. W. WELLS, M.D., C.M.ED., D.P.H.

WE regret to record the death, at his residence in Blackburn, of Dr. J. W. Wells, who had been suffering for some time from consumption. The deceased gentleman, who was unmarried, was a native of Blackburn, and after receiving his education at the Grammar School he went to Edinburgh University, where he graduated some 19 years ago. For three years he sat in the Council Chamber in the Conservative interest as one of the representatives of St. Andrew's Ward, being returned in 1899. He was appointed a member of the Free Library Committee in that year, and retained the position until last November, when he retired. The late Dr. Wells secured his M.B.C.M. (Edinburgh) in 1887, his D.P.H. (Manchester Victoria) in 1891, and his M.D. (Edinburgh), with commendation, in 1903. He was also a Fellow of the Chemical Society, and was known as an authority on the chemistry of cod liver oil. He had a contribution in the *British Medical Journal* on cod liver oil and cod liver oil emulsions, and another appeared in the "Manchester University Press" last year on the influence of cod liver oil on tuberculosis.

SIR JOHN DENIS MACDONALD, K.C.B., F.R.S.

WE regret to announce that Inspector-General Sir John Denis Macdonald died on Friday last at Southsea in his 82nd year. He was Professor of Naval Hygiene at the Army Medical School, Netley, from 1870 to 1880, and Inspector-General of Hospitals and Fleets from 1883 to 1886, in which year he was placed on the retired list. Educated at Cork School of Medicine and King's College Medical School, Sir John entered the Navy as Assistant-Surgeon in 1849, and in 1852 joined Her Majesty's ship *Herald* for exploring and surveying service in the South-West Pacific. In 1859, when only 33 years of age, he was elected F.R.S. He was the author of numerous scientific papers, and was created K.C.B. in 1902.

REVIEWS OF BOOKS.

INJURIES OF THE EYE. (*a*)

AT a very opportune moment appears a capital little book on injuries to the eye by Mr. Beaumont, of the Bath Eye Infirmary, for such questions are perplexing many medical men called in to advise in connection with cases arising under last year's Workmen's Compensation Act. The work deals briefly with the various Acts of Parliament under which accidents fall for purposes of legal classification, and then presents hints on the giving of expert evidence. After dealing with the eye in connection with industrial diseases, the author has a useful chapter on injuries of the orbit in base of the brain in which the eye is affected. Ophthalmic surgeons are often called upon to see cases of head injury which have been followed by blindness in one or both eyes, and the exact nature of that lesion it is often impossible to determine, but generally the injury is a retro-bulbar or intra-cranial fracture or hæmorrhage, and the prognosis is guided accordingly. Chapter III. concerns injuries to the eye-lids and lachrymal apparatus, and Chapters IV., V., and VI. those of the globe and its contents. They are all not only of a very practical nature, but are full of useful points, garnered from the author's wide experience, which are not to be met with in ordinary works on the eye, and which for the practitioners who have lost touch to a certain extent with ophthalmology are invaluable in that estimation of the extent, nature, and outcome of injuries to the eye. But most important of all is the last chapter on malingering and the various tests by which it may be detected. Malingerers, as Mr. Beaumont says, may be divided into three classes, those who pretend to have a disease which they have not; those who intentionally exaggerate the symptoms of a real disease; and those who produce a disease for the purpose of getting recompense. To detect those who have rubbed grit or coal-dust into the conjunctiva may not be a difficult task, but to detect the others is often no easy task. The amount of vision which a man has, after all, must, to a great extent, depend on subjective tests, that is to say, when there are no ophthalmoscopic changes present. The author's suggestions as to tests and probabilities reveal both experience in this difficulty and ingenuity in overcoming it, and we have ourselves picked up valuable "tips" from the perusal of his book. Snellin's test is a particularly useful addition to the medical examiner's armament, and should "floor" any ordinary impostor; but all the others are good. It is with great pleasure that we welcome this handy, clever book.

CAMPBELL'S AIDS TO PATHOLOGY. (*a*)

To compress the facts of pathology into a volume of 184 pages, and those small ones, is no easy task; but in the book before us Dr. Harry Campbell has achieved it with no small measure of success. We can readily understand that some teachers of pathology would endeavour to find fault with a book of this kind because of its compression; but, if it be used as an "aid," not as a substitute, for the larger text-book, and it enables the student to assimilate and to remember the facts he has gathered, it should be a welcome addition to the books needful for his examination. It must undoubtedly be admitted, that text-books of pathology very often serve only to confuse the student by the multiplicity of facts and theories which they contain. It is for this reason that we welcome these "aids." They supply the much-needed outline of the subject which the student can fill in as he goes along.

This book will prove specially helpful to the junior student, who is apt to feel very much at sea when brought face to face for the first time with pathological problems. A study of this small volume will clear up many of the initial difficulties which confront the student. For perusal prior to examination, Dr. Campbell's pages will be valued, as they give the salient facts in an easily remembered form. If we singled out certain portions of the book for special commendation where all is so excellent, we might refer to the sections on "Diseases of the Kidneys" and "Tumours." The portion of the book which deals with the antitoxic treatment of disease is also very valuable, and we are favourably impressed by his remarks on opsonins and vaccine-therapy. There are a number of useful engravings, which add not a little to the value of this really helpful little volume. Practitioners who have fallen behind in their knowledge of pathology cannot do better than make a pocket companion of this up-to-date skeleton, while students will find it the best *résumé* of the subject that has appeared.

BLACK'S MEDICAL DICTIONARY. (*b*)

THE appearance of the third edition of this book shows that it supplies a want among general readers. It is somewhat difficult to define the exact place of this volume in literature, for while it cannot rank as a scientific medical work of reference, on the other hand it is certainly not a popular production, using the adjectival term in its usual significance. The text has been drawn up by skilled and careful writers, and scattered through its pages are no less than 384 illustrations, most of them clear and excellent. Turning to locomotor ataxy, we find a really concise and good description of that malady, including Fränkel's much employed gymnastics. The description of "spotted fever" is equally to the point. So far as we have tested the book, its contents are trustworthy and up-to-date, and likely to be useful to that increasing class, such as nurses colonists, district visitors, journalists, teachers and others to whom a simple book of medical guidance is an acknowledged want.

(*a*) "Injuries of the Eyes of the Employed and the Workmen's Compensation Act; Problem in Progress." By W. M. Beaumont, Surgeon to the Bath Eye Infirmary. London: H. K, Lewis. 1907. Price 5s.

(*a*) "Aids to Pathology." By Harry Campbell, M.D.Lond., Bachelor of Surgery and Fellow of the Royal College of Physicians, London; Lecturer at the Polyclinic; Senior Physician, North-West London Hospital; Physician, West-End Hospital for Nervous Diseases; late Pathologist at the North-West London Hospital. Pp. 184. Fcp. 8vo. Paper, 3s. net.; cloth 3s. 6d net. London: Baillière, Tindall and Cox. 1908.

(*b*) "Black's Medical Dictionary." Edited by John D. Comrie, M.D., M.B.Edin. Third Edition. London: Adam and Charles Black. 1907. Price 7s. 6d. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for **The Medical Press and Circular.**

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

The Procedure to Adopt in Cases of Pregnancy Complicated by Uterine Fibroma.—P. Hardoüin (*Rennes. Archives Générales de Chirurgie*, December 25th, 1907) discusses, under this heading, the methods of dealing with such cases, and as a basis to this discussion cites a case which came under his observation of a young woman, æt. 28. Menstrual history regular and abundant, slightly tending to increase, but no metrorrhagia. Married for six months; and pregnant two months, with usual signs of early pregnancy. Supervening upon these, other symptoms of a grave nature appeared—constipation and frequency of micturition, pains in the pelvis radiating to thighs and lumbar region. On palpation a tumour the size of a fœtal head at term, rising two finger-breadths out of the pelvis and incorporated with the uterus, which, on vaginal examination, was found retroverted and incarcerated. It was decided to operate. This was done by Professor Dayot, assisted by M. Hardoüin. The tumour, which proved to be a fibroid attached to the front of the uterus, was enucleated, the bed of the cavity being in part formed by the mucous membrane of the inside of the uterus. The uterus was reposed, and the wound closed by deep sutures. Hæmostasis was difficult, and had ultimately to be assisted by two gauze wicks which were brought through the abdominal wound. Recovery was uneventful, and delivery accomplished at term by the means of forceps, the head being delayed at the perinæum. The questions arising are: Ought we to interfere in cases of this kind by operative measures or by induction of abortion? Again, if the patient is in labour, what would be the best procedure? The writer warns the medical man against a false idea as to the number of cases in which difficulty arises, and quotes statistics. To sum up his ideas of procedure in cases where pregnancy or labour is complicated by uterine fibromas:—I. During Pregnancy.—(1) In cases where no grave symptoms exist, especially incarceration. In the vast majority of cases there is no indication for doing anything. Should the situation of the tumour be recognised as one likely to cause complications in labour, myomectomy should be performed. (2) Where grave symptoms exist. Leaving aside torsion and suppuration of a fibroid, which rarely call for intervention. The accidents arising from incarceration will be dealt with. Here the surgeon ought to interfere, but the interference depends on several things:—(*A*) The fœtus not being viable. Three proposed methods: (*a*) induction of abortion; (*b*) abdominal hysterectomy; (*c*) myomectomy. Induction of abortion: everywhere rejected; to quote Delagénière, "infinitely more serious than all the radical operations." Abdominal hysterectomy, total or sub-total, easy of execution, and rapid, but sacrifices the infant, and, of course, prevents further child birth. Myomectomy: more complicated than hysterectomy, but the method of election in all cases of pedunculated fibroids, and can also be employed as we have shown in sessile fibroids. Abortion sometimes follows upon the traumatism, but infection of peritoneum is of a mild nature, as a rule. (*B*) When the fœtus is at or near term. In this case he believes the method of choice to be abdominal hysterectomy, the result being advantageous to mother and child. II.—During Labour.—(1) When the tumour does not lie below the pelvic brim: await spontaneous labour; (2) when the tumour fills up part of the genital canal: (*a*) push up the tumour with the hand above the brim; (*b*) if this manœuvre fails, perform Cæsarean section; this will seldom be conservative; it will be the first step to supra-vaginal amputation.

H.

The Prevention of Ophthalmia Neonatorum.—Griffith, London (*British Medical Journal*, February 1st, 1908), discusses the methods of procedure, but believes that the most efficacious method is the careful washing of the eyelids when the head is born and before the child opens its eyes, then later on to use the nitrate of silver solution. Should irritation of the lids arise as a result of the silver nitrate, he advocates the use of a few drops of castor-oil placed between the lids.

H.

Rôle of the Gonococcus in Disease.—Taylor (*Amer. Jour. Obst.*, Jan., 1908).—The accumulated knowledge presented in this paper shows that the gonococcus is one of the most formidable microbes met with in pathology, and takes a high place with those of syphilis and tuberculosis. The following is a summary of its activities:—(1) It attacks the human urethra, and there gives rise to both a catarrhal and hyperplastic inflammation, from which may follow chronic urethritis and a tendency to stricture. (2) By contiguity of tissue it invades the testes and their appendages, and thus threatens sterility in men. (3) Limited in its effects, as a rule, to the sub-epithelial connective tissue layer, it in some cases by further invasion gains a foothold in the venous and lymphatic radicles of the male and female genitalia, and produces local and general disturbances. By this extension the whole organism may be more or less seriously attacked, and local disorder, much suffering and disability may result. The gonococcus then becomes a true factor of septicæmia, and serious and even mortal illness is to be feared. Arthritis and rheumatism are the most constant concomitants of gonorrhœal invasion, and induce marked changes in the joints, the tendons, the bursæ, and the muscles. (4) Such is the anti-toxic power inherent in the blood serum, that in very many cases, even when vital parts are attacked, the gonococcus is destroyed; but, on the other hand, by reason of its toxins, or perhaps of the microbe itself, more or less structural change is produced in the cerebro-spinal system, which may be local or generalised. (5) The question as to whether an inhibitory serum may be produced to kill or jugulate the virulent microbe is still unsettled. (6) While the gonococcus may become latent, and may hibernate in tissues, crypts, and follicles, it may at any time become potential. It also may lead to mixed infection, and prepare the soil for other microbes which may run a severe course.

F.

The Supports of the Pelvic Viscera: A Review of Some Recent Contributions to Pelvic Anatomy.—Fothergill (*Jour. of Obst. and Gyn.*, Jan., 1908).—The following is a summary of the conclusions arrived at in this paper:—(1) The so-called ligaments of the uterus lie loosely upon the subjacent structures, and have no supporting action. The broad ligament is simply a mesovarium and meso-salpinx. The utero-sacral and utero-vesical folds are incapable of resisting downward pressure, as is the round ligament, which, moreover, is a vestigial structure (gubernaculum ovarii et uteri). (2) The external muscular layer of the pelvic floor has a sphincteric rather than a supporting action. The internal muscular layer of the pelvic floor being the degenerated representative of the tail muscles of lower animals, has largely lost its muscular action, and the lower part of the levator ani merely acts as an adjuvant to the sphincters of the rectum and of the vagina. (4) The classical description of the pelvic fascia should be given up, and the fascia should be regarded as the sheath of the muscles, the vessels, and the viscera. (5) The internal muscular layer, with its fascial investment, forms the funnel-shaped pelvic diaphragm. (6) The pelvic diaphragm does not support the pelvic organs by its muscular action; it could not do so in virtue of its shape, were they not firmly attached to its sloping lateral walls. (7) This attachment is accomplished by the fibrous sheath of the blood vessels and accompanying structures, which supply the pelvic viscera. The one constant essential cause of prolapse is relaxation of the perivascular sheaths. (8) The rectum has attachments to the back of the pelvis quite distinct from those of the urino-genital organs to its sides. It does not descend with them in prolapsus. When the anterior rectal wall descends in rectocele, it is united with the posterior vaginal wall by cicatricial tissue, the result of infection during the healing of perineal tears. F.

Prevention of Peritoneal Adhesions by Adrenal Salt Solution.—Marvel (*Amer. Jour. Gyn.*, Jan., 1908).—The tendency of peritoneal adhesions to re-form after operation is very marked. An exudate of blood and lymph is poured between the raw surfaces, which, if permitted to fall together, immediately unite. Adhesions are more likely to form when the exudate is of high density. On the other hand, when the exudate into a fluid is of low density, adhesions are not formed. It is therefore desirable to dissolve the exudate into a fluid of low density, and saline solution is a most excellent agent for that purpose. The addition of adrenalin to the solution has the advantage of constricting the blood vessels and preventing further oozing. Marvel uses a quart of normal saline solution with one drachm of adrenalin chloride solution at a temperature between 100° and 110°. The advantages claimed for this solution are, that its bulk keeps the separated surfaces apart, that it dilutes the exudate from the peritoneum, that it prevents further oozing, and finally that it counteracts thirst and shock. F.

Purulent Ophthalmia Neonatorum of Intra-Uterine Origin.—Holzbach (*Monatschrift für Geb. und Gyn.*, Bd. 27, Hft. 1) states that owing to the prophylactic measures adopted, gonorrhœal ophthalmia neonatorum is rarely seen in maternities, that when it does arise it is usually of a mild character, but that we must still confess that it is quite impossible to completely prevent it. Statistics reveal that most cases appear on the third day after labour, and that the incubation period is normally three days. Most infants were therefore infected during the final stages or at the end of labour. Those cases in which the disease appeared on the first and second days after labour were ascribed to a particularly rapid progress of the disease, but that the infection may occur in the uterus itself is proved by the not inconsiderable number of cases in which infants have been born with marked signs of inflammation. The author describes a case which induced him to write this paper. The membranes had ruptured nearly four days before the child was born. There was a purulent discharge from both eyes, the right cornea was clouded, and on the left in addition to the cloudiness was a large ulcer. On the next day an ulcer began to show itself on the right cornea. Gonococci were present in the secretion from each eye. Consideration of the cases which have been already recorded shows that in nearly every case the membranes had been ruptured for several hours before the child was born. The author concludes that purulent ophthalmia of intra-uterine origin is to be regarded as due to contact-infection which may arise when the membranes rupture at any place, the bacteria ascending from the vaginal secretion, or being directly implanted in the eyes from the adjacent walls of the cervical canal. All cases of premature rupture of the membranes therefore indicate special care in applying the prophylactic treatment of ophthalmia, as in these cases only immediate instillation can help. Finally, as the children of mothers suffering from gonorrhœa are usually badly developed, and not very capable of resisting any injury during the first weeks of life, the prognosis of purulent ophthalmia of intra-uterine origin must be regarded as particularly unfavourable. G.

MEDICAL NEWS IN BRIEF.

Harveian Society.

AT the annual general meeting, held at the Society's rooms, the following officers were elected for the ensuing year:—

President: Mr. D'Arcy Power, F.R.C.S.

Vice-Presidents: Dr. G. A. Sutherland, Dr. C. Buttar, Dr. H. J. Macevoy, Dr. W. H. Blenkinsop.

Treasurer: Mr. Francis Jaffrey.

Honorary Secretaries: Mr. T. Crisp English, Dr. W. H. Willcox.

Council: Dr. G. A. Barton, Sir John Broadbent, Bart., M.D., Mr. A. C. Butler Smythe, Dr. F. W. Cock, Dr. Elliot, Mr. Laming Evans, Dr. A. James, Mr. Lawrence Jones, Mr. E. L. Payne, Dr. Sidney Phillips, Dr. H. A. Sansom, Mr. Campbell Williams.

The following programme has been arranged:—

February 13th.—"The Diagnosis and Treatment of Abdominal Injuries," by Mr. Maynard Smith, F.R.C.S.; "The Treatment of Bronchial Asthma by Inoculation with a Bacterial Vaccine," by Dr. Carmalt Jones.

March 5th.—Dr. Samuel West will open a discussion on "The Treatment of Pneumonia."

March 26th.—Harveian Lecture by Sir Almroth Wright, M.D., F.R.S., "Some Points in Connection with Therapeutic Immunisation."

April 9th.—"The Surgical Treatment of the Incompletely Descended Testis," by Mr. L. B. Rawlings, F.R.C.S. Clinical cases will also be shown.

May 7th.—Clinical Evening at the Paddington Green Children's Hospital.

Examinations in Hygiene.

A SERIES of examinations in hygiene has been promoted and organised by the Incorporated Institute of Hygiene of London, which should stimulate the acquisition of knowledge in regard to those important subjects which affect the health and well-being of the people, and which may be expected also to have most beneficial and far-reaching results on the physical fitness of the race.

These examinations will be held at the leading centres throughout England, Scotland, and Ireland, and are of special interest to ladies, as they will include not only the necesary examination showing general proficiency in hygiene, but the following additional Honours subjects, viz.:—The Hygiene of the Home; The Hygiene of Motherhood; The Feeding and Rearing of Children; Food and Cooking; Home Nursing and First Aid; School Hygiene; Physical Training.

The future heads of households are those to whom this syllabus more particularly appeals, and there is no doubt that the young ladies of this country have still much to learn in connection with personal and domestic hygiene before their own health receives the attention it deserves, and the hygiene of our homes can be greatly improved.

Nursing and the needs of the invalid, and the feeding and rearing of children are subjects which are not unworthy of being placed in the forefront of a girl's education, as they are likely to be of far more practical use in her daily life than many branches of study which now receive an attention out of proportion to their value. The prevalent ignorance in regard to child life is one of the chief causes of infant mortality, and not until this ignorance is removed and the duties and responsibilities of motherhood are more fully recognised, can we expect any serious amelioration of the present sad state of affairs.

An Examining Board, composed of some of the leading physicians and scientists throughout the country has been formed to further this branch of the educational work of the Institute of Hygiene, and every assistance and encouragement will be given to candidates, who may carry on their studies at school, college, or at home, while they will receive the certificate of the Institute for proficiency in elementary knowledge, and the diploma of the Institute for proficiency in advanced knowledge should they pass the examination successfully.

Metropolitan Asylums Board.

AN ordinary meeting of the managers of the Metropolitan Asylums District was recently held at the offices of the Board, Mr. J. T. Helby, the chairman, presiding. A letter was read from Lieutenant L. Menzies, R.N., resigning his appointment as chief officer of the training ship *Exmouth*. Reporting upon an application jointly signed by the several medical superintendents in the hospitals' service for an increase of their remuneration, the Hospitals Committee stated that the salary assigned at present to a medical superintendent begins at £400 and rises annually by £25 to a maximum of £700 per annum, with certain emoluments. In recent years the work of the Board's hospitals had grown both in volume and importance. Comparing the past with the present, it was found that the proportion of notified cases admitted to hospitals had increased from 65.5 per cent. in 1898 to 84 per cent. in 1906, which was mainly due to the confidence the public had in the efficiency of the Board's arrangements for the care of the infectious sick. The medical superintendents were a body of men who were constant in their endeavours to co-operate with the Board in carrying out the important duties which were laid upon them. The committee were of opinion—(a) that the minimum salary of a medical superintendent was too low; (*b*) that seeing it took 12 years as against four years in the Board's asylums service for a medical superintendent in the hospitals' service to reach his maximum, the rate of increment should be accelerated; and (*c*) that the maximum did not adequately represent the value to the Board of a medical superintendent of experience. They submitted a revised scheme under which the rate of increment will be accelerated and the maximum salary increased to £800 per annum. Notice was given that its adoption would be moved at the next meeting.

Poor-Law and Sanitary Legislation in Ireland.

TWO questions of interest to medical men in Ireland were asked in Parliament during the past week. On February 4th Mr. Fetherstonhaugh asked the Chief Secretary to the Lord Lieutenant of Ireland whether it was intended to introduce any legislation during the present session to give effect to the report of the Commission on the Irish Poor-Law Administration, and in particular to deal with the grievances of the Irish Poor-Law medical officers.—Mr. Birrell replied that it was the intention of the Government to introduce legislation to amend the Irish Poor-Laws, but that he could not hold out any hope that an opportunity will arise during the current session.

The following day Mr. Augustine Roche asked the Chief Secretary to the Lord Lieutenant of Ireland whether, in view of the unanimous expression of public opinion all over Ireland during the past six months on the urgent necessity of taking steps to check the ravages of consumption in Ireland, any action would be taken this session to amend the law in conformity with the views expressed at the meetings.—Mr. Birrell replied that it is intended to introduce a Bill on the subject referred to in the question. The Bill, which has been drafted, is entitled, "The Tuberculosis Prevention (Ireland) Bill, 1908." He hoped it would pass into law during the present session.

Sanatorium for Cheshire.

MUCH regret has been expressed in Cheshire at the refusal of the County Council to accept from an anonymous donor the gift of Oakwood Hall, a splendid estate at Romiley, as a sanatorium for tuberculous patients. Many authorities are anxious to secure the gift. The Councils of Chester, Stockport, Birkenhead, and Crewe are combining to approach the donor through Dr. Hewitt, of Northwich, requesting that the offer may be made to them.

IT has been decided, at an extraordinary meeting of the Chelsea Board of Guardians, to ask for a Local Government Board inquiry into the management of the Poor-Law Infirmary. This proposal has arisen from the recent scandal connected with the death of a patient who had been left unattended in the bathroom for several hours.

Royal College of Physicians—New Licentiates.

AT the quarterly Comitia of the Royal College of Physicians, held on January 30th, licences to practice were conferred upon the following 68 gentlemen who have passed the final examination of the Examining Board in England in Medicine, Surgery, and Midwifery, and have complied with the by-laws of the College:—

Alexander C. Anderson, Charles E. Anderson, Arthur G. Atkinson, B.A., Tobias R. H. Blake, B.A., Harry Blakeway, B.Sc., Stanley L. Brimblecombe, John P. Buckley, B.A., William A. Burr, M.D., Howard J. B. Cane, B.A., Ernest P. Carmody, Arthur J. W. Cunningham, B.A., Sidney T. Davies, Bernard Day, B.A., Arthur F. W. Denning, Alban Dixon, John McD. Eckstein, John Everidge, Arthur L. Foster, Herbert Gall, Eric W. Gandy, B.A., Eric G. Gauntlett, William Gilliatt, Harold D. Gillies, Gathorne R. Girdlestone, B.A., Alexander E. Gow, John L. Graham-Jones, B.A., Archibald Hamilton, B.A., Charles T. Hawkins, Claud A. Holburn, Nelson W. Jenkin, B.A., Gordon Ley, Edward L. M. Lobb, Dermot Loughlin, Alexander T. McCaw, Donald Macrae, Claude H. Marshall, John B. Martin, Thomas M. Miller, Roderick J. G. Parnell, Eustace M. Parsons-Smith, Hubert Pinto-Leite, B.A., Horace J. D'A. G. Price, Robert B. Price, Joseph F. E. Prideaux, Edward J. J. Quirk, Percy C. Raiment, Roland W. Rix, Harold T. Rossiter, Mulk Raj Sawhney, Francis C. Searle, Leonard W. Sharp, B.A., Charles H. Smith, M.B., Frank H. Stephens, Hugh Stott, Gilbert F. Syms, Wilfred R. Taylor, Ernest W. Toulmin, Nusserwanji Hormasji Vakeel, Cuthbert F. Walker, B.A., Alan G. Wells, Ernest G. Wheat, James N. Wheeler, B.A., Edward B. C. White, William C. Wigan, Cyril O. O. Williams, Rajaiya R. Williams, L.R.C.P. and S. Edin.; John S. Williamson, William L. R. Wood, L.S.A.

Diplomas in Public Health were also granted (in conjunction with the Royal College of Surgeons) as follows:—Robert C. T. Evans, L.S.A., Ernest E. S. J. Galbraith, L.R.C.P. and S. Edin., L.F.P. and S., Glas.; William H. Hillyer, M.D., Dur., L.R.C.P., M.R.C.S.; Wharram H. Lamplough, M.D., B.S., Dur., L.R.C.P., M.R.C.S.; Arthur R. Litteljohn. L.R.C.P., M.R.C.S.; James Mair, M.B., C.M.; Fairlee R. Ozzard, Major I.M.S., L.R.C.P., M.R.C.S.; George E. F. Stammers, Captain R.A.M.C., L.R.C.P., M.R.C.S.; James B. Stephens, M.B., B.S., Lond., L.R.C.P., M.R.C.S.; and John Tate, L.R.C.P., M.R.C.S.

Royal Army Medical Corps.

THE successful candidates for commissions in the Royal Army Medical Corps at the recent examination in London, for which 64 candidates entered, were as follows:—

J. James, M.B., B.S.Lond., 614 marks; H. H. Blake, M.B., B.S.Durham, 583; A. C. H. Suhr, M.B.Cantab, 577; W. J. Dunn, M.B. Ch.B., B.A.O.Univ.Dublin, 576; J. E. Ellcombe, M.R.C.S.Eng., 575; B. Varvill, M.R.C.S.Eng., 565; F. B. Dalgliesh, M.R.C.S.Eng., 560; A. G. Wells, M.R.C.S.Eng., 559; G. J. Keane, M.D., 554; F. H. Bradley, M.B.Edin., 553; R. M. Dickson, M.B., Ch.B., 553; F. Worthington, B.S., B.A.Cantab, 548; C. M. Rigby, M.R.C.S.Eng., 545; A. L. Stevenson, M.B.Univ.I., 545; M. Leckie, M.R.C.S.Eng., 535; S. G. Walker, M.B., 534; C. E. L. Harding, M.B.R.U.I., 533; A. Shepherd, M.B., Ch.B.Aber., 526; W. J. Tobin, L.R.C.P. and S.I., 522; L. Murphy, L.R.C.P. and S.Edin., 516; A. H. T. Davis, M.R.C.S.Eng., 515; W. H. S. Burney, M.R.C.S.Eng., 512; A. L. Foster, M.R.C.S.Eng., 512; J. W. Houston, M.B., Ch.B., 510; T. S. Eves, M.B., Ch.B., 507; R. O'Kelly, L.R.C.P. and S.I., 505; F. M. Hewson, L.R.C.P. and S.I., 503; C. McQueen, L.R.C.P. and S.I., 496; A. E. G. Fraser, M.R.C.S.Eng., 495; J. S. McCombe, M.B.Univ.I., 495.

Apothecaries Hall of Ireland.

AT a special meeting of the Court held on Monday, February 3rd, the following candidates, having passed the necessary examinations, were admitted Licentiates in Medicine, Surgery, Midwifery, and Pharmacy of the Apothecaries Hall of Ireland:—Synott Valentine O'Connor and John Hargreaves Robinson.

NOTICES TO CORRESPONDENTS, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Enquirer (Co. Clare).—You had better apply to Dr. G. L. Eastes, Laboratories of Pathology and Public Health, 38, New Cavendish Street, London, W. There is a regular tariff, which may be had on application to him

Respice Fimen.—Our correspondent's letter, we regret to state, is too long for insertion, owing to the crowded condition of our columns.

A FAMILY OF DOCTORS.

The late Dr. John Trotter, of Choppington, was a member of an old Scottish county family, with a remarkable trait of character. His father, grandfather, and great-grandfather all adopted the medical profession, and he himself was the last surviving son of a family of doctors. "All the Trotters must be doctors," used to be a family saying The deceased gentleman was born in Kirkcudbrightshire. The family went to Blyth in 1865, Dr. Alex. Trotter founding an extensive practice there, Dr. James Trotter settling at Bedlington, and Dr. John Trotter at Choppington.

R. S.—Messrs. Allen and Hanbury were undoubtedly the first chemists to prepare and place upon the market trypsin in solution for hypodermic injection. The preparation was introduced upon the suggestion of Dr. Shaw-Mackenzie, and a sample of it was forwarded to Edinburgh for experimentation upon cancerous mice. "Honour to whom honour is due."

Robert Bacon.—The contribution is scarcely suitable for the pages of a medical journal, otherwise we should have been pleased to publish it.

Meetings of the Societies, Lectures, &c.

Wednesday, February 12th.

Royal College of Surgeons of England.—5 p.m.: Dr. J. W. H. Eyre: The Importance (Surgically) of the Pyogenetic Activities of Diplococcus Pneumoniæ. (Erasmus Wilson Lecture.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. R. H. J. Swan: Carcinoma of the Breast, its Early Recognition and Treatment.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

Thursday, February 13th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20, Hanover Square, W.).—7.45 p.m.: The President, Dr. Macnaughton-Jones, Dr. E. Holland, and Dr. A. Routh: Specimens. Dr. R. Andrews and Dr. D. Maxwell: A Case of Difficult Labour, with Remarks on the Specimen of the Frozen Section of the Uterus. Dr M. Randall: An Ovarion Dermoid with Secondary Cysts connected with the Omentum, with Pathological Report and Remarks by Mr. T. W. P. Lawrence.

Ophthalmological Society of the United Kingdom (11, Chandos Street, Cavendish Square, W.).—8 p.m.: Clinical Evening: Mr. L. Paton, Mr. J. S. Hosford, Dr. F. W. Edridge-Green, Mr. J. H. Fisher, and others: Cases and Demonstrations. 9 p.m.: Discussion of the Cases.

United Services Medical Society (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Dr. Pembrey: The Physiological Principles of Physical Training.

Harveian Society of London (Stafford Rooms, Tichborne Street, Edgware Road, W.).—8.30 p.m.: Mr. M. Smith: The Diagnosis and Treatment of Abdominal Injuries. Dr. C. Jones: The Treatment of Bronchial Asthma by Inoculation with a Bacterial Vaccine.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. E. Squire: Pneumothorax.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Treatment (Constitutional and Local in all its Forms).

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Corner: Injuries and Diseases of the Epiphyses.

Friday, February 14th.

Royal Society of Medicine (Clinical Section) (20, Hanover Square, W.).—8.30 p.m.: Dr. L. Guthrie and Mr. S. Mayou, Mr. J. P. Roughton, Dr. H. French, Mr. R. J. Godlee, Dr. S. Taylor, Dr. A. Latham, and Dr. F. P. Weber: Exhibition of Cases. Dr. F. G. Batten and Dr. J. G. Forbes: Note on a Case of Gaertner Infection in an Infant. The patients will be in attendance at 8 p.m.

Royal College of Surgeons of England.—5 p.m.: Mr. L. S. Dudgeon: Infection of the Urinary Tract due to Bacillus Coli. (Erasmus Wilson Lecture.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. St Clair Thomson: Clinique. (Throat.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie). 4.30 p.m.: Demonstration:—Mr. R. P. Brooks: Selected Eye Cases.

Great Northern Central Hospital (Holloway Road, N.).—3.30 p.m.: Lecture:—Mr. G. B. M. White: Urethral Stricture.

Appointments.

Bird, W. E. F., M.R.C.S., L.R.C.P.Lond., Medical Officer to the York Post Office.

Charles, Herbert, M.R.C.S., L.R.C.P.Lond., Anæsthetist to the Paddington Green Children's Hospital.

Collier, James, M.D., F.R.C.P.Lond., Physician in Charge of Wards to St. George's Hospital.

Edington, G. H., M.D.Edin., F.F.P.S.Glasg., Assistant to the Professor of Clinical Surgery, University of Glasgow.

Jardine, Robert, M.D.Edin., M.R.C.S.Edin., F.F.P.S.Glasg., F.R.S.E., External Examiner in Obstetrics to the Victoria University, Manchester.

Maynard, Edwin, F.R.C.S.Eng., L.R.C.P., D.P.H.Lond., Senior House Surgeon at the Bristol General Hospital.

Mudge, Zachary Belling, L.R.C.P.Lond., M.R.C.S., Medical Officer of Health for the Hayle (Cornwall) Urban District Council.

Stevenson, Thomas Henry Craig, M.D., B.S.Lond., L.R.C.P. Lond., M.R.C.S., D.P.H.Cantab., Chief Medical Inspector of Schools by the Somerset County Council.

Vacancies.

Joint Counties Lunatic Asylum, Carmarthen.—Second Assistant Medical Officer. Salary, £160 per annum, with board, lodging, washing, and attendance. Applications to W. Morgan Griffiths, Solicitor, Clerk to the Visitors, Carmarthen.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

Kent County Asylum, Maidstone.—Male Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

County Borough of Brighton.—Medical Officer of Health. Salary, £600 per annum. Applications to Hugo Talbot, Town Clerk, Town Hall, Brighton.

Mullingar District Lunatic Asylum.—Resident Junior Assistant Medical Officer. Salary, £100 per annum, all found. Applications to Chairman, District Asylum, Mullingar.

Lindsey County Council, Lincolnshire.—County Medical Officer of Health and Chief Medical Inspector of School Children. Salary, £400 per annum, with necessary out-of-pocket travelling expenses, office and clerical assistance. Applications to Chas. Scorer, Clerk of the Lindsey County Council, Stonebow, Lincoln.

Norfolk County Council.—Medical Officer of Health. Salary, £500 per annum. Applications to G. Christopher Davies, Clerk to the Norfolk County Council, The Shirehouse, Norwich.

Births.

Anderson.—On Feb. 2nd, at Newholme, Pittorbury, the wife of John Anderson, M.B., C.M.Edin., of a daughter.

Marriages.

Eeles—Wolfe.—On Feb. 5th, at St. Mark's Church, Marylebone Road, London, Francis Carolus Eeles to Mary Hall, daughter of the late J. R. Wolfe, M.D., F.R.C.S.E., Glasgow.

Deaths.

Macdonald.—On Feb. 7th, at 42, Granada Road, Southsea, Inspector-General Sir John Denis Macdonald, K.C.B., R.N., F.R.S., M.D., in his eighty-second year.

Rowntree.—On Feb. 6th, at 31, Fellows Road, Hampstead, of acute pneumonia, William Augustine Rowntree, M.B., B.Ch., aged 37.

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OXO is digested without effort. It is most valuable for patients recovering from Influenza. It embodies both the extractives and fibrine of beef, and is absolutely pure and safe.

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and differs from it in composition, and therefore in efficacy. We call the attention of Dispensers to this point because it seems natural to suppose that when the B.P. imitates an article such as 'Liquor Carbonis Detergens' it is not immoral to substitute the official preparation for the proprietary one. This is, of course, absurd, because the compilers of the British Pharmacopœia have

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, FEB. 19, 1908. No. 8.

NOTES AND COMMENTS.

Honour to whom Honour is Due.

OUR younger but more bulky contemporary, the *British Medical Journal*, publishes this week a disclaimer, in which it renounces the attribution to itself of our suggestion that the Government would make a good investment by setting aside funds to find a cure for, or method of prevention of, influenza. Our proposal was noticed at the time by several papers, the *World* and the *Daily Chronicle* among others, but the writers in these journals spoke of the question as having been raised by the *British Medical Journal*, and not by ourselves. As our object is to benefit the public through the medical profession, we should have been content to allow the *kudos* attaching to the idea to have rested with our contemporary, if it had not magnanimously refused the credit. The self-denying ordinance which it has imposed on itself by its disclaimer, however, is somewhat discounted in generosity by the fact that it says: "We have no wish to steal out contemporary's thunder, and therefore we hope it (THE MEDICAL PRESS AND CIRCULAR) may be duly credited with the proposal, as to which we do not think it necessary to express an opinion." We cannot but think this a little unkind. Is it "by such enlightened means that the bubbling passions of our contemporary find vent," we wonder? Is it, in fact, chagrin at having been forestalled in this Titanic conception? If the article in question be indeed a mere outpouring of jealousy we will try to be as philosophical as possible in bearing our blushing honours, and as the *British Medical Journal* expresses a desire to "render to the Cæsar of Henrietta Street that which belongs to him," we, for our own part, hasten to assure it that we will even be equally punctilious towards the deity of Catherine Street, not even laying claim to the encomiums it published of the methods of the "Horspool Natural Voice Academy (Limited)," which was so mercilessly shown up in the Courts last week.

Children's Bill.

THE Children's Bill introduced last week by the Under-Secretary of the Home Office is welcomed on every side, a fact which shows how rapidly we have travelled in the last few decades on the path of humanity and reason. Duty to the child was regarded in a very different light in the middle of the last century to that in which we now look at it, and though the newer ideas run at times into certain fond foolishnesses, they advance as a whole in the right direction. Still this country is very far behind some of the Colonies, notably Australia and New Zealand, and still further behind Japan, in recognising the advantage to the State of the proper nurture and upbringing of the young, and the Children's Bill in which we are priding ourselves would look to those countries about as tardy an act of wisdom as, say, compulsory elementary education in another country would to us. The chief complaint that can be lodged against the Bill is that it does not go far enough, especially in leaving the single baby-farmer immune from inspection. That question is to be probed by a Select Committee in the course of the session, but the vast magnitude of the evil is well-known to medical men who practice in poor neighbourhoods, and the objections to inspection can easily be overcome by discriminating administration.

Juvenile Smoking.

FOR our own part we regret that the Government have been captured by the "juvenile smoking" enthusiasts to the extent of making smoking by lads under sixteen a crime. Nobody supports juvenile smoking, just as nobody supports throwing stones at cats or "hanging on behind" vehicles, but it is plain to every man of sense that these childish tricks will not be put away till manhood is reached, and that in the meantime such actions may be foolish, but they are not criminal. We know of no evidence that smoking as a habit is at all frequent in boys under sixteen, although sporadic cases have been reported from time to time, but the youngster in the street who can secure a "fag" would be more or less than human if he denied himself the pleasure of puffing the last few whiffs out of it, and there is certainly no scientific basis for the idea that half-a-dozen puffs a week made a jot of difference to the health of any child in the world. From the speeches and writings of the anti-tobacconists, one would be led to believe that all the physical degeneration which we hear about, but which does not exist, is due to smoking in children, and we have seen it gravely stated that the decay of teeth, which, alas! is so prevalent, is due to the "habit," the supporters of the theory disregarding the fact that in respect to caries there is little or nothing to choose between girls who do not smoke and boys who (occasionally) do. The pity of it all is, that although the Government Bill is directed largely against making children into criminals, by providing special courts, and so on, the measure actually manufactures a crime by fining lads who have been once warned. We hope this objectionable and dangerous feature will be removed in Committee.

Anti-Crocodile Alliance.

IN these days of anti-rat campaigns and mosquito-destroying brigades, it is but natural that Professor Koch, having fastened on the crocodile as the alternative host of the sleeping-sickness trypanosome, should suggest an anti-crocodile alliance. This association he wishes to be of an international character, the English allying themselves with their Teutonic cousins in sworn hostility to the leviathan. As the Germans are particularly chary of entering into any bonds, political or fiscal, with us, this opportunity may be a favourable one for breaking the ice, and if taken at the flood may sweep away all misunderstandings and render extended Naval Programmes as obsolete as the torpedo-gunboat. The cosmopolitan or humanising influence of medical science could scarcely receive a more splendid *cachet* than that of removing the last bone of contention which occidental civilisation has to growl over. But would it not be well, before exchanging *pourparlers* on this alliance, to make quite sure that the crocodile is the faulty factor? It would be a thousand pities if, after equipping a fleet of *Dreadnoughts* or *Vaterlands* to patrol the rivers and lakes of Uganda, it were found that they were bombarding the wrong foe, as there would be no little danger of the milk of the holy alliance being turned to gall in consequence. We hesitate to think what effect it might have had on the peace of the world if Anglo-German amity had hinged on the therapeutic success of tuberculin when it was first introduced, or on the views taken by pathologists in the two countries on the identity of human and bovine tuberculosis.

A Criminal Libel.

A painful case of criminal libel on a medical man was tried at the Leicestershire Assizes last week, the defendant, a lady whom it is charitable to regard as being mentally unhinged, pleading guilty immediately. Dr. W. R. Tuckett, the medical man who was libelled, wisely placed his case in the hands of the Medical Defence Union, and as the libels were of a very offensive nature, and the lady expressed her determination to continue with them, there was no alternative but to prosecute her. The Medical Defence Union is not very popular with the blackmailing and welshing gentry who prey on medical men, and no doubt it has had some hard things said about it in its time by some of these disappointed ruffians, but we should be surprised if it was ever before informed, as it was by the defendant in this case, that it is "nothing but a powerful association for the protection of blunderers and criminals." Coming as it did, and from the source it did, we fancy this is indeed praise from Sir Hubert Stanley, and the General Secretary may plume himself on the reputation his Union possesses when it receives unsolicited testimonials of this kind from the publishers of criminal libels who find themselves in his toils.

Research Defence Society.

We hope that the newly-formed Research Defence Society will take every means to make its constitution and objects familiar to medical men, for such a body has long been needed. Scientific workers have for far too long taken the assaults made upon them "lying down," and the immunity which has attended the defaming of physiologists and pathologists—except in one memorable instance—has tempted mud-slingers to more and more daring efforts. With six or eight anti-vivisection societies spreading the tentacles of their organisations over the land, it is not astonishing that a good many recruits are gained to the cause, as their slanderous and unworthy statements are quite uncontradicted. Many people are hungering for instruction in the truth about scientific research, and it is only right and fair that it should be placed before them. When, as occasionally happens, a scientific man tackles anti-vivisectionists at one of their meetings, no more useful discussion takes place than if a member of the Cabinet were to try to argue the question of women's right to vote in a meeting of Suffragettes. What is really needed is instruction, not controversy; and if the Research Defence Society can manage to provide this, it will do a great and beneficent work.

LEADING ARTICLES.

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND AND HOSPITAL APPOINTMENTS.

For many years past the attention of the medical profession has been drawn from time to time to the restrictions as to professional qualifications imposed in many hospital appointments. As a matter of fact, one of the higher English qualifications is requisite to the holding of nearly all the important London staff appointments, and of a considerable proportion of those in the country. This state of things creates a virtual monopoly in favour of certain examinations of certain Corporations and of the holders of certain privileged qualifications. It needs little argument to show the undesirablity of such an arrangement from the point of view of the hospitals, the medical profession, or the public. One of the first incentives to good work is freedom of competition and the possibility of rising to better things. The Fellows and Members of the Royal College of Surgeons, however, apparently do not seek to remove any restrictions that may have the effect of throwing open to competition hospital appointments, of which Fellows of their own College now enjoy the monopoly. They have requested their Council to use their moral influence with hospital authorities to recognise members of the College as having equal rights with Provincial, Scotch and Irish graduates to become candidates for hospital appointments. That is to say, the Member of a College is in future to rank with the graduate of a Scottish or Irish University. No English Universities are mentioned, so that we presume the Member of the Royal College of Surgeons of England, although he feels himself on an equal footing with the Scotch or Irish graduate, at the same time tacity admits his inferiority to the graduate of London. The nicety of these distinctions, we are bound to confess, rests on grounds too subtle for our comprehension. The Council of the College have determined to issue a memorandum on the subject prepared by a special committee, to hospitals in England and Wales. It is to be hoped that the grounds upon which they have undertaken to use their moral influence will be made abundantly clear to all concerned. Reduced to a plain proposition, the Council of the Royal College of Surgeons is asking the various hospital authorities throughout England and Wales to give their diplomates the advantages which attach to the graduate of a University. The depths of this plan will be disclosed to the hospitals only when they learn that it is not intended to provide the London student with a University degree. Had the College been in touch with the trend of modern thought, it would have sought to bring into open competition those hospital posts which have for so long been monopolised by their own Fellows. Why should not Fellows of Scotch and Irish Colleges have an equal chance of securing hospital appointments in all parts of the Kingdom? The advancement of medical skill and education is clearly a matter that concerns the community at large, and not the selfish interests of any single College and its Fellows. The report from the Committee of the Council appointed to deal with the matter referred to the returns from the medical examinations of the Royal Navy, the Royal Army Medical Corps, and the Indian Medical Service for the past five years. They showed that the candidates holding the diploma of M.R.C.S.Eng. and L.R.C.P.Lond. had obtained a very high percentages of places, and that in twenty-seven examinations they had gained the first place on eighteen occasions. We cannot admit that excellence of examination standards furnishes all-sufficing proof of a man's fitness for hospital work. Nor, on the other hand, do we for a moment question the soundness of the education tests exacted by the English conjoint examiners. It is another and a very different matter, however, when we are asked to say that holders of the qualifications referred to are to be placed forthwith on a footing with Scotch and Irish medical graduates, in order that the English College may retain its monopoly. If the members are of such importance, how is it that the Council of the College refuses them a voice in the government of the College? If the English conjoint qualification is to be henceforth considered morally as an equivalent to a Scotch or Irish degree why do not the Colleges face the situation squarely and unite with a third great Corporation and grant a London University degree on terms of a reasonable standard? Unconsciously this step of the College of Surgeons in addressing the hospitals of England and Wales has promoted a strong argument in favour of the one portal system. Well may the hospital authorities ask, What is the use of taking a university degree when a college diploma will do as well? If these things be equal why should there be any distinctions between them? If the lawyers be content with one portal to qualification, why should the medical profession want twenty? Some day medical men generally will probably realise that their interests will be advanced and consolidated by the fusion of a number of competing corporations into one representatively-governed qualifying body.

CURRENT TOPICS.

The Parasites of Medical Science.

THE root principles that govern mankind appear to be much the same under all suns. In the case of legitimate medicine and quackery the two seem bound to go hand in hand until the age of perfect wisdom dawns upon the earth. As things go, whenever the virtues of a new drug are proclaimed amongst medical men, it is a foregone conclusion that within a few weeks it will be advertised to the public under some fancy name with claims to curative powers that would simply make its original investigators and discoverers stand aghast. Yet a tolerant Government looks on and permits the community to be plundered by wares that are sold under obviously false pretences. In other countries (such as the Cape) the plague is rampant. Curiously, in Japan it flourishes as the green bay tree, and is carried on by a vast organisation of pedlars. We say "curiously," because the facile Japanese have rapidly seized upon the best of our western medical knowledge and applied it thoroughly and scientifically in their everyday life. May we presume that it is the difficulty of interfering with vested interests that leads them to tolerate the flood of quack medicine with which the land of the Rising Sun is flooded? We learn from the Asiatic Society of Japan's journal that the quacks employ such euphonious names as "life-supporting powders," "touch-the-spot pastilles," "spirit-cheering pills," and one supremely comprehensive nostrum is called "best-everything powders."

An Open-air Scheme for Consumptives.

A GOOD beginning is being made in Buckinghamshire in the treatment of convalescents from consumption. As medical men know there is a critical stage after the disappearance of the signs and symptoms of active tuberculosis, when the sufferer if often compelled to return prematurely to the undesirable environment of home and workshop. Could he be safely tided over that period of convalescence his chances of permanent benefit would be greatly multiplied. Thanks to the co-operation of Lord Carrington, twenty-eight acres of land have been acquired at High Wycombe for the class of patients in question. The scheme provides for their employment in the open-air, and is to be started forthwith by the breaking up of the land. The present intention is to commence with the growing of vegetables, after which more extended market-gardening operations are to follow. It is also proposed to undertake the rearing and fattening of pigs, and, later, to begin experiments in fruit culture. A partially self-supporting scheme of this kind appears to be formed on a sound basis, and furnishes the supplementary open-air course that is needed after sanatorium treatment. The actual cost will not be great, especially when compared with the excessive outlay upon palatial sanatoria that has been witnessed in recent years.

Rules and the Coroner.

THE Westminster Coroner, Mr. John Troutbeck, appears to have somewhat peculiar views as to the rights of medical witnesses. His theory, judging from a report of a recent inquest, is that a medical practitioner should attend as a witness without fee if his evidence be required in self-defence. Mr. Troutbeck, however, has, not unnaturally, lost the confidence of the profession of his district, where the medical practitioners have been for a long time past deprived of a source of legitimate income by the employment of a so-called "expert" pathologist in the Coroner's Court. In the case under notice, a medical man attended an epileptic for burns sustained while in a fit. The patient was removed to the Wandsworth Infirmary, where he died after a succession of fits. The medical evidence gave the cause of death as heart failure while suffering from epilepsy, accelerated by burns. The medical man who put in evidence was told by the Coroner's officer that there was a complaint against him, but he refused to attend the inquest unless summoned. The Coroner thereupon said (so it is reported in the *Times*) that he was not going to pay a gentleman a guinea for explaining an accusation; it was not right to put that amount on the rates, especially as there was no doubt as to the cause of the death. The jury took the Coroner seriously, and added to their verdict an opinion that the medical man did not exercise proper medical skill when first called in, and was deserving of censure. Mr. Troutbeck pointed out that the treatment had not been discussed by technical witnesses, and only a lay opinion had been given. We are glad to believe that very few Coroners would adopt so extraordinary an attitude with regard to the summoning of medical witnesses. Lest the absence of Dr. Freyberger's name from this particular inquest should arouse any medical anxiety on the part of local practitioners, it may be added that a few days later he gave evidence in Mr. Troutbeck's Court as to the death of a professor of physical training due to heart failure following influenza. It is to be presumed that Dr. Freyberger's evidence cost the rates at least two guineas, and it is not easy to say why the nearest practitioner would not have been equal to the occasion and given satisfactory evidence as to the cause of death, even under the exacting jurisdiction of the Westminster Coroner.

Fisherfolk and Influenza.

LAST week it was announced that a famine of fish had followed an outbreak of influenza among the fisherfolk of Grimsby. To the man in the street this looks like a reversal of the ordinary laws of Nature. Surely, of all men, he would argue, fisherfolk, who live so much in the open, should be free from rheums and infective catarrhs. So they should, in theory, but, as a matter of fact, a large portion of their lives is spent in miserably small, overcrowded, and ill-ventilated dwellings. Taken as a whole, it may be doubted if there is any single class of society worse housed than the fisherfolk of the United Kingdom. Then when they go to sea, their cabins are on the same cramped and ill-ventilated scale. It is clearly of little use for a man to spend his time at sea in wholesome air when a great portion of it is passed in a noisome atmosphere. Even then, such is the hardihood of the seafaring constitution, he may go on well enough for many a year. The risks of his environment are brought into relief only when his cribbed quarters are invaded by some acute infection. Then the close contact of crowded cottages and cabins acts like a spark in gunpowder, and the results are such as have marked the outbreak of influenza at Grimsby.

The Royal College of Surgeons of England.

AT an ordinary meeting of the Council held on the 13th inst., Mr. Henry Morris presiding, the Council appointed Mr. Arthur Keith, F.R.C.S., to the office of Conservator of the Museum, rendered vacant by the death of Professor Charles Stewart. With reference to the resolution carried at the annual meeting of Fellows and members asking the Council to use their moral influence with hospital authorities to recognise members of the College as having equal rights with Provincial, Scotch and Irish graduates to become candidates for hospital appointments, the Council decided to circulate a memorandum on the subject, prepared by a committee of the Council, to hospitals in England and Wales. The report from the committee referred to the returns as to the examinations from the Medical Department of the Royal Navy, the Royal Army Medical Corps, and the Indian Medical Service during the last five years, and showed that candidates holding the diplomas of M.R.C.S.Eng. and L.R.C.P.Lond. had obtained a very high percentage of passes, and that in twenty-seven examinations they had gained the first place on eighteen occasions. A form of circular to the Fellows and members of the College asking their opinion as to whether or not women should be admitted to examination for the diplomas of the College was adopted, and the secretary was instructed to issue the circular to all Fellows whose addresses are registered at the College, and to all members whose addresses are entered upon the "Medical Register" of the United Kingdom or elsewhere. In the meantime the Council decided to inform the Royal College of Physicians that, pending the result of this inquiry, they did not propose to take any further steps with regard to the petition from the London School of Medicine for Women. Mr. W. Watson Cheyne, C.B., F.R.S., was appointed Bradshaw Lecturer for the ensuing collegiate year, and Mr. J. Ward Cousins was re-elected the representative of the College upon the Central Midwives Board for a further period of one year. Upon the suggestion of the President a small committee was appointed with the object of keeping the Council informed as to what is being done from time to time regarding the medical inspection of school children and the arrangements for teaching elementary hygiene in training colleges and schools.

The Discovery of Chloroform.

IT is not wonderful that in many instances the claims of men to the credit of an invention usually associated with their names are questioned. In many cases, indeed, the ascription is due to an error, the propagandist being mistaken for the discoverer. In other cases, he who has contributed some important development is credited with the invention of the thing he has developed. Thus, a large proportion of the population of the Kingdom is under the impression that Stephenson invented the steam engine, whereas he applied it to railway locomotion. In other fields, the rights of Harvey to be called the discoverer of the circulation have been questioned in favour of Servetus and others, who certainly taught very much the same truths as Harvey, though they may not have grasped them in their entirety. The title of Garcia to the laryngoscope is also open to question, though whether he had priority or not, the discovery was with him an original one. The battle over the contending claims to the discovery of the use of ether as an anæsthetic is of long standing and severe. It is no wonder, therefore, that the right of Simpson to the title "discoverer of chloroform" is also questioned. An interesting correspondence took place last month in the columns of *The Pharmaceutical Journal* on the subject, and there seems to be little doubt that the discovery was certainly not due to Simpson alone, but was due to the co-operation of a group, including Matthews Duncan, Waldie of Liverpool, and Keith, as well as Simpson, and that Duncan was probably the first to try the effects of the drug on himself. It is true, too, that the effects of the drug on animals had been established five or six years earlier by Glover. In spite of these facts, it would be a narrow mind which would make little of Simpson's work, since it was he who first appreciated the greatness of the discovery, and devoted himself, in the teeth of bitter opposition, to securing for chloroform its proper place in the world of surgery.

Deaths by Poison.

THE Registrar-General's returns of the deaths by poisoning in 1906 contain some points of interest. Among the poisons as causes of accidental death, opium and its derivatives take first place with 73 deaths out of 245; carbolic acid caused 21 deaths, hydrochloric acid 17, lead 14, ammonia 13, and oxalic acid 11. Phosphorus matches caused six deaths. Of the total number of accidental deaths by poisons, 144 were of males and 101 of females. Males had a similar preponderance among the suicides by poisoning—331 out of a total of 534. As usual, carbolic acid is the favourite drug for suicide, being responsible for 120 deaths. Oxalic acid caused 98 deaths, hydrochloric acid 86, opium and its derivatives 52, potassium cyanide 35, hydrocyanic acid 28. It is obvious that it is rather facility in procuring than any question of choice which determines the poison for suicide. The returns of deaths under anæsthetics are specially interesting; 183 deaths were recorded, the agents employed and the deaths credited to them being: A.C.E. mixture, 3; chloroform, 107; chloroform and ether, 8; ether, 8; ethyl chloride, 8; nitrous oxide, 3; not stated, 46. The preponderance of chloroform in the fatality list is as usual in these returns. Deducting the 46 cases in which the agent was not recorded, it is to be seen that chloroform was employed in 118 of 137 fatal cases. Ether alone was employed in 8, and in conjunction with chloroform in 11 others. In spite of such returns, which year after year point to the dangers of chloroform, it is still a favourite anæsthetic throughout England.

PERSONAL.

LORD LISTER has been awarded the Mary Kingsley Medal by the Liverpool School of Tropical Medicine.

DR. J. O. AFFLECK is to be the recipient of an honorary LL.D. at Edinburgh University.

MAJOR J. HARPER, M.D., will succeed Col. V. Matthews in the command of the London companies of the Royal Army Medical Corps early in April.

DR. P. W. MACDONALD will preside at the next quarterly meeting of the Medico-Psychological Society to be held to-morrow at Warwick County Asylum.

THE University of Edinburgh propose to confer the honorary degree of Doctor of Laws upon the Lord Mayor of Liverpool, Dr. Caton.

MR. ARTHUR KEITH, F.R.C.S., has been appointed Conservator of the Museum of the Royal College of Surgeons of England, rendered vacant by the death of Professor Charles Stewart.

MR. BERNARD H. WEDD, M.B., M.R.C.P., D.P.H., has been appointed Bacteriologist to the Royal London Ophthalmic Hospital, E.C. Mr. A. N. Leeming succeeds Mr. Wedd at Guy's.

DR. R. C. JEWESBURY, M.R.C.P., of Charing Cross Hospital, has been appointed Physician with Charge of Out-Patients at the Victoria Hospital for Children, Chelsea.

DR. J. A. W. PEREIRA, of Exeter, has been presented by the police force of that town with a portrait of himself as a mark of their appreciation of his services.

DR. J. KINGSTON FOWLER will take the chair at the 135th anniversary dinner of the Medical Society of London on March 11th at 7.30. The dinner will be held at the Whitehall Rooms.

COLONEL DOUGLAS WARDROP has been appointed Commandant and Director of Studies at the Royal Army Medical College, *vice* Lieutenant-Colonel H. E. R. James, R.A.M.C.

THE Freedom of the City of London is to be conferred on Miss Florence Nightingale. A special subcommittee of the Common Council has been appointed to make the necessary arrangements.

DR. R. OWEN MORRIS has been appointed Medical Officer of the Council Schools at Birkenhead, and Dr. R. S. Marsden, Medical Officer of Health to the borough, Superintendent Medical Officer of Schools.

DR. ALEXANDER BRUCE and Mr. F. M. Caird have been re-appointed for five years to their present posts, those of Pathologist and Resident Physician and Surgeon respectively, at the Edinburgh Royal Infirmary.

DR. DAVID FERRIER, M.D., F.R.C.P., has resigned his appointment of Physician to King's College Hospital after many years' service to that institution. He will, however, retain the Professorship of Neuro-Pathology in the King's College Hospital Medical School.

THE Assistant Physiciancy at the Royal Free Hospital has been filled by the appointment of Dr. W. P. S. Branson, M.D., M.R.C.P., of St. Bartholomew's Hospital, where he holds the post of Junior Curator of the museum.

THE Middlemore Prize for Ophthalmology has been awarded by the Council of the British Medical Association to Mr. Simeon Snell, F.R.C.S.Edin. The prize, £50 and an illuminated address, will be presented to him at the next annual meeting.

THE sum of £1,000 has been collected among the patients and friends of the late Dr. W. S. Playfair, and is to be presented to King's College Hospital with a view to erecting a memorial to him at the institution with which he was so long associated. It has been decided by the Removal Fund Committee to devote this money to the building and equipment of an appropriate department of the new hospital shortly to be erected at Denmark Hill, this department to be named after him, and to bear an inscription recording his thirty-five years' work at King's College Hospital.

A CLINICAL LECTURE

ON

THE DIAGNOSIS OF INJURIES ABOUT THE SHOULDER. (a)

By J. DUNDON, M.B., F.R.C.S.Eng. and Irel.,

Surgeon, Mercy Hospital, Cork; Senior Assistant Surgeon, North City and County Infirmary, Cork.

GENTLEMEN,—The subject which I wish to bring under your notice to-day is one of considerable importance, embracing, as it does, injuries of comparative frequent occurrence that are attended with serious and disastrous consequences if not properly diagnosed and treated. Fractures and dislocations seem not to have that interest for students that we would expect from their importance and frequent occurrence. Students seem to be more interested in the daring exploits of abdominal surgery rather than in the full and accurate study of the more common ailments of the community. This, to my mind, is a very serious mistake on their part, and I have not the least doubt that, from different causes, not more than 5 to 10 per cent. of those now reading surgery will ever get an opportunity of putting into practice that knowledge of abdominal surgery which they are now so intent on, whilst 90 to 95 per cent. will have to treat perhaps frequently injuries that include fractures and dislocations. The treatment, if successful, may in any individual case have a very important influence in your chance of success in practice, but if results are bad, serious, if not fatal, impediments to your advance will arise, apart altogether from the wrecking of the usefulness and earning capacity of probably a bread-winner. Advances in treatment in this particular part of surgery have taken place, but as they require great operative dexterity and scrupulous conformity with rigid asepsis, are only to be carried out by an experienced surgeon who has all the requisite skilled help. They are not for the general practitioner. The latter has, in the great majority of cases, to depend on less heroic and simpler forms of non-operative treatment. The best results from treatment will only arise when you can be absolutely sure of your diagnosis. Precision in diagnosis is often rendered difficult by swelling, slight or doubtful physical symptoms, and frequently by the fact that more than one injury may be present. Accurate diagnosis may be impossible when the fragment broken off is small or fracture impacted. Inaccuracy of diagnosis must be attended by unskilful treatment, and this in turn by results prejudicial, temporary or permanent, to the restoration of the normal functions in a part. This failure to restore a limb to its normal condition may be a matter of grave import to the patient and those dependent on him, and I would like to impress on you that a painstaking and conscientious surgeon who labours to restore an injured limb to its proper functions is as deserving of our praise as the laparotomist whom we are accustomed to loudly acclaim. You may be assisted in some cases by the use of the X-rays or fluorescent screen, and it is well to make use of these in all doubtful cases when they are available. But you should accustom yourself to make your diagnosis without their use, as they may not be available. Another form of help that you will find of considerable advantage in obscure cases will be the use of an anæsthetic to enable you to make a thorough and exhaustive examination, especially in nervous patients.

Some injuries are obvious, and by even superficial examination, as well as on comparison with opposite limb present little or no difficulty. Do not be satisfied with the recognition of an obvious injury—make it a practice to make your examination thorough, so as to obviate the annoying mistake of overlooking a complication, or perhaps a second injury. Some injuries are obscure, and it is only by the most careful and methodical examination that a correct diagnosis can be made. Such a method of examination, with appropriate remarks, I intend to bring before your notice to-day.

Full history of case is most important, as it gives us information of previous injuries to the part, probably fractures or dislocation may have occurred formerly, leaving symptoms that may obscure our present inquiry.

Nature of the violence, whether direct or indirect, and the direction of application, have often an important bearing on the diagnosis of injuries round the shoulder-joint. Dislocations occur more frequently with indirect, and fractures with direct violence.

Time of occurrence, whether recent or long duration, as in the latter case atrophy of muscles from disuse or paralysis may simulate superficially the deformity of dislocation. This is specially marked in atrophy of the deltoid. Next inquire from patient what it is he complains of. The answer to this may help you as fixing the seat of localised pain.

Now remove all clothes from the upper part of body, fully exposing both sides. Place patient on a chair, and exposed to a good light. Then, by means of inspection, note the *attitude* of patient, the latter assuming an attitude that is frequently characteristic, especially in non-impacted fractures. Observe the curves of both clavicles, the prominence of acromion processes, the contour of shoulder over deltoid, the length of anterior boundary of axilla (lengthened in practically all dislocations of humerus), the direction of the axis of humerus, and compare the groove between deltoid and pectoralis major (usually obliterated in dislocations inwards).

Next: Determine the amount of active and passive movement, and if movement is associated with pain. If passive movement, in contrast to active movement, is considerable, but attended with pain, probably a non-impacted fracture is present.

Next: Measure from the following points, and compare with the sound side:—

Clavicle from acromion process to sternum: if shortening, probably a fracture; if no alteration, a dislocation can be excluded.

Acromion to elbow: shortening, probably fracture of shaft or upper end of humerus, with rarer forms of dislocation—*e.g.*, sub-spinous and supra-coracoid.

If lengthened—sub-glenoid dislocation: fracture of glenoid cavity and possibly fracture of the outer part of acromion process.

Next measure width around axilla; if increased, probably inward dislocation of humerus.

Measure from greater tuberosity to mid-line: if lengthened, fracture of greater tuberosity; if shortened, dislocation of head inwards.

Measure distance of coracoid below outer third of clavicle: if lengthened, probably fracture of coracoid or fracture of glenoid cavity, with coracoid process.

Next you employ *palpation*. Standing behind patient, run your finger along the clavicle from the supra-sternal notch outwards on both sides. As the clavicle is subcutaneous in its entire course, you note any alteration of curves or anterior surface. A fracture at middle third is quite obvious, and is attended with the usual symptoms. A fracture at inner extremity is rare, and must be distinguished from dislocation of clavicle by no alteration in length of latter and absence of crepitus, and from separation of epiphyses, by age of patient and nature of crepitus. Doubtful cases presenting little or no deformity are inter-ligamentous fractures (between coracoid and trapezoid ligaments), and greenstick fractures of children. They may be suspected, and a guarded diagnosis given if you find slight irregularity, with localised pain and tenderness. In greenstick fractures you may also be able to detect alteration in the anterior curve, and some irregularity on carefully palpating posterior surface. Further out, beyond the clavicle, you feel the acromion process, where you may get fracture, dislocation and separation of epiphyses. Irregularity, mobility, and crepitus, with slight flattening of deltoid, would denote fracture. Always compare acromion process carefully with the one of the opposite side, as there is frequently a gap or sulcus in the situation of the joint which simulates a dislocation, but is usually symmetrical. Dislocation of acromion is usually below and rarely above clavicle. Careful examination and comparison with opposite side will enable you to diagnose it.

(a) Lecture delivered at the North Infirmary, Cork.

Next examine scapula by running your fingers along the spine and vertebral border of both sides. Grasping the inferior angle of scapula and moving arm will enable you to detect fracture of body, which always results from severe and direct violence. Below the outer third of clavicle will be found the coracoid, fracture of which is due to direct and severe violence, and is usually accompanied with extensive extravasation.

Next examine the region of the shoulder-joint proper. Here you may have fractures, dislocations, or both, as well as contusions of muscles and sprains of joint, and owing to the depth of part as well as the extensive extravasation that may be present, great difficulty may be experienced in making a diagnosis. An accurate diagnosis is absolutely essential, otherwise serious impairment of function may result. It is in these cases that X-rays and an anæsthetic are of great importance as an aid to diagnosis.

Always examine the uninjured shoulder first, as it gives you a definite idea of the normal condition, and will enable you to better appreciate and value symptoms on the injured side. If there be great swelling of parts, it is probably due to great violence, and it is particularly in these cases you may expect several injuries, and it is advisable, in the absence of X-rays, to put the patient under an anæsthetic which may be utilised if the injury turns out to be a dislocation.

Now, having taken note of the prominence of acromion process, contour over deltoid, length of anterior border of axilla, and direction of axis of shaft of humerus, try to locate head of humerus. Normally, this is immediately *below* and *projects slightly beyond acromion process*, and if by pressing in our fingers immediately below the acromion we find a depression as compared with sound side, we know we have to deal with a dislocation of humerus. This method is simple, quick, absolutely reliable, and can be corroborated by other methods, such as—

Duga's sign—that the patient cannot place the fingers of the injured limb on the sound shoulder, nor allow them to be placed there by the examiner while at the same time the elbow touches the side.

Calloway's sign—that the vertical measurement round the axilla and through the acromion process is greater than the sound side by one to two inches.

Hamilton's sign—when a straight piece of board, such as a splint, is placed with one end resting on the external condyle of the humerus, and the other on the prominence of the shoulder, in a healthy arm the upper end should be separated from the acromion process about one inch, but in dislocation it rests against the process.

Now, having decided that we have to deal with a dislocation, we ask ourselves the question: Are there any injuries like a dislocation? and the answer is, as you know, that fracture of acromion process and fracture of neck of scapula present some symptoms such as flattening of shoulder and lengthening of arm somewhat similar to dislocation; but in these cases there is always well-marked resistance below the acromion; never the marked depression noticed in dislocation. In these two injuries also, reduction can be readily produced with possibly signs of crepitus, but the deformity immediately recurs on releasing the pressure. By feeling also through the axilla, especially in a thin subject, or in one in whom there is little extravasation, the head of humerus may be found in glenoid cavity, or in an abnormal position.

Next, if there is a dislocation, how do we determine the position of head, and so the variety? We do this by noting the direction of the axis of humerus; the more abducted the shaft, the lower the head. If slight abduction, probably sub-coracoid, to confirm which we examine the groove between pectoralis major and deltoid, and we find it obliterated, and the position of coracoid obscured. If marked abduction, probably sub-glenoid, which we confirm by noticing the bulging of floor of axilla by lengthening of arm, and possibly pressure on vessels and nerves. If the axis is directed backwards, we have the rarer form of sub-clavicular dislocation, with other obvious symptoms. If axis be directed forwards, we have the sub-spinous variety. The supra-coracoid and luxatio erecta need not detain us, as they are very rare.

The next question we have to answer is, what complications may arise with dislocation? We know that compression of the circumflex or musculo-spiral nerves are the most usual complications of fractures. We look out for symptoms of these.

Remember that usually in dislocation the arm is away from the side, and that in fracture it usually lies helpless by the side.

Next we investigate to see if we have to deal with a fracture. The usual signs of a fracture are, as you know, bony crepitus and præternatural mobility between two joints, and some modification of length of bone, usually shortening, as well as loss of function. Unfortunately, these are not always present in cases of fracture at the shoulder-joint, as one may have an impacted fracture without crepitus, præternatural mobility, or any appreciable alteration in the length of limb. Still, measurements of the length of the limb are of great importance, as, if we can exclude dislocation (and this we can do very readily by noticing the presence or absence of head under acromion process), any shortening of the limb points to fracture of the shaft or upper end. Now the two methods we adopt to ascertain the presence or absence of fracture are as follows:—First, we measure from the acromion process to the internal or external condyle of each side. This gives us alteration in length, if any be present, and we get:—

(1) No alteration in length: possibly no fracture, though fracture of head of humerus and fracture of greater tuberosity may be present without alteration in length.

(2) Shortening: possibly fractures.

(3) Slight lengthening: fracture of acromion; fracture of glenoid cavity.

We note the amount of these, and then measure from outer surface of greater tuberosity to the mid-line. This gives us:—

(1) No change: possibly fractures at neck it accompanied by shortening of length of axis of limb.

(2) Shortening: inward dislocations.

(3) Increase: fracture of greater tuberosity.

Next we examine for crepitus, and it is well to do this in a methodical and routine manner. Place hand on outer surface of deltoid, grasp limb at elbow, and rotate shaft in and out. Note whether—

(1) Head moves with shaft, or

(2) Head does not move with shaft.

Having noted that head moves with shaft, examine carefully for crepitus. The following deductions may be made:—

If no crepitus, no complete fracture is present, but there may be an impacted intra- or extra-capsular fracture.

In the latter case you would expect that the injury was applied directly to the part, was the result of comparatively great violence, and that the length of limb would be variably altered from slight or scarcely appreciable shortening in intra-capsular to a shortening of ½ in. to ¾ in. in impacted extra-capsular. A far more important point than the shortening, which may be very slight and difficult to accurately estimate, is a close and attentive examination of the outline of the head of humerus, as felt in the axilla and at anterior and posterior border of the deltoid. Any irregularity of head of humerus favours the diagnosis of impacted fracture.

Next, if head moves with shaft and distinct crepitus is felt, you have two classes:—

(*a*) Without lengthening of limb.

(*b*) With alteration of length of limb, and crepitus, movement of head with shaft, and lengthening of limb.

(*a*)—(1) Fracture of glenoid cavity; (2) fracture of anatomical neck of scapula.

(*b*) Fracture of neck of scapula, including separation of coracoid process.

In (1), the alteration in length is slight, if any; crepitus can be felt on moving head of humerus, and remember that it is not a common injury, and rarely occurs without dislocation. The same applies to (2). These injuries have been more frequently diagnosed only since the advent of the X-rays or screen, but are possible as the result of great violence. In (*b*) the injury is like a sub-glenoid dislocation. There is lengthening of limb, flattening over deltoid prominence of acromion process, but in moving limb crepitus is marked, especially by placing one hand over acromion process and then lifting up limb by grasping the elbow. The superficial resemblance to a dislocation is readily removed on elevation of limb, with the production of crepitus, but readily returns on relieving pressure.

In (*a*) we found crepitus without any alteration of length of limb, and head moves with shaft. This is also found in fracture of greater tuberosity. This fracture is the result of great direct violence, and in it we usually find increase in length of line from greater tuberosity to mid-line, and occasionally a groove or sulcus between shaft and greater tuberosity.

Now, supposing head does not move with shaft, and there is distinct crepitus, marked shortening and deformity, we may have one of several conditions:—

(1) Intra-capsular—non-impacted fracture.
(2) Extra-capsular—non-impacted fracture.
(3) Separation of upper epiphyses.
(4) Fracture and dislocation.

In these injuries we get well-marked symptoms of crepitus, shortening, varying from slight in intracapsular to great in separation of epiphyses and fracture and dislocation combined. We also get more or less characteristic deformities in extra-capsular non-impacted fracture and separation of epiphyses. In the former we get a condition which is superficially like a dislocation—that is, flattening and alteration of the contour of deltoid, but if we examine closely we shall find resistance immediately under the acromion process, showing head is in the glenoid cavity, and we note that the flattening does not begin at acromion, but at level of greater tuberosity. We also have to remember that in intra- and extra-capsular fracture the injury is generally due to direct violence, and that when non-impacted a careful examination through axilla gives great help. Even when non-impacted, the intra-capsular may not show marked signs of crepitus or shortening, and it is advisable not to be too persistent in our endeavours to elicit these points, or, if having once ascertained them, to avoid undue injury by frequent repetition. Separation of upper epiphyses will occur under 20 years, is somewhat similar to an extra-capsular fracture, and, like it, may be partially or wholly separated from the shaft. When completely separated from shaft, it presents a characteristic deformity, the upper end of shaft projecting at axilla in the form of a nipple-shaped projection (the conical end of the diaphyses). Separation of the epiphyses and extra-capsular fracture are very like inward dislocation, but a diagnosis can be made by noticing the head of humerus in the glenoid cavity immediately below the acromion process, flattening of deltoid and prominence of acromion will not be so marked, and a depression and want of resistance on pressure will be found immediately below greater tuberosity.

In these fractures there may be comparatively slight to extensive shortening, and the more marked the shortening the less doubt you will have as to the site or nature of the lesion. Slight or doubtful shortening occurring in intra-capsular fracture, impacted or non-impacted, marked shortening only in separation of epiphyses, extra-capsular, and fractures of shaft.

Having excluded intra-capsular and extra-capsular fractures, and separation of the epiphyses, and having noticed that head of humerus does not move with shaft, we ascertain if there is a fracture with dislocation. Now, in severe injuries, especially due to direct violence, it has been known for a long time that dislocations are often attended by fractures of some of the component parts of the joint. The exact nature of these injuries has been investigated by Robert Jones by means of X-rays, and he finds that the frequency of fracture with dislocation is more common than is usually supposed, that it is usually met with in middle-aged people as the result of great and direct violence, and that we may suspect the association of fracture and dislocation if there is a marked hæmorrhagic extravasation in the axilla, if pain be severe and mobility at shoulder more marked than in ordinary cases of dislocation. He finds that the order of frequency of fracture with dislocation is (1) fracture of surgical neck; (2) separation of greater tuberosity; (3) separation of anatomical neck with tuberosities; (4) neck of scapula with coracoid process; (5) lesser tuberosities; (6) fracture glenoid cavity; (7) fracture glenoid cavity and anatomical neck.

The most difficult cases you will have to deal with will be cases seen a few days after the injury has occurred with possibly great swelling of parts, cases in which the injury is the result of great violence, and where possibly you may have more than one lesion, or possibly some rare and unsuspected injury. In these cases you must be extremely careful in your diagnosis and guarded in your prognosis, and it behoves you to make use of all the help that physical science gives you, but remember that whilst using and trusting these methods of diagnosis that they are not infallible, are oftentimes not available, and that by a careful but methodical plan of investigation possibly, in the hands of experienced surgeons, equally good results may be obtained. Whether that is so or no, what I want to particularly impress on you is to educate yourselves so that you can in the great majority of cases make an accurate diagnosis, for without accuracy of diagnosis appropriate treatment can scarcely be applied with the anticipation of getting useful or satisfactory results.

In conclusion, I would strongly impress on you the following points: Make a thorough, and above all, a methodical examination. Do not be too ready to assume the presence of contusion of deltoid or sprain of shoulder-joint, if you have failed after a superficial and cursory examination to elicit marked symptoms. Remember that an impacted fracture of the neck in a very muscular patient may present very slight symptoms, and may be and often is overlooked in a hasty examination. Do not try to make a diagnosis on one symptom or on so-called pathognomonic sign (*e.g.*, Duga's Symptom for Dislocation). If a dislocation be present you can get other and more reliable symptoms if you persevere in your investigation. If you have any doubt, use an anæsthetic and the X-rays if available, but even the use of the X-rays ought not to make you lax in your thorough examination by inspection, mensuration, and palpation. If you remember that severe direct violence is likely to produce cases troublesome from a diagnostic point of view you will make your examination as full and as exhaustive as possible.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Dr. Vilmos Goldzieher, Professor of Ophthalmology at the University of Budapest. Subject: "The Treatment of Pannus following Trachoma by Inoculating the Eye with Gonorrhœal Pus."*

A PROVINCIAL sessional meeting of the Royal Sanitary Institute was held at the Exchange, Nottingham, on Saturday. Mr. H. D. Searles Wood (chairman of the Council of the Institute) presided over a large attendance. The subject under discussion was road requirements in their relation to the dust nuisance. The Mayor of Nottingham (Councillor J. T. Spalding) extended an official welcome to the members.

ORIGINAL PAPERS.

CONVALESCENCE AND ITS STAGES; AND SOME OF THE PHYSICAL AIDS AVAILABLE FOR THEM. (*a*)

By WILLIAM EWART, M.D.Cantab., F.R.C.P.,

Consulting Physician to St. George's Hospital; Senior Physician to the Belgrave Hospital for Children.

The greater or less rapidity of our cures is of some importance to all classes of patients, and not least to the breadwinners who are to be found in hospitals. For them it is vital not to be long detained from home and from work, though not less important not to be discharged in a state of unfinished recovery, or of imperfect convalescence. As a fact, there is seldom any stint, but sometimes an excess of liberality in the time allowance; and this reminds us that the precept "*Cito, tuto, et jucunde,*" should be applicable, not only to treating, but to convalescing our patients rapidly. The time question touches the economical interests of the charity and the health interests of the community. How to shorten the period of treatment is not before us to-day; but it may be worth considering whether a saving of the patients' time, and of the hospital "beds" might not be effected by additional attention to the management of convalescence. As the majority of convalescents are of the medical description, my remarks will apply largely, but by no means exclusively, to them.

A liberal diet is a first essential; and I need not dwell upon the obvious principle that true economy consists in "feeding up" our patients, if possible, during their illness, but at any rate during their convalescence. *The suitable medicinal management* of the cases is another subject not under our present consideration. It is to *the physical hygiene of convalescence* that I would turn your attention, with special regard to the mechanical assistance which can be provided for hospital patients, as well as for private patients, for the more rapid restoration of their muscular energy and tissue.

The stages of convalescence may be conveniently described as:—(1) The Bed Stage; (2) the Out-of-Bed Stage; and (3) the Out-of-Door Stage.

The third stage is that which eventually takes private patients away to distant climates for recuperation; and our hospital patients away to convalescent homes. I believe that it might sometimes be much less delayed if both previous stages could be more actively managed, and somewhat shortened.

I am of impression that an over anxiety for our patients is apt now and then to prolong the bed stage. Doubtless the management of wards is in a measure simplified by keeping some of the patients quietly in bed. And it cannot be gainsaid that, so long as a liberal diet is supplied, the principal purpose is being served, along lines of absolute safety. At the same time the main indication in convalescence is *the recovery of the tissues and of the functions by their graduated use*. Any unnecessary delay in this systematic re-education is wasteful, for unless we can exercise our bedridden convalescents in their beds it must be slow work for the muscular system and for the heart to regain weight and power in the absence of the natural stimulus of movement.

In surgical practice, it is now a recognised common-sense principle "to rest and protect the damaged part or limb, but to set the body free." In most medical cases we have to deal with two similar indications, which are not incompatible if we know how to combine them, viz.: (1) the improvement of the general and of the cardiac nutrition; and (2) the improvement of the local health and strength of the suffering or impaired peripheral mechanisms. Practical care devoted to these objects will be amply rewarded in the results.

The Bed Stage.

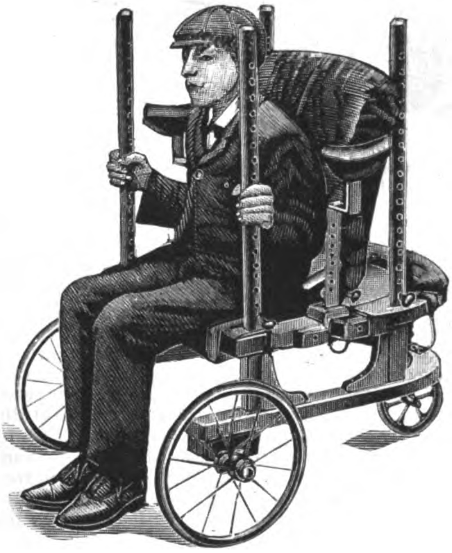
As regards the management of the convalescent during the resting period, time will not permit me to enter again into the details of the method which I have described to you on previous occasions. To build up the strength and to grow the tissues, there are two requisites: food and oxygen. We have all been taught as students to supply food; but not all of us sufficiently taught to supply the oxygen.

The earliest, the most indispensable, and the most profitable exercise for our bedridden convalescents is *the systematic exercise of the respiratory function*, which feeds and exercises the heart through its own perpetual stimulus, the work of the respiratory muscles. On the other hand, by improving the blood and the circulation, it improves the nutrition of bone, cartilage, muscles, and joints, and of all the organs. *Massage and resistance movements* are the next instalment to be provided for the patient whilst he is still confined to his bed. With these helps it is often possible to materially reduce the period of recumbency. Having secured this solid basis of respiratory and circulatory efficiency, the patient can soon be lifted out of bed without any fear of overstrain for heart, lungs, or limbs.

The Out-of-Bed Stage, and the "Convalescent Machine."

At this stage I have found considerable advantage from the use of a versatile commodity, for which I know no better name than that of the *Convalescent Machine*. Its construction was first suggested to me by a desire to secure for the adult the special advantages obtainable in infants and children with the "Baby Rest" and the "All Fours' Exerciser." No description has hitherto been published of these useful additions to the furniture of the nursery. But you may remember my having shown them to you at the Polyclinic; and I have also written an incidental reference elsewhere. (*a*)

Fig. 1.



The Convalescent Machine as a Wheeled Chair.

The purposes secured in these two appliances are: (1) Efficient *rest* with *varied posture*, and, when desired, with locomotion; and (2) *complete freedom of* the four extremities and of the head for every variety of movement, combined with complete support of the body, so that none of its weight is allowed to be borne by the limbs. In this respect they might be likened to a sort of "swimming board"

The general plan of the machine, best seen in Fig. 4, is that of a strong wooden, U-shaped, movable *upper frame*, capable of an extensive variety of horizontal positions by altering the place of the iron pins in the holes of the vertical wooden poles. These are firmly fixed in a lower U-shaped frame also made of wood, to which the wheels are attached.

The upper frame is padded in front for the tender hands of gout, of rheumatism, or of paralysis. It is

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(*a*) From Notes of a Clinical Demonstration at the Post-Graduate College and Polyclinic, October 20th, 1907.

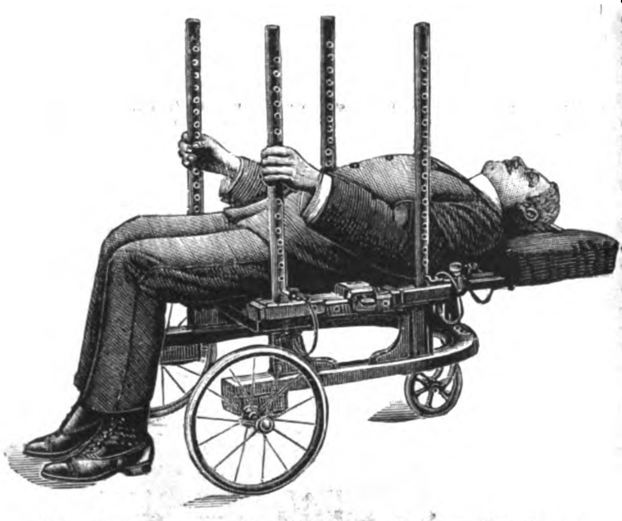
(*a*) Cf. Reports of the Society for the Study of Disease in Children. Vol. vii. P. 201. 1906-1907.

furnished at the sides with crutches capable of sliding up and down for the finer adjustment of their height. By taking out the pins they can be readily lifted out when not required.

The other parts of the machine are equally easy to handle. They consist: (1) of a removable padded seat, which simply lifts in and out of the upper frame; (2) of the head and shoulder support, which can be readily fitted as an horizontal extension to the front of the upper frame; and (3) of two metal rods (not shown in the illustrations) which slide out under the upper frame to support the legs and feet on a canvas-stretcher when the machine has to be used as a complete couch.

This preliminary description of the Convalescent Machine will help us to understand its varied uses, some of which are illustrated in the figures.

Fig. 2.



The Convalescent Machine as a Supine Couch, or Supine Exerciser.

As a Wheeled Couch, the machine cannot pretend to compete in all points with the most perfect modern pattern of couch. Nevertheless, it presents advantages besides that of mere compactness, and of its adaptability to most ages and sizes. The poles, though rather unsightly, are of practical service for leverage in all cases where the hands and arms can be used. And there is the other great advantage that the reclining convalescent can wheel the couch about for himself.

As a Wheeled Chair, the purpose of rest is fulfilled by arranging the head and shoulder support, as shown in Fig. 1, to serve as the back of a chair, and by lowering the crutches to a position of comfort for the support of the elbows. But special indications can also be carried out in connection with the lower limbs, with the spine, and with the shoulder-joint.

(1) The canvas-stretcher or leg-rest is available in all cases where elevation of the lower limbs is required. (2) The crutches can be used with due reservations to encourage a correct attitude of the spine during the period of sitting. And (3) with suitable adjustment of height and of padding they can be used for passive stretching of the axilla in cases of contraction.

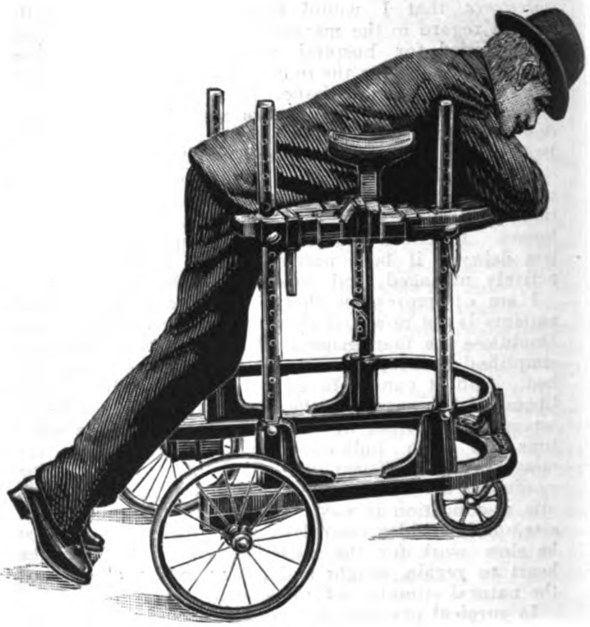
Exercise is the soul of convalescence, though rest is the indispensable basis, and its fundamental principle is *graduation of exertion*. This is taught us by the object lessons of Nature, when the immobility of prostrating disease gives way to the slighter movements in bed, such as turning, leaning up, and finally sitting up spontaneously. There, however, with adult convalescents the progression often stops; and unless given special opportunities many of their muscles remain unexercised. In children, putting aside special cases of disablement, Nature is not to be thwarted; and if they are confined to bed beyond the preliminary stage their muscular activities soon develop into acrobatics. It is only fair to say that "bed" is often the most convenient gymnasium we can offer them. But as any wheeled chariot has enduring fascinations for the young, a good deal of time might usefully be disposed of "on wheels."

So much for the special case of juveniles. The ordinary convalescent, if afforded a fair opportunity, will, like any infant placed on the "Baby Rest," find out for himself, or, rather, fall unconsciously into, the performance of those muscular movements of which he is capable without any stress or strain. It is obvious then that the earliest exercising function of the Convalescent Machine is that which it provides in the three positions of rest, the prone, the supine, and the seated. But the graduation of conscious and systematic exercise is the purpose for which it is specially adapted. With the "All-Fours' Exerciser" it shares the principle of "lifting off" the weight of the body, and of exercising the muscles in the "*unloaded state*." But it affords an additional advantage in the *weight-and-pulley attachment*, which can be fixed at the top of the poles, to exercise the limbs in the supine position on the plan of the *resisted movements*.

The application of these principles enables us to fulfil the two indications we had in view: the systemic or nutritional indication, that of improving the circulation and all the functions by movement; and the special or local indication, which aims at restoring strength and mobility to muscles and joints.

As a Wheeled Prone Exerciser, the illustration, Fig. 3, demonstrates the method of progressive re-education of disused mechanisms. The weight of the trunk rests entirely upon the machine, and the level of its support is so adjusted as to allow only a tip-toe touch of exertion for the muscles and joints of the lower limbs.

Fig. 3.

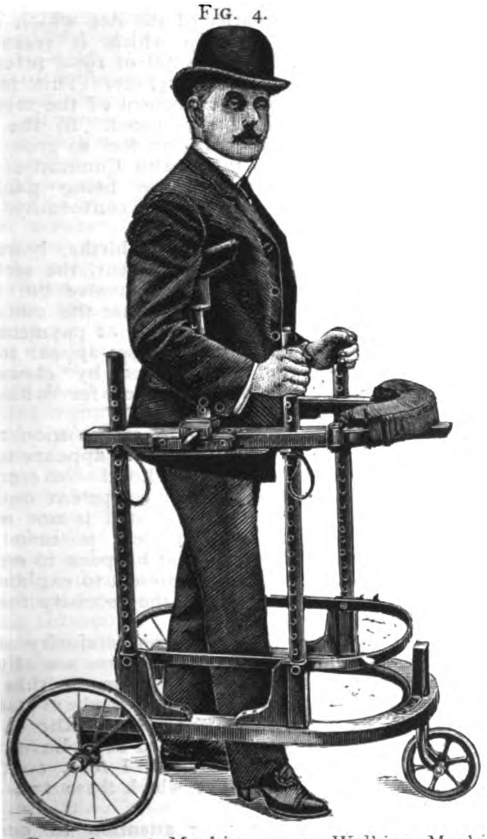


The Convalescent Machine as a Prone Exerciser, or (when lowered as in Fig. 2 and fitted with a Leg-rest) as a Prone Couch.

When used as a *Walking Machine* the same progressive principle is provided by the apparatus; and the adjustability of the crutches is found on trial to be most satisfactory.

Muscular exercise for the limbs and joints is by no means the only line of employment for the machine. *The treatment of the viscera* is one of its chief uses, as subsequent communications will show. Of all the positions the most valuable is the *prone position*, both for the abdomen and for the chest. And of all pulmonary diseases, those which will benefit most are bronchiectasis and the chronic catarrhal affections. By raising the posterior level of the supporting cushions higher than the anterior it is possible to obtain a declivity of the thorax in the prone attitude, that is to say, the ideal posture for the spontaneous drainage of the bronchial tree, of the larger bronchi, and of the trachea.

FIG. 4.



The Convalescent Machine as a Walking Machine, or "Crutches on Wheels."

Rest, which is the chief requisite at all stages of convalescence, is not always easy to enforce; and we must be prepared to deal not only with the normal restlessness of youth, but also with the *constitutional nervous restlessness* of some individuals. For both these classes the Convalescent Machine can lend us welcome help. It is possible to prescribe its employment for stated periods in the day either as a couch to rest the entire body, or as an armchair which combines with the repose some slight work for the loins.

The foregoing remarks have referred mainly to medical ailments and their convalescence. It is obvious, however, that facilities offered by the Convalescent Machine must prove of special service in the large group of *crippling and paralysing affections and lesions*, whether medical or surgical. It is unnecessary to enter into the details of their treatment, which would carry us too far; and it remains for me only to offer to Mr. John Ward, of 246, Tottenham Court Road, the thanks which he has so well earned by his skill and success in carrying out the construction of the Convalescent Machine.

NOTIFICATION OF BIRTHS ACT, 1907. (a)

BY E. W. HOPE, M.D.,

Medical Officer of Health, Liverpool.

FOR a great number of years the subject of infant mortality has engaged the attention not only of the medical profession, but, in fact, of all those engaged in dealing with questions affecting the public health.

Just twenty-one years ago I read a paper upon this subject in this Institution, and the views then expressed have been fairly borne out by subsequent experience. It is largely owing to the fact of the low birth-rate in France, and the consequent stationary condition of the population in that country, that very particular attention has been paid to the infant. As Mr. Broadbent expressed it, "France appears to be the only country which has discovered the baby. Contrast the lack of information as to births with the superabundant information as to the records of deaths, and one becomes aware of the curious paradox that death appears to be a much more important and interesting event than birth."

The appended table (Table "B ") gives the rate of mortality below five years of age, and also of infants under one year of age, and the figures are sufficiently impressive.

In the fulness of time, legislative and administrative measures have been devised in various directions, with a view, if possible, to lessen the loss of infant life. One of the most recent is the Midwives Act. I make but a single reference in order to say that the Act has proved an extremely beneficial one, and is gradually fulfilling the objects it was designed to accomplish.

The Act to which I wish to call attention now is one called "An Act to Provide for the Early Notification of Births," and the chief provisions of it are as follows: The Act is an "adoptive" Act; that is to say, the local authority may adopt its clauses in their area, or they may leave it alone, but the resolution of adoption cannot take effect until the consent of the Local Government Board has been obtained. It does not appear that the Local Government Board can prevent its adoption, but they may by order declare the Act in force in any area which has not adopted it.

The Act provides:—

(1) That it shall be the duty of the father of the child, if he is residing in the house at the time, and also the duty of any person in attendance upon the mother at the time of, or within six hours after, the birth, to give notice, in writing, of the birth to the Medical Officer of Health in the manner prescribed, namely:—

(2) The notice shall be given by posting a prepaid letter or postcard to the Medical Officer of Health, giving the necessary information of the birth within 36 hours after the birth, or written notice may be given if this is preferred. The local authority shall provide stamped addressed postcards containing the form of notice to any medical practitioner or midwife who applies for them.

(3) A penalty of 20s. attaches to failure to give notice.

(4) The notification required under this Act is an addition to, and not instead of, the requirements of any Act relating to the registration of births.

(5) The section shall apply to any child born after the 28th week of pregnancy, whether alive or dead.

(6) Any expenses incurred by the local authority in the execution of this Act shall be paid as part of the general expenses relating to public health.

There are about 24,000 births annually in Liverpool, and I reckon that some 15,000 of these are attended by midwives.

Obviously the Act is one which will primarily affect the medical attendant or midwife, for it is well known to all of you that when Acts of Parliament impose obligations alternatively upon one of two people, one of whom is the medical attendant, it is he who bears the brunt of the burden. This is the universal experience of the Notification of Infectious Diseases Act, and in this case there is no doubt whatever that the new Act will affect the medical man in the same way. Amongst the poorer classes the midwife will be the person from whom the notification will come.

The object in bringing the matter forward now is to ascertain whether the members of the Institution have any views as to the way in which the obligation imposed upon them can best be carried out with a minimum of inconvenience, and whether they have preference for any special form, either of letter or postcard, by which the intimation can be conveyed. If so, I will endeavour to meet the general wish in these directions. In the meantime I suggest the form here reproduced.

(a) Paper read before the Liverpool Medico-Chirurgical Society.

CITY OF LIVERPOOL.

NOTIFICATION OF BIRTHS ACT, 1907.

....................190....

To the MEDICAL OFFICER OF HEALTH FOR THE CITY OF LIVERPOOL.

Dear Sir,

I hereby notify that on ....

.... 190..........

....

residing at ....

was delivered of a { male / female } infant { living. / stillborn.

(Signed) ....

Address ....

....

N.B.—If notified by parent, the name and address of the person in attendance must be given below:—

Name ....

Address ....

....

Observations by Medical Attendant:—

....

....

I may explain that the ultimate object aimed at by this Act is to secure, by means of a trained and educated staff, that advice shall be available for the poor mothers who, but for such action on the part of the local authority, would have no one to advise them; it will also serve as a basis for important investigations affecting infant mortality, one of which the Home Secretary has already set on foot. The importance of the notification from the public health point of view, and the action which will follow upon it, will vary considerably in the different social classes. Amongst those, whether rich or poor, upon whom a medical man is in attendance, I anticipate that the medical man will indicate what action he desires, if any—much, in fact, as he now does in the notification of phthisis; and this circumstance renders it desirable either that the notification should come direct from the medical man when there is one in attendance, or that the notification, if made by the father, should state whether or no a medical man is attending. With regard to midwives, a greater discretionary power will, of course, require to be exercised.

When the notification is received, the next point to determine will be when the first visit of the visitor should be made in those cases in which a visit is needed, and upon this the opinion of the medical profession would be valuable. Our general experience leads us to the view that the infants of the poorer classes are for about 28 days after birth fed at the breast; but it would nevertheless be desirable, and in many cases necessary, to pay an earlier visit than this, perhaps at a period of about seven days after birth, unless circumstances suggest that an even earlier visit is desirable. The circumstances which would suggest an earlier visit are those in which there is extreme poverty, and where perhaps the mother may be without any help whatever in attending to the infant, or even to the ordinary domestic necessities. The actual date of the first visit, therefore, after confinement, must, I think, vary, but I must point out that one-fourth of the total infant mortality takes place before the first month is reached, and more than one-half of these deaths occur during the first week after the birth of the infant; thus, last year there were 4,137 deaths of infants under 1 year; of these, 1,057 were below 1 month, and 571 below 1 week of age.

It must not be supposed that visiting of this character is a new thing in this city. Three years ago I inaugurated a similar system of visitation, but hitherto the long delay in receiving the notification of the birth has handicapped the work; under this system the notification of births, when received at the Education Office, were copied by members of the staff of the Health Department, and the addresses in certain districts were visited. I show you the forms upon which the results of those visits have been recorded.

I turn now to a peculiarity of the Act which calls for a word of observation, in which it resembles certain clauses in the Midwives Act of 1902, referring to medical aid in time of emergency. This is the omission of any provision for payment of the medical man or midwife for services rendered. In the case of the Midwives Act, the omission was so gross that when I pointed it out to the Health Committee they at once assented to a uniform fee being paid to medical men who gave assistance in conformity with the requirements of the Act.

In the case of the notification of births, however, the circumstances are somewhat different, the services rendered are very much less, and involve but little time, and whilst I am of opinion that the omission from this Act of any specific mention of payment for the service is a regrettable one, it does appear to me that such payment would be covered by clause 1, section 6. Upon this point I will confer with the Town Clerk.

I have one final observation to make upon these omissions, and that is, that their cause appears to me to be a very simple one. The Local Government Board, as you know, has a highly competent medical staff, but, unhappily, that medical staff is not represented upon the Board. Its business is merely to report; and everybody knows what happens to reports when the author of them is not present to explain, to amplify, or, if necessary, to urge the necessity for the recommendations made.

We may safely assume that the great majority of the measures in which the medical profession are alluded to, or by which they are affected, come within the purview, directly or indirectly, of the medical staff of the Local Government Board. Until the Local Government Board is so reconstituted as to have upon it medical representatives, we shall, I fear, continue to labour under the difficulties which these two Acts of Parliament illustrate.

In conclusion, I invite your attention to one or two diagrams on the screen, illustrating the fact that the very early age periods are the fatal ones in this city, and that after five years of age the differences in the mortality rates of all England and Wales and Liverpool are but slight.

TABLE B.—INFANT MORTALITY, YEAR 1905.

	Per 1000 Births.	Per 1000 Survivors.				
	Under 1 year.	1 to 2 years.	2 to 3 years.	3 to 4 years.	4 to 5 years.	All ages above 5 years.
England and Wales... ...	128·15	37·50	15·07	9·82	7·28	11·9
Liverpool ...	154·08	58·51	22·49	15·58	11·84	12·9

Liverpool: At all ages above one year, death-rate = 14·5 per 1,000.

The year 1905 is taken for illustration, but the three years 1905, 1906, and 1907 taken together show very similar results.

CLINICAL RECORDS

A NON-TYPICAL CASE OF LUPUS DIAGNOSED BY CALMETTE'S TUBERCULIN METHOD.

By DAVID WALSH, M.D., EDIN.,

Senior Physician, Western Skin Hospital; Physician, Skin Department, Kensington General Hospital.

A. B., æt. 24, sent early in December by Dr. Arthur Douglas, Enfield Lock. Patient complained of a rash on nose and face of two months' duration. Good family history. Patient well nourished, and general health always good on the whole; had enteric fever at 19 years. Has bad teeth, and suffers from chronic dyspepsia. There had been a few irritating papules on face for years past, and small scars had been left by them, especially on the lower right cheek, and at the time of first examination several acne spots were seen on forehead, etc.

The rash on the nose first appeared about six months ago. It began as a papular rash, and was seen three weeks after its appearance by Dr. Douglas, who, after a short trial of calomel, scraped it and applied pure carbolic acid. Little benefit followed, and later some more spots appeared on cheek and nose.

Present Condition.—The lower half of the front and sides of nose is covered with a bright red rash; the margins extend halfway towards cheek, and are fairly well defined, with some outlying patches. The edges may be said to have in parts rather more marked papules than the rest of the main patch. The latter nowhere shows scarring, but is studded with numerous small comedones of uniform size, which may be seen projecting from the surface. There is nowhere to be seen anything resembling an apple jelly nodule. On the cheeks are a few discrete papules over the malar bone, and more on the right (about half a dozen) than on left. These are darker in colour than the rash on nose; about the size of a hemp seed; and almost level with the surface. Over the left naso-frontal region was a smooth, dull-red, slightly-raised patch, which was certainly suggestive of lupus vulgaris. The ears were free.

The patient was first treated with mercurial and antiseptic applications in the form of plaster. As there was not much improvement after a few weeks, the whole of the patches and outlying papules were scraped and painted with pure carbolic acid. As the result of this was not altogether satisfactory, it was determined to test the patient with Calmette's diagnostic tuberculin. Accordingly, a minim of the fluid (Martindale's) was dropped into the right eye, the conjunctiva of which was previously ascertained to be in a healthy state. (The mucous membrane of the left eye was in a condition of mild catarrhal conjunctivitis.) Some 12 hours later a reaction appeared in the right eye and attained its maximum about 20 hours after the application, with much redness, photophobia and lacrymation.

Remarks.—This rash was one of the borderland kind so far as appearances went; one of those transition forms on which the French writers lay a good deal of stress. In these atypical eruptions it is impossible for even the most experienced to be certain of the diagnosis, except under prolonged observation. The rapid settlement of diagnosis, therefore, by so simple a method as that afforded by Calmette is obviously of considerable practical value. In this case the balance of probabilities lies in the supposition that the skin rash is of a tubercular nature. Although it may, of course, happen that a patient may have a non-tubercular skin rash, but may furnish the ophthalmic reaction of Calmette owing to latent tuberculosis elsewhere. There was no reason to suspect the latter condition in A. B. The patient was accordingly informed that it was desirable to repeat the scraping at an early date. At the next operation it is proposed to scrape the whole surface and to include the discrete papules on the cheeks in the process, and afterwards to apply the acid nitrate of mercury..

A few words may be added for the benefit of those who may not have had an opportunity of testing this new method, which promises to be of special value in diagnosing early or obscure cases of tubercular infection. At present there is much doubt as to the precise relation of lupus erythematosus to tuberculosis. Several cases of that malady, however, have been already found to give the ophthalmic reaction. An interesting case of Bazin's disease (erythema induratum) in a young woman, æt. 21, with a tuberculous family history (two aunts on mother's side). Dr. J. M. H. MacLeod (a) obtained a positive reaction of an acute character coming on six hours after the instillation of one drop of Calmette's solution into the conjunctiva.

Professor Calmette first published his method of administering tuberculin for diagnostic purposes in June, 1907. It was brought to the notice of English writers by Mr. Sydney Stephenson (a). Two recent American writers, Drs. Frank Smithier and R. P. Walker (b) have fully published a collection of cases by French writers, in which a positive reaction was obtained in 176 out of 185 cases clinically tuberculous, with 9 negative reactions. Of 28 cases doubtfully tuberculous, 21 gave positive and 7 negative reactions. Of 188 persons suffering from disease not tuberculous, and including a proportion of apparently normal individuals, 186 gave negative and only 2 positive reactions.

OPERATING THEATRES.

GUY'S HOSPITAL.

Operation for Old Fracture of the Radius and Ulna.—Mr. Arbuthnot Lane operated on a boy, æt. 12, who had sustained a fracture of the radius and ulna above the middle of the shaft six months previously. The fractures had been produced by direct violence, and were on the same transverse level. Mr. Lane pointed out that, as so often happens in this form of fracture, there had been some overriding of the fragments, which had united so that their axes formed a considerable angle, and the functions and appearance of the forearm were very much depreciated. The ulnar junction was first exposed and divided in an oblique plane, so that the angle formed between its fragments could be subsequently obliterated. The seat of the fracture of the radius was then freely opened up, and a wedge of bone was removed. In consequence of this the axes of the fragments were got into perfect continuity. They were secured by two small dumb-bell plates by means of four screws, two of which crossed the others at right angles and rendered the fragments immobile and any displacement impossible. The ulnar fragments were then rotated upon the obliquely-cut plane till their axes were continuous, and they were retained in this position by an axial screw and a controlling metal plate and screws. Mr. Lane said that these operations for fractures which have united in bad positions are infinitely more difficult to perform than are those for recent fractures, for the reason that in the latter the surgeon can fit the fractured ends accurately into position, and can ensure perfect continuity, while in the former the operator has to deal with deformed bones, which he has to divide in three, and perhaps four, places, and also in the young subject with a callus extending along the whole length of the fragments, altering the form of the bone, and making it most difficult to recognise the relationship of the axes of the fragments to one another. Again, in recent fractures, the length of incision is not necessarily so great, and the chance of doing damage is very much less. Indeed, the risk of interference in expert hands is very small indeed, while the benefits which the patient derives from a perfect restoration of his anatomy is enormous.

Excision of Rectum.—The same surgeon performed the second stage of an operation for excision of the rectum for malignant disease. This patient, Mr. Lane said, had seen two eminent surgeons three months previous to his admission to Guy's, and he had been informed that the condition was inoperable. The growth commenced about an inch above the anal aperture, and extended around the bowel for some distance. The pain and distress to the patient from the condition were very great. A fortnight before Mr. Lane had opened the abdomen three-quarters of an inch to the left of the middle line by an incision extending from the umbilicus to the symphysis pubis. The upper limit of the growth in the rectum was defined, and the extent of the glandular infection in the mesentery determined. The sigmoid was freed from the adhesions that bound down first the meso-sigmoid and later the bowel itself into the iliac fossa. Then Mr. Lane pointed out precisely the same in character and in mode of production as those which develop in chronic constipation, which he has described fully in his papers on the operative treatment of this condition. The bowel and mesentery having been freed, the former was turned out through the abdominal incision, the mesentery controlling the rectum above the line of the growth, and the sigmoid at its lower part was divided. The sigmoid was divided with the cautery, sufficient length being left protruding to allow of a suitable drainage apparatus being connected. The rectum was then ligatured immediately above the growth, and after its division by the cautery above the ligature the latter was prolapsed into and buried by means of purse-string and other sutures in the rectum. The peritoneum covering the bladder and sides and back of the pelvis was so united by gut sutures as to shut off the portion of the true pelvis containing the remainder of the rectum from the general peritoneal cavity. The abdominal incision was then rendered firmly secure, the orifice of the sigmoid appearing just below and to the left of the umbilicus. At the present operation the remainder of the rectum with the growth in its wall was carefully dissected out from adjacent structures, no bone being divided in doing so. The patient is progressing most satisfactorily, and has suffered neither pain nor distress in consequence of the operation.

(a) "British Journal of Dermatology," January, 1908. P. 17.

(a) *British Medical Journal*, October 19, 1907.
(b) Calmette's Ophthalmic Reaction. "The Journal," Chicago, January 25th, 1908. P. 259.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Clinical Section.

Meeting held Friday, February 14th, 1908.

The President, Sir Thomas Barlow, in the Chair.

Mr. J. Paul Roughton showed a case of

LYMPHANGIOMA OF FACE.

M., æt. 11. The whole of the right side of the face, with the exception of the region below and to the right of the mouth, was occupied by a swelling of a doughy consistency, the upper eyelid especially being very swollen. The swelling crossed the middle line on the forehead and upper lip. There were many cords and knots distributed throughout the swelling, especially on the forehead, over the parotid, and in the cheek, and there is a distinct cord running immediately behind the facial artery over the ramus of the jaw. There was no pulsation. Eight years ago the mother had noticed that the right eye looked smaller than the left, and shortly afterwards the outer canthus began to swell, from whence the swelling had gradually spread.

Mr. R. J. Godlee suggested that the case was one of plexiform neuroma, a view that was strongly supported by Dr. Parkes Weber. Mr. W. G. Spencer advised operation, and referred to a similar case that he had successfully operated on. Dr. G. A. Sutherland had shown a similar case to the Society two years ago; in his opinion also the condition was one of neuroma.

Dr. Herbert French showed a case of

TUMOUR OF MEDIASTINUM (? HYDATID).

The patient, a woman, æt. 42, looked perfectly well, and her only complaint was that she could not see properly with her left eye. There was complete paralysis of the left cervical sympathetic nerve. This dated back for over two years. There was ptosis of the left upper eyelid; the left pupil was continuously small; the patient could not blush upon the left side of her face, and when she perspired the right side of her face sweats, but the left did not. There was distinct fulness of the left external jugular vein, and of the veins over the upper part of the left chest in front. There was complete absence of breath and voice sounds over the region where the upper two-thirds of the upper lobe of the left lung ought to be. The conclusion was that, in the region of the left upper lobe, there was a mass nearly as big as an orange, large enough to displace or destroy the lung there, to extend back far enough to compress the cervical sympathetic nerve, and forward enough to compress the left innominate vein.

Dr. C. J. B. Williams suggested that the growth might be a lymphoma, of which he had seen two examples. Dr. A. C. Garrod recalled a similar case he had seen in a child, and which proved to be a hydatid.

Mr. R. J. Godlee showed a case of

OLD FRACTURE OF HUMERUS, WITH OSTEO-ARTHRITIS OF ELBOW.

Patient was a man, æt. 34. Twenty-one years ago he had injured his right elbow. Three and a-half years ago a small, painful swelling appeared on the elbow. Soon afterwards a swelling appeared on the inner side of the back of the forearm, 2 in. below the internal condyle, which increased in size during the last year till it reached that of a walnut. It proved to be a "ganglion " with a thin wall, the pedicle of which extended up towards the joint along the internal intermuscular septum. The skiagram shows an old fracture of the internal condyle and irregular masses of bone attached to both the upper ends of ulna and radius. The movements of the joint were almost perfect. The case suggested that an injury to a joint in youth might determine the onset of osteo-arthritis later in life. No signs of osteo-arthritis had been discovered in other joints.

Mr. R. J. Godlee also showed a case of

OLD-STANDING DISLOCATION OF PATELLA, WITH OSTEO-ARTHRITIS OF KNEE.

The patient, a man, æt. 50, said that his right knee had been out of shape since birth. It had not caused him much, if any, inconvenience until he had a blow upon it six months ago, since which time his knee had been painful. On flexing the knee the patella would slip right over to the outer side of the joint. There was marked genu valgum, and the signs of osteo-arthritis were unmistakable.

Mr. T. M. Openshaw agreed with Mr. Godlee with regard to the significance of past injury to joints, both recent and remote, in the causation of monoarticular osteo-arthritis. Dr. Seymour Taylor described a ganglion that had developed on his own forefinger in connection with a traumatic osteo-arthritis. Dr. F. J. Poynton said that such trauma was not essential but predisposed to the affection. Intravenous injection of organisms sometimes produced osteo-arthritis strictly confined to one joint. Dr. A. E. Garrod said that trauma played a part in most joint affections, notably in gout, and also in infective arthritis.

Dr. Seymour Taylor showed a case of

RUPTURED AORTIC VALVE.

The patient, a man, æt. 34, complained of tightness across the chest, a choking sensation on exertion, and a buzzing noise in the chest, which he heard best when lying down. These symptoms supervened suddenly after the strain of lifting a heavy weight. He had twice suffered from lead colic. He had a typical blue line at the edge of the gums. A diastolic thrill was felt, most intense over the second and third spaces on each side. On auscultation a loud murmur was heard, loudest over the aortic area, diastolic in period, and musical in tone. The musical note corresponds to about B below the staff. The murmur was heard all over the chest, and even over the upper thirds of the humeri. The condition of the valve was probably one of perforation of one cusp rather than of detachment or true rupture.

Sir John Broadbent had observed a case of traumatic rupture of the aortic valve, which was followed by acute heart failure and death within a month. Dr. F. J. Poynton had seen two cases followed by autopsy; in these there had been no pain and but little general disturbance at the time of the accident. Dr.

C. J. B. Williams had also made autopsies on such cases. He thought that a musical murmur was due rather to a free tongue depending from the cusp. Dr. Parkes Weber said that it was sometimes doubted whether rupture ever occurred apart from malignant endocarditis; he had performed an autopsy however on a case that was due neither to this nor to accident. Dr. Seymour Taylor, in reply, said that a free tongue should produce a double murmur, not a single one.

Dr. Arthur Latham showed a case of

CASEATING PULMONARY TUBERCULOSIS TREATED BY TUBERCULIN (T.R.) AND HORSE SERUM, BOTH ADMINISTERED BY THE MOUTH.

Dr. C. J. B. Williams congratulated Dr. Latham on the result of his treatment.

Dr. F. Parkes Weber showed a case of

SPURIOUS (?) ACROMEGALY.

The patient was a woman, æt. 46, rather corpulent, and very anæmic. Her face and head, with the large lower jaw, prominent chin, and big nose, could have been used as a model for an illustration of acromegaly. She had thick, fleshy hands and thick fingers, but she had no ocular symptoms of acromegaly, and her occasional headaches and shortness of breath seem to be connected with her anæmia, which in its turn may be accounted for by frequent hæmorrhoidal bleeding, from which she had suffered during the last six or seven years. There was no evidence of any progressive change having occurred in the shape or size of the hands, feet, face, skull, or other bones of the body since she ceased growing at the ordinary age. An old photograph (the only one obtainable for comparison), which was taken three or four years ago, shows her face looking just as it does now.

The President asked whether a skiagram had been taken? Dr. Weber replied in the negative.

Mr. H. A. T. Fairbank showed a case of

A LARGE SARCOMA OF THE THIGH IN A MALE CHILD, AGED FOUR.

The duration was two months. The growth did not proceed from the bone. Deep glands were involved, and the growth was inoperable.

Baker and Forbes

Mr. W. G. Spencer showed a case of

LATERAL CURVATURE RAPIDLY DEVELOPING IN A BOY.

M., æt. 3, was all at once noticed to have a marked lateral curvature. He had a marked left thoracic and lumbar scoliosis, and walked with lordosis; both of these curvatures disappear when he is suspended by the arms. The muscles of the left side of the spine appeared unduly weak, and the abdomen was irregularly protuberant.

Mr. R. P. Rowlands showed a

CASE OF EXCISION OF THE BODY OF THE SCAPULA.

M., æt. 35, from whom the whole of the body of the left scapula was excised for enchondroma fifteen months ago. It was possible to save the coracoid process, with its important muscles and ligaments, the glenoid cavity with the capsular ligament of the shoulder-joint, and the acromion process, with the attachments of the deltoid and trapezius to it. The patient showed that both the functions and the deformity following this procedure were much less than after complete excision of the shoulder-blade. The man had been able to do his work as a painter's labourer at Guy's Hospital from two months after the operation. It was claimed that preservation of the processes and glenoid cavity was both practicable and advisable in preference to complete excision of the scapula for inflammatory conditions and innocent growths, and possibly for some malignant growths.

Dr. Frederick E. Batten and Dr. J. Graham Forbes read a

NOTE ON TWO CASES OF GAERTNER INFECTION IN INFANTS.

Both cases were clinically ones of acute diarrhœa, with no special features. The first one was recognised during life, for the blood reacted to Gaertner's bacillus but gave no Widal test. At the autopsy a number of deep, small, irregularly situate ulcers were found in the small intestine. Gaertner's bacillus was isolated from the spleen, blood and mesenteric glands. The second case gave no Widal; no agglutination with Gaertner's bacillus was tested, but the bacilli were isolated from the stools. Dr. Forbes detailed the cultural distinctions between Gaertner's and allied micro-organisms.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Anatomy and Physiology.

Meeting held Friday, January 24th, 1908.

Professor A. Fraser in the Chair.

THE ANATOMY OF THE ILIAC COLON IN RELATION TO HERNIA.

Dr. R. A. Stoney read a paper on the above. The subject was suggested by three cases which were recently seen by the speaker, where a hernia of this portion of the large intestine had occurred. Two were hospital patients who were operated on for the radical cure of left inguinal hernia, and in each case, the sac on being opened, was found to contain a piece of the large intestine invaginated through the posterior wall, the sac being incomplete. The third case was an old dissecting-room subject (male) with a large femoral hernia on the left side, which was found to contain, in addition to about three feet of the small intestine, a loop of large intestine which proved to be about three inches of the iliac colon. Though the iliac colon usually has no mesentery and lies far back in the iliac fossa, there are two conditions sometimes present which may increase the liability of this part of the intestine to become extruded from the abdomen—first, the presence of a mesentery (ten per cent., according to Jonnesco); and secondly, a low position in the iliac fossa, the intestine running along in close relation to Poupart's ligament. There are three ways in which a hernia of the iliac colon may occur:—(1) It may be drawn down into or through the inguinal canal by an extra attachment of the gubernaculum—this is the congenital hernia; (2) it may be drawn down by a protrusion of the peritoneum covering it in the formation of the sac of an ordinary hernia; (3) there may be a giving way or lengthening of the supporting apparatus of this portion of the intestine, and a subsequent protrusion of it by the expulsive action of the abdominal muscles. The relations of the peritoneum forming the sac and covering the gut will differ according to the mode of formation of the hernia. In the congenital form the sac is probably always incomplete, as there is merely a displacement of the gut and the surrounding peritoneum into the scrotum, so that they maintain their normal relations to one another—*i.e.*, the peritoneum only partially covers the intestine. In the second form also the sac is probably always incomplete, as even if the gut had a mesentery to start with its left or lower layer would be taken up first in the formation of the sac before the gut was drawn into the hernia. Unless the hernia is of an enormous size this form is only likely to occur if the intestine has an abnormally low position. In the third form the presence or absence of a complete sac will depend on which of the two factors is at work. If it is due to a giving way of the attachments of the intestine it slides down behind the peritoneum and the sac is only partial. This may be truly described as a "hernia *en glissade*." If, however, it is due to a lengthening or stretching of the support of the intestine, the latter either has a mesentery to start with or obtains one which finally becomes long enough to allow the gut to reach the internal abdominal ring and be herniated like any other portion of intestine. In this case, of course, the sac will be complete—in fact, it is probably only in the hernia formed in this way that the sac is ever complete.

Professor M'Loughlin said that the attachment of the gubernaculum to the peritoneum of the iliac fossa and the drawing down of the testis on that peritoneum was the general rule. It was a rare event to have it left behind. If the pulling of the gubernaculum on this peritoneum was to be considered as the sole cause of the congenital variety of hernia of the iliac colon we should expect to find this form of hernia a common one; but, as stated by the lecturer, it is one of rare occurrence. The cause, in consequence, is more likely to be *rarely* present. Now, in the fourth month, when the gubernacular bundle is beginning to push its way through the abdominal wall into the scrotum, the hind gut is provided with a mesentery. Should that mesentery be *unusually* long, especially about its centre or iliac colon portion, the free gut will swing low in the iliac fossa and the future iliac colon will come to lie in the dangerous zone beside the internal abdominal ring. Fusion of the mesentery with the peritoneum of the iliac fossa (as is the rule) may then take place, and the fusion will be with the peritoneum close to the opening in the wall into which the testis is passing. That peritoneum will be drawn down into the opening by the action of the gubernaculum, and so the gut will pass down the canal in the wall of the hernial sac. The cause of the congenital form is thus more likely to be a two-fold one —(1) The *accidental* lengthening of the mesentery of the mid-gut; (2) the action of the gubernaculum—the first being the determining factor.

Dr. **Stoney**, in reply, said that Professor M'Loughlin's suggestion was extremely interesting, and was quite as probable an explanation as his own.

Mr. **Adrian Stokes** exhibited a foetus showing transposition of viscera with a tricoelian heart, and gave the following brief account of the specimen:—The specimen which I have here to-night was obtained by Dr. Jellett in 1896, and was shortly described by him in the *Lancet* of 1897 as a case of transposition of the viscera with a tricoelian heart. Last year Professor Dixon very kindly gave me the opportunity of dissecting the specimen which had previously only had its thoracic and abdominal cavities opened. It soon became apparent that there were present further abnormalities which, I hope, will make it in some way worthy of your attention. The fœtus is well formed, and lived for a few minutes; the viscera and great vessels show complete transposition; the heart has a single large ventricle and two auricles. It is very remarkable that the left or systemic auricle has no direct communication with the common ventricle, its blood passing through a large patent foramen ovale into the right or pulmonary auricle in order to reach the ventricle. This must be an extremely rare condition. There have been a few cases recorded in which the pulmonary auricle did not communicate with the ventricle, but none, so far as I can find, in which the systemic auricle did not do so. The only other condition which I desire to note is that the pulmonary artery lies behind the aorta, a condition which is not accounted for by the general transposition of the viscera. Professor Young lately described a very interesting case of a tricoelian heart in a man of about 37 years. In it the chambers of the heart were in their normal positions, but the aorta arose, he believes, in front of the pulmonary artery. The condition of transposition of the viscera is rare. But few cases have been exhibited in Dublin, among which the best known case is the one exhibited by Professor Fraser before the Academy of Medicine in 1894. The condition of the heart is unlike any case of which I can find a record.

Professor **Fraser** exhibited and made remarks upon—

(*a*) THE HEMISPHERES OF AN ENCEPHALON, WITH WELL-MARKED INTERRUPTION OF BOTH CENTRAL SULCI.

The isthmus which connected the anterior and posterior central gyri lay on the same level as these gyri, and somewhat nearer the medial than the lateral ends of the sulci. The width was slightly over 1 c.m. This condition of the central sulcus is said to be rare. Professor Burt G. Wilder, in his essays—Vol. VIII., p. 158, and Vol. IX., p. 108, of the "Reference Handbook of the Medical Sciences"—gives the number of recorded cases as ten or twelve. He illustrates a case where the central sulci were interrupted (as in the above) in the hemispheres of a philosophical writer of some standing.

(*b*) A DUODENUM OF UNUSUAL FORM.

The third or transverse portion, instead of passing across the structures in front of the vertebral column in the usual manner, passed upwards on the right side behind the second or descending portion as far as the foramen of Winslow, thus forming a U-shaped loop, the two limbs of which could only be seen from the right side. Each limb measured slightly over 10 c.m. At the level of the foramen of Winslow the ascending limb passed across behind the superior mesenteric artery to the left side, and then formed the ordinary duodeno-jejunal flexure. The common bile duct passed between the descending and ascending limbs of the loop. The root of the mesentery had its origin from the duodeno-jejunal flexure from the processus uncinatus of the pancreas, and from the sharp bend formed by the descending and ascending limbs of the loop.

(*c*) ON THE MAIN ARTERY OF THE LIMB PASSING DOWN ON ITS POSTERIOR ASPECT.

Professor Fraser had observed this on the left limb of a middle-aged female during the summer session of 1907. He expressed regret at being unable to show the specimen, which he had thought to be well preserved until a few days before the meeting, when he found that in consequence of some inattention of the anatomical attendant it had gone astray. In this case the inferior gluteal artery was the size of the common femoral. It accompanied the great sciatic nerve and became the popliteal at the back of the knee. This latter vessel had the ordinary distribution. On examining the front aspect of the limb the external iliac was found to be smaller than ordinary, but of some size, until as common femoral it gave off its deep division. The superficial was of slight calibre, and was lost in small branches at the knee. Unfortunately he did not at the time examine the course of the veins. According to Quain, this form of distribution has been recorded ten times, but none of the sources are given. On turning to Henle's *Gefässlehre*, Professor Fraser found on pp. 303 and 312 a case illustrated (from Dubrueil) exactly similar to the one noted above. Also cases that have been described in English—Green (*Lancet*, February, 1832), who described a French specimen (as Fagge notes); Professor Ellis (*Med. Chir. Trans.*, Vol. XXXVI., p. 439), double, but in malformed limbs; and, finally, that of Fagge (*Guy's Hospital Reports*, Vol. X., p. 151), where an aneurysm had been found on the artery. Mr. Fagge considers that the cases recorded by Cailliard and Dubrueil were written from the same specimen, although at an interval of years.

Professor **M'Loughlin**, in discussing the latter communication, stated that only that morning, in his dissecting-room, he had seen two examples of portion of the abnormal artery described by Professor Fraser On *each limb* of a female subject the following was shown:—(1) The normal sciatic artery coming out of pelvis internal to sciatic nerve, and running down in superficial fascia. (2) A *second artery* (the abnormal one) coming out of the pelvis, through a 2-inch long cleft in the sciatic nerve and running down deep to the biceps to the popliteal space. Here the artery of the right side communicated with the popliteal artery by a branch about the size of a small digital artery.

DORSAL ORIGIN OF THE RIGHT SUBCLAVIAN ARTERY, WITH ASSOCIATED VASCULAR IRREGULARITIES.

Professor **M'Loughlin** exhibited a case of above. The right subclavian artery arose from the lower part of the arch opposite the disc, between the third and fourth vertebræ. It was bulbous and wide (24 mm.) at its origin; then, passing behind œsophagus and trachea, its anterior wall was deeply cupped, the posterior bulging markedly, so that the vessel would be crescentic on section. The vessel ran upwards and to the right, crossing in the middle line the disc between the second and third vertebræ. Its calibre was here much reduced, the tube—although flattened—measuring 13 mm. It now ran up the side of the body of the second vertebra, and, opposite middle of the body of the first vertebra, gave off a very large vertebral artery, the remaining three branches coming off the artery 1 cm. further on. The internal mammary was large, the superior intercostal small, and the thyroid axis small. The length of the artery up to origin of vertebral was 6.25 cm.; the whole of the first stage 7.50 cm. Its calibre just before origin of vertebral was 10 mm. The small superior intercostal artery gave off a profunda cervicis branch, which passed back *below* inner end of first rib, and not, as is usual, above it. The branch to the second space was joined, as is frequently seen, near the posterior end of the space by a small artery, which came up across the body of the third vertebra and was found to arise from a small first aortic intercostal, which was itself a branch of a very large right bronchial artery. This small artery linking the aorta (through its first aortic intercostal branch) with the subclavian (through its superior intercostal branch) has been held (just as the small aberrant artery which is occasionally seen linking the aorta directly with the subclavian) to represent in miniature the right dorsal aorta between the fourth arch and the point of fusion of both dorsal aortæ to form the descending aorta; but its presence in this specimen *in association with the irregular subclavian*, which is a persistent right dorsal aorta, is in contradiction to this view. This occasional aberrant theory, however, runs a course similar to that of the irregular subclavian, and should certainly be regarded as a vestige of the right aorta. Of other arterial irregularities present in this subject two may be specially noted. (1) The lingual artery was a very small twig arising a short distance above a small superior thyroid. It ran up to the hyoglossus, where it gave off its suprahyoid branch, and ended under the posterior part of that muscle by ascending in the position of a dorsalis linguæ branch. The greater part of the lingual area was supplied by a large artery which came off a large submental branch of facial. This artery pierced the mylohyoid far back, ran forwards on surface of anterior part of hyoglossus, giving forwards a sublingual branch, and backwards—under anterior border of muscle—a dorsalis linguæ branch. It then ascended to under surface of tongue, where it ran in the intermuscular cleft, as the ranine artery, to meet the opposite ranine at the tip of the tongue. The opposite lingual artery was normal. If we regard the lingual artery as a prolongation from the ventral end of the second aortic arch, and the facial artery from the end of the first aortic arch, then our abnormally constituted lingual artery represents two arteries, one of the first arch and one of the second arch, brought together about the middle of the tongue, or just about the line to which the second arch portion of the tongue reaches forwards to embrace the tuberculum impar and first arch portion of that organ. (2) The *vertebral* artery arising from the irregular subclavian was very large, the left vertebral very small. Both ran normal courses, and formed the basilar at lower end of pons. The left vertebral was a very slender twig at the point of union. At the upper end of the pons nearly the whole artery turned to the left as the left posterior cerebral artery, a small branch only going out to the right; the posterior cerebral of right side being mainly formed by a very large posterior communicating artery from the internal carotid. There was no direct communication between the internal carotid and the posterior cerebral arteries on the left side, the posterior communicating artery being but a very small twig which failed to reach the posterior cerebral. Associated with the irregular subclavian artery was a *thoracic duct* which, as is usual in such cases, ended on the right side of the neck. The duct lay in the middle line over the twelfth dorsal vertebra, passed to left over body of eleventh vertebra, and then ran up on right side of aorta, crossing the origin of the large right bronchial artery. Opposite the fourth dorsal vertebra it divided into two parts, which swept round in a circle and soon reunited, and then the duct turned over to the right (directed by the subclavian trunk which lay on its left), lying on third and second vertebræ. Then crossing over the front of the subclavian artery, half an inch below and internal to origin of vertebral and outside the vagus nerve, it passed up to end in the outer and posterior aspect of the internal jugular vein about one-third of an inch above junction with subclavian. A small lymph vessel, corresponding to the jugular trunk, opened just beside it into the jugular vein. No trace of a thoracic duct could be found on left side of neck, but on examining upper part of posterior wall of thorax on left side a large vein was seen running over the heads of the ribs. It opened above into the left end of the left innominate vein, and at its lower end turned transversely across disc, between seventh and eighth dorsal vertebræ, to end in ventral azygos major. It drained the upper eight intercostal spaces of the left side.

UNUSUAL POSITION OF LARGE INTESTINE.

Professor **M‘Loughlin** also called attention to the unusual position of the large intestine in the same subject. The ascending colon lay altogether in the iliac fossa, the cæcum was in the pelvis, and the descending colon was buried in a recess behind the lower third of the kidney and deep under cover of the psoas lower down.

IRREGULAR DISPOSITION OF THE HIND GUT DIVISION OF THE COLON.

Professor **M‘Loughlin** gave an account of a case of the above which he had seen recently in the dissecting-room. From the splenic flexure the colon ran down in its normal position to the iliac fossa. Near outer border of psoas it turned sharply on itself and ran straight upwards on the mesial side of the first tube. The second tube was provided with a short mesentery. Reaching the front of the lower part of the kidney, it again turned sharply and ran down along inner side of second tube, and, dropping over brim of pelvis just behind iliac bifurcation, it turned almost immediately backwards into curve of sacrum, where it soon lost its mesentery and became the rectum. The second and third tubes were obviously the sigmoid flexure, and the unusual position was probably due to the fact that the middle portion of the mesosigmoid failed to grow in proportion to the upper and lower parts, and that, in consequence, during the growth of the lumbar region, the central part of the flexure was left stranded high up in the position of the second bending over the lower end of the kidney. The line between the second and third tubes lay immediately over the course of the ureter, and the shallow recess beneath the second bending already noted might be regarded as an unusually highly placed intersigmoid fossa.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Clinical Evening.—Meeting held February 13th.

Mr. Treacher Collins, F.R.C.S., in the Chair.

Mr. L. Paton showed a case of detachment of the retina treated by operation. The patient had been sent to the National Hospital for the Paralysed with the diagnosis of double optic neuritis, and the remark that both visual fields were lost. The right eye had been useless 36 years, and for a year there was mistiness in the left. Vision was then 3/60, now it was 6/18. To get at the main point of detachment, he trephined above the tendon of the external rectus, and pulled the eye well forward by a tenotomy hook under the external rectus. He cauterised through the sclera until the subretinal fluid escaped, and aspirated the rest with a lachrymal syringe. He then perforated the retina above and below. In the middle of January the field was quite full.

Mr. **Horsford** showed a case of buphthalmia with malformation of the iris, and the causation of the condition was discussed.

Dr. F. W. **Edridge-Green** gave a lantern demonstration on some primary facts of colour perception, and an interesting discussion eventuated in a resolution being passed, on the proposition of Mr. C. D. **Marshall**, that a Committee of the Society be appointed to go into the whole question of colour-blindness and the tests for its detection, and report to the Society. Mr. **Lang** seconded the proposition.

Mr. **Marshall** asserted that the present tests failed in many instances, and that Holmgren's test could not be relied upon.

Mr. J. F. **Cunningham** showed an orbital case for diagnosis. It was thought to be apical periostitis, or caries of the apex of the orbit, or an optic nerve tumour.

Mr. J. H. **Fisher** showed a patient with microphthalmos, and a case of fundus changes resulting from injury at birth. The second of these patients was born with great difficulty, and there was a huge hæmatoma of the left frontal region, and soft tissues in the right temple and orbit were much damaged and lacerated by forceps. Possibly the optic nerve was damaged, and there was hæmorrhage from the lacerated vessels into the hyaloid canal, and that this formed the basis for the connective tissue organisation. He did not think there was any shrinking of the globe.

Mr. **BARDSLEY** showed a case of retinitis proliferans. A large bundle of connective tissue came forward into the vitreous. He regarded it as congenital, as there was a large detachment of the retina, and only a very small field. There was no history of injury, either at birth or since, but the eye had been defective as long as the parents could remember.

Mr. C. **WRAY** showed a case of follicular conjunctivitis, which he considered to be perfectly curable. It was contagious, and among 1,400 children in the Croydon schools, there were 12 cases of the condition.

Mr. **PARSONS** showed a patient the subject of a condition which he thought was probably metastatic neuro-retinitis. A woman had a glistening mass of exudate over the left disc, with considerable swelling, and some hæmorrhages on the disc. Then she suddenly lost the sight of that eye. The exudate diminished, leaving a glistening white star resembling that seen in albuminuric retinitis. She had no albuminuria.

CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, FEBRUARY 13TH, 1908.

Dr. CHAMPNEYS in the Chair.

THERE were present Dr. Stanley Atkinson, Mr. Fordham, Mrs. Latter, Miss Paget, Miss Wilson, and Mr. Parker Young. Mr. Bertram, the solicitor, also attended.

The correspondence included a letter from the Registrar of the Royal College of Physicians informing the Board that Dr. Champneys had been unanimously re-elected the representative of the College on the Board for the year ensuing April 1st next; also a letter from Miss E. M. Wright, of Leeds, informing the Board of the death of her father, Mr. C. I. Wright, one of the Board's Examiners for the Newcastle-on-Tyne centre. It was agreed that the Chairman should write, on behalf of the Board, a formal letter of regret. Dr. Donald, of Manchester, had written resigning his post as Examiner at that centre, as he could not spare the time for it. The Chairman was in receipt of a letter from Dr. Hellier, of Leeds, respecting his willingness to accept a post as Examiner, and it was accordingly agreed that he should be appointed to the vacancy at Newcastle-on-Tyne, in place of the late Dr. Wright.

The report of the Penal Cases Committee showed that various local supervising authorities had, at the request of the Board, sent in reports on the conduct of midwives previously censured or cautioned. About half of these reports were satisfactory. In the case of Mary Bent, against whom sundry indefinite charges had been made, it was agreed that the County Medical Officer for Lancashire be informed that the Board is extremely anxious to deal with drunkenness and other serious offences in midwives, but in the present case the local supervising authority have not found a *primâ facie* case, nor have they produced any direct evidence. The Chairman added that they could not censure a woman upon hearsay.

The Committee had prepared a list of 27 women to be cited to appear before the Board, which will hold a penal sitting on March 26th and 27th, to hear their cases.

The Standing Committee reported that a letter from the Clerk of the Council transmitting a copy of a letter from the Local Government Board enclosing a letter from the Executive Committee of the Rural Midwives' Association in regard to the question of the training of midwives, and the possibility of the grant of State aid in respect thereof, had been further considered.

A letter from the Clerk of the Council transmitting a copy of a memorandum addressed to the Secretary of State for the Home Department by Canon Dobell on the subject of the supply of midwives in rural districts, was further considered at the same time. A reply had been drafted by the Chairman, which raised some lengthy discussion. It was Dr. Champneys' view that the present impasse, caused by the lack of provision for the payment of medical men called in to midwives' cases, should be clearly represented to the Privy Council. Mr. Parkes Young wholly agreed, and considered that the Government was greatly to blame for neglecting to provide for this difficulty. The law obliged the midwife to summon medical aid in abnormal cases, and in a great number of cases—some of which were quoted at the meeting—medical aid was not forthcoming, as the doctors refused to answer the summons. It had been evident that for some time past there had been a general condition of friction between medical men and widwives, and the Chairman said he was not at all proud of a great number of his fellow members in the medical profession in their attitude towards midwives. It was neither humane nor national. After all, the first and most serious thing to be considered was the lives of our mothers and infants. After some amendments had been discussed, it was agreed that the reply should be sent to the Privy Council, and should be entered in full on the minutes of the Board.

A letter from Miss B. M. Worrall, Hon. Secretary of the Midwives Defence Association, as to the action of the local supervising authority for the County of London in regard to Rule E. 26, was further considered.

Memorials on the same subject from the Midwives' Institute, and from the Committees of the British Lying-in Hospital, the City of London Lying-in Hospital, the General Lying-in Hospital, and Queen Charlotte's Lying-in Hospital were considered at the same time; also a letter on the same subject from Dr. H. Scurfield, Medical Officer of Health for Sheffield.

The Board agreed that the Privy Council be asked to approve the addition of the following words to Rule E. 26:—

"Provided that a midwife whose name has been admitted to the roll in virtue of having passed the examination of the Central Midwives Board, or in virtue of a qualification under Section 2 of the Midwives Act, 1902, acquired by passing an examination in midwifery, may add the words 'by examination' after the words 'certificated midwife.'"

Letters were read from the Master and the Hon. Secretary of the Coombe Hospital, Dublin, submitting for the observations of the Board certain rules and regulations adopted by the Board of the hospital with respect to the training of pupil midwives.

The recommendation of the Committee was adopted —(*a*) That the Board of the Coombe Hospital be referred to the public Press for the results of the Board's examinations; (*b*) that, subject to the foregoing, the Board express general approval of the rules.

A letter had been received from a registered medical practitioner complaining of the conduct of a certified midwife, but the Board replied that the midwife did not appear to have infringed any of the rules.

The next meeting was fixed for March 19th, at 2.45 p.m.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 16th, 1908.

AMENORRHŒA OF LACTATION.

IF opinions touching the influence of menstruation on the secretion of milk and on the infant vary considerably, the majority of authors, at least, are agreed in considering amenorrhœa of lactation as the most natural, most frequent physiological law. Statistics, however, published within the last few years, seem to affirm that half of the women menstruate during nursing. In presence of this proportion, one might ask if a law presenting so many exceptions could be in reality a law, or if the law itself should not, on the contrary, be considered as an exception. Some years ago Gilliet, basing his opinion on the fact that he found that the nurses who menstruated during lactation were those who seemed to enjoy the best health, affirmed that amenorrhœa was the exception, and the return of the menses a normal and physiological fact. Essen-Muller and Gallard went so far as to suggest that in the interest of the infant nurses who menstruated regularly should be preferred.

Jacob established statistics to prove that the frequency of cases of menstruation diminished with the number of periods of lactation, and that amenorrhœa was the rule after the third period; but other statistics published by Hell and Ponsoyve would seem to show that amenorrhœa was only absolute after the fifth period of nursing.

This decrease in frequency is both interesting and significant. It is generally admitted that the multipara realises the most perfect type of nurse. Consequently the best nurse is the woman in whom amenorrhœa is the rule.

Tuberculous Cystitis.

Tuberculous cystitis requires prompt treatment on account of its gravity. Medical treatment should be first tried and addressed to the tuberculous diathesis—country air, rest, cod-liver oil, creosote, cacodylate of soda:—

Creosote, 1 drop.
Iodoform, 1-3rd gr.
Arseniate of soda, 1-50th gr.
Ext. of opium, 1-5th gr.
For one pill. Three daily.

As local treatment, instillations of iodoform, 5 per cent.; guaiacol, 1—20; corrosive sublimate, 1—5,000 to 1—1,000; which Guyon considers the best treatment of tuberculous cystitis. Nitrate of silver should not be employed in the first stage of the disease, as it might provoke congestion of mucous membrane, and even hæmaturia. But in the second stage, or that of secondary infection, instillation of a solution of nitrate of silver gives, according to Le Fur, excellent results. Irrigation of the bladder is always counter-indicated on account of the extreme sensitiveness of the mucous membrane. When the general and local treatment fail, recourse might be had to surgical treatment. The bladder will be incised in the supra-pubic region, and the granulations removed by the curette and the superficial ulcerations cauterised with the thermo-cautery.

In cases where the tuberculous ulcerations are consecutive to tuberculosis of a kidney, the removal of this organ completely cured the vesical disease, proving the intimate relation between renal and vesical tuberculosis.

Treatment of Vomiting.

Hydrochlorate of cocain }
Hydrochlorate of morphia, } āā ½ gr.
Lime water, 4 oz.
A tablespoonful every hour.

Or

Antipyrine, 30 gr.
Hydroch. of cocain, 1 gr.
Syrup of orange, 6 oz.

Tincture of iodine is frequently used in the vomiting of pregnancy.

Tincture of iodine, }
Chloroform, } āā 1 dr.
Five drops every half hour, up to 15 drops.

It can be associated with spirits of chloroform.

Tincture of iodine, 30 drops.
Spirits of chloroform, 1 dr.
Water, 4 oz.

In cancer or ulcer of the stomach, vomiting is frequent and provoked by the pain produced by the contact of the food with the ulcerated mucous membrane.

Rest in such cases is of the first necessity, no solid food being allowed, while alkalines in large doses will allay the pain.

Bicarb. of soda, 15 gr.
Calcined magnesia, 30 gr.
Prepared chalk, 10 gr.
Sub-nitrate of bismuth, 10 gr.
Lactose, 15 gr.
Codeine, 1-5 gr.
For one powder; two or three daily

Periodic vomiting coming on suddenly without any apparent cause is best treated by lemonade, bromides, belladona, opium, valerian, and revulsion in the form of the icebag to the pit of the stomach, mustard, and blisters.

An enema of a quart of physiological serum repeated twice or three times daily frequently arrests the vomiting of pregnancy.

GERMANY.

Berlin, Feb. 16th, 1908.

At the meeting of the Medinische Gesellschaft, Hr. Immelmann stated that he was in a position to confirm statements put forward by some observers that after RÖNTGEN ILLUMINATION the mucous secretion in cases of bronchitis became thinner. He had therefore made use of the X-rays in cases of chronic bronchitis, in both children and adults, and those who suffered from asthmatic troubles. Improvement had taken place very quickly, after even one or two sittings. He had not been able to make use of the treatment in acute cases.

Hr. Levy-Dorn had also seen improvement in such cases, but not in all. He attributed the effect to suggestion. He had put the apparatus in action without submitting the patients to the rays. In three cases this had no effect, and then the rays were actually applied. Improvement took place in one of the cases, but it was a question whether the strengthening of the suggestion did not play a part.

Hr. L. Casper spoke on RECURRENCES OF PAPILLOMA OF THE BLADDER

His remarks were based on nine cases, some of them his own; others were cases operated on by other surgeons. In all these tumours no malignant constituents were found, but it must not be concluded from this that no malignant germs were present. As all the tumours were operated on long before, some of them years, even, they were not to be looked on as malignant. Taken strictly, they were not local recurrences, as they did not occupy the site of the original tumour, they were not in their cicatrices, but elsewhere. They grew rather rapidly, in some months, and sprang up in a fungus-like manner from the whole interior of the bladder, so that the whole of this underwent papillomatous degeneration. From this behaviour it was a natural thought that there was some connection between the operation (sectio alta, which was the operation made use of in all the cases), and the rapid growth of the recurrent disease.

Amongst the 92 papillomata he had seen there were many muliple tumours, but never such extensive growths as after sectio alta. This confirmed him in his supposition.

That anything was left behind at the operation was excluded by the names of the operators. Transmission of the papilloma to the healthy mucous membrane was more likely, analogous to the experimental observation that warts were transmitted to healthy surfaces from other warts through inoculation with some irritating material. But this assumption was as unsafe as that which attributed the recurrence to vestiges of malignant disease left behind at the first operation. That a benign tumour could occasionally set up metastases could not be denied altogether, although it was a rare occurrence, and contradicted our ideas of the benignancy of tumours. "Metaplasation" of benign tumours was more readily conceived when they had a malignant germ in their deeper parts, and this was rendered mobile by the operation.

In the speaker's opinion the sectio alta was only to be employed when unconditionally called for, as experience taught that papillomata could remain in the bladder for 20 years, that their presence was not a matter of indifference, however, numerous examples showed, hæmorrhage, limitation of space, infection of the bladder, and malignant metaplasias were the dangers that threatened the patient suffering from papilloma of the bladder. It was therefore not possible simply to leave every papilloma to itself. Nitze had shown the proper way of removing them. This consisted in their intravesical removal, which the speaker reinforced by the injection of a strong solution of resorcin into the bases of the growths and their immediate neighbourhood. He had treated 65 cases in this way. There were recurrences—he had observed them 16 times—but they were never so extensive as after the sectio alta.

If the tumours had a very broad base, there was nothing for it but the high operation, with subsequent resorcin treatment. But the operation must be reserved for the exceptions. To get at the exceptional cases early diagnosis was necessary. When bleeding from an uncertain source took place from the bladder, therefore, the cystoscope should be used at once. The danger of hæmorrhage in intravesical removals was but slight. One way of seeing whether the tumour was malignant or not was to lift up the tumour with a loop under the guidance of the cystoscope; if the surrounding part of the bladder wall was not infiltrated it was shiny and translucent; if so, it was clouded and indurated.

Hr. J. Israel agreed, on the whole, with the speaker, but demanded more statistics before he would reject the high operation. Recurrences always took place when at the operation very small papillomata were seen, sometimes only with a lateral light, and after close looking for. These might possibly be excited to more rapid growth after operation. Some observations had taught him that the connection between papilloma and malignant disease was very close, although papillomata must undoubtedly be reckoned as benign. Twice in cases of cancer of the kidney he had seen papilloma at the openings of the ureters. One patient with papilloma of the pelvis of the kidney came back a year later with papilloma of the bladder, but died a short time afterwards from carcinomatous metastases in the internal organs.

He would operate intravesically if the tumour could be easily reached, and was not too large, otherwise he would remove by the high operation.

AUSTRIA.

Vienna, Feb. 16th, 1908.

SYPHILIS.

AT the Gesellschaft, Menzel presented a patient with a primary sore in the left nasal cavity, which had existed four weeks. Associated with this was the maculose exanthemata and multiple swollen glands. No other primary sore could be discovered over the body. The bacilli spirochæta were found in number in a small portion scratched off the sore. The virus seems to have been conveyed by the finger boring in the nose.

Ehrmann said he had several of the cases where the initial sclerosis or chancre commenced in the nose, but all of them ended in severe syphilis of the brain. Chiari thought the initial sclerosis was more common in the pharynx.

Lang said he had frequently met with primary sores on the head. He had also one on the lower jaw from the extraction of a tooth by which the virus had been conveyed. This case finally ended in dementia two years after the infection. He thought these cases had the nerves infected that carried the disease more readily to the higher centres. The hæmogenic theory was not excluded even in these cases, but the results seem to be more virulent in these cases than in those regularly infected about the genitals.

Nobl could not admit that these primary sores were different on the head and face from the extra-genital. It was true that fewer glands were affected, and that the virus would pass directly into the membranes and centres of the brain more readily; but if this were so we should have a larger number of such deaths, as a very large number of these cases are to be met with in everyday practice. He thought the subject was worth pursuing further, but nothing definite could be established with our present knowledge of the disease.

RUPTURE OF INTESTINES.

Föderl presented a case on which he had operated for a suspected rupture. The young man had received a kick from a horse, but the symptoms were not of such a nature as to convince the attendant that a rupture had taken place. It was decided to operate, and a rent in the small intestine discovered. He appealed to his colleagues, from this example, never to hesitate to operate where any suspicion remained after an injury to the abdomen of this kind. The only symptoms in this case were pain and tense contractions of the musculi recti.

As a contrast, he brought forward another case of perforation from peritonitis arising in the first place from an ulcer of the stomach. After describing his method of operation and the happy result, he said the mortality average was very high, being 66 per cent. The results are less affected by the method than the condition of the patient, the intensity of the peritonitis, and the extent of the operation. The virulence of the germ will greatly influence the prognosis. Eiselsberg's maxim of strengthening the patient is a good one, but how is this to be accomplished when the lesion is in the very organ that provides the strength. Lorenz prefers a gastrostomy fistula in the first place, and feed below the ulcer, or perform a jejunostomy with the ulcer after Eiselsberg's method. In the case brought forward both of these methods were impracticable. After opening the stomach, a long tube was inserted into the duodenum, and the patient fed for some time in this way till the strength recovered.

ACNE NECROTICA.

Spiegler showed a patient on whose face were large cicatrices, some white and smooth, others red or darkly pigmented. The disease seemed to be of a chronic nature, and belonged to the class of acne necrotica. Sulphur preparations seem to give the best results.

CEREBRO-SPINALIS EPIDEMICA.

Alt read a paper on meningitis cerebro-spinalis, which had become epidemic this winter, and had produced a considerable amount of permanent deafness owing to the purulent inflammation. He has had 50 cases where the auditory organs had been completely or partially destroyed. He showed microscopic preparations to demonstrate the changes, and agreed with Trolstch that the purpulent infiltration of the ependyma of the fourth ventricle, where the acoustic nerve is embedded, was the cause of the permanent deafness. He affirmed that the deafness was sometimes the first symptom, the facial nerve from its anatomical relations is little affected as it is more influenced by the local pressure. The vestibular nerve and its terminal branches suffer most, and hence the unsteady gait of the patient during the first week of the disease. Gradually the patient learns to steady himself by the other senses, but the younger the patient the longer the co-ordinating disturbance lasts. In young children, more than a year elapses before the child can walk steady. In older persons six months suffice, but it is difficult to account for the severity in some cases where the physical signs are but trifling, while in others the symptoms may be very severe, and little or no disturbance in co-ordination or hearing. The best form of treatment is large doses of iodide.

JAMAICA.

Kingstown, Jan. 1908.

THE latitude and longitude of Jamaica are still the same, and the climate has not changed more than that of other parts of the world are said to have changed; and yet this island, once looked upon as the graveyard of every European who landed on its shores, the home of the terrible "Yellow Jack," has become the health resort of thousands of Americans and others who annually visit it in the pursuit of health, or to escape the rigours or inconveniences of their own countries. Most of the writers on this really beautiful island, "the Queen of the Antilles," as it has been justly called, have contented themselves in describing the beauties of the island and the charms of its varied climates. I write "varied climates," for such, indeed, is the case; but these writers have never attempted to explain, so far as I have seen, the reason why Jamaica has been discovered to possess such health-giving powers. Before, however, attempting to advance a reason for this change, I must say a few words on the "varied climates" of the island, for this is a most important factor for those seeking the island in pursuit of health. From the torrid heat of the lowlands to the cool and bracing air of the Blue Mountains, whose highest peak reaches over 7,000 ft. above the sea, there is a constant change of climate. On the slopes of the mountains close to the sea one gets the sea and land breezes—the former known as "The Doctor." In the central parts of the island among the mountains there is a climate at once delightful and exhilarating. All that the visitor has to do is not to expose himself to the direct rays of the sun in the hottest part of the day, and to avoid being out as much as possible during the night, so as to escape the heavy dews, which, while they encourage the luxuriant tropical vegetation, are also the producers of rheumatic and catarrhal affections. These precautions being adopted, and another to which I shall now draw attention, will, I hope, show that there is no reason why Jamaica and the other West Indian islands should not be as healthful places of residence as any other parts of the world.

To describe the other point to which reference has been made, I must have recourse to the "Journal" of Lady Nugent, whose husband was once Governor of the Island. The "Journal" was written just a hundred years ago, and although it lacks the charm of those interesting character sketches which renders the reading of Pepys' and other diarists so delightful, it yet contains a very good account of the manners and customs of the people at the time it was written. From her account of the breakfasts and dinners in vogue at the time, it cannot be doubted that the excessive eating and drinking then indulged in were responsible for the sick and terrible death rates of the period. I cannot do better than give an account of a dinner in Lady Nugent's own words:—"Our dinner, at 6, was really so profuse that it is worth describing. The first course was entirely of fish, excepting jerked hog, in the centre, which is a way of dressing it by the Maroons. There was also a black crab pepper-pot, for which I asked the recipe. It is as follows:—A capon stewed down, a large piece of beef and another of ham, also stewed to a jelly; then six dozen of land crabs, picked fine, with their eggs and fat, onions, peppers, ochra, sweet herbs, and other vegetables of the country, cut small; and this, well stewed, makes black crab pepper-pot. The second course was of turtle, mutton, beef, turkey, goose, ducks, chickens, capons, ham, tongue, crab patties, etc., etc., etc. The third course was composed of sweets and fruits of all kinds. I was really sicker than usual at seeing such a profusion of eatables, and rejoiced to get to my own room, and, after my usual levee of black and brown ladies, to go to bed." Further on she says:—"I don't wonder now at the fever the people suffer from here—such eating and drinking I never saw; such loads of all sorts of high, rich, and seasoned things, and really gallons of wine and mixed liquors as they drink! I observed some of the party to-day eat of late breakfasts as if they had never eaten before—a dish of tea, another of coffee, a bumper of claret, another large one of hock-negus; then Madeira, sangaree, hot and cold meat, stews and fries; hot and cold fish, pickled and plain; peppers, ginger sweetmeats, acid fruit. sweet jellies—in short, it was all as astonishing as it was disgusting." "Mr. M.'s delight is to stuff his guests, and I should think it would be quite a triumph to him to hear of a fever or apoplexy, in consequence of his good cheer."

Apropos of the drinking habits of the times, I recently expressed surprise to a lady from Barbadoes at the size of the dining and drawing-rooms, and fewness of bedrooms in Jamaica and in the other islands. "Oh," she said, "bedrooms were not necessary, as the gentlemen were supposed to sleep under the tables." No wonder, with all this feasting, that estates bringing in a yearly income of £30,000 were heavily mortgaged, and that the death-rate was proportionally large. The immorality of the period, where one owner of several estates had a large coloured family on each of them, must also be taken into account. A more rational mode of living has therefore been the chief factor in the improved healthfulness of Jamaica and in human longevity.

The returns of the Registrar-General show that there are as many old people in the island as in supposed more favoured countries. For the year ending March, 1906, there were 187 deaths registered of people of 95 years of age and upwards. The one exception to this improved longevity is to be found in the infant mortality, but this is not the effect of climate so much as morality. With an illegitimate birth-rate of 65.2 per cent., it is not surprising that the death-rate of children under one year was 29.2 per cent., and 44.4 per cent. under five years. This is an important fact—that the death-rate of the parish of Manchester is 8.65 per cent. for legitimate, and 18.23 for illegitimate children, and this condition of things holds good for the other parishes of the island. Under the present conditions it seems almost impossible to prevent this fearful mortality among the negro races. Few of these people, comparatively speaking, marry till they have a family of groomsmen and bridesmaids to take part in the marriage ceremony of their parents. It is no uncommon thing to come across a woman who has had children by other men married to a man by whom she has had children before they were married. I was once present when an infant about a year old was shown to a medical man who had been for some years in practice in the island. The child had an enormous tense belly, swollen legs, with large blebs on the legs and instep. I asked what was the matter. "Worms," was the reply. A powder containing santonin and jalap was given, and the medical man informed me that the children crawl about the yards round the huts and eat all the garbage that comes in their way, and that from his experience worms were the cause and santonin the cure, and that in most cases it was always safe to administer a dose of that drug. Under such conditions is it wonderful that the infantile mortality is so terrible, nearly half of the children dying before they are five years old. It must not be thought that the authorities are blind to this fearful state of things, for the island spends £60,000 a year on so-called education, and it is to be hoped that eventually some good will result.

Very comfortable steamers are run by the Imperial Direct West India Mail Service between Bristol and Jamaica at stated periods and at moderate cost, whilst tourists going to the island who do not happen to have friends there can obtain comfortable accommodation at the Constant Spring Hotel.

LETTERS TO THE EDITOR.

CHRISTIAN SCIENCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is unfortunately impossible to examine into the nature and claims of the cult which Mr. Dixon represents without wounding the susceptibilities of its ardent and sincere votaries of whom no doubt he is one; and it is remarkable that he does not recognise this, and refrain from charging his critics with "ostentatious discourtesy" when they employ the language alone fitted to meet the case. There exists neither cause nor place for spiteful feelings in this discussion. With the theology of Christian Science we have nothing to do, save in so far as it is bound up in the question of the cure of disease by miracle; and with this I dealt in my last letter. In common with all Christian Science literature Mr. Dixon's writings are so vague that it is difficult to discover any tangible statement to take hold of. He seems to imply that because our knowledge of Nature is limited, we are to disregard the solid facts of natural science, and look upon disease with eyes of mediæval mysticism. Our knowledge of the qualities of matter and force is incomplete, and our knowledge of pathology has its limitations, but this does not prevent us from recognising and dealing effectually with many of the gross concrete phenomena of disease. For example we cannot at present perhaps trace finally the primeval evolution of the itch insect or the tapeworm; but we know that we can by medical means destroy and expel these parasites from the system, and so put an end to the symptoms to which they give rise. We have proved our power here by experiment repeated ten thousand times with the same result. We call the knowledge gained by such experiment and observation, science. Itch insects and tapeworms are very tangible objects; but they are not really more tangible than the poisons which give origin to a vast number of diseases, although these poisons may not be demonstrable, except with the use of the microscope and by methods of minute investigation.

Many of the diseases to which these poisons give rise are amenable to medical treatment. We therefore do not believe "that disease can only be radically cured by Divine power casting out errors of human sense," "and that to trust implicitly in Divine power is to be cured of physical disease." This was the explanation of the claims of Christian Science given at the inquest this week by the practitioner in charge of the case. The treatment was daily prayer by the practitioner, and the patient was required to "put his trust in God." The efficacy of such treatment could be believed in only by those who, like this Christian Science practitioner, "had not studied medicine, and had never made any pretence to do so." Is it not evident that the wide acceptance of such teachings must lead to a vast increase in the amount of human pain and misery; and is it not the duty of the profession to strive to make plain to the public the real character of such anti-scientific and pernicious nonsense?

I am, Sir, yours truly,
HENRY SEWILL.

February 12th, 1908.

THE NATIONAL TELEPHONE COMPANY AND MEDICAL MEN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As you doubtless know, the National Telephone Company, whose monopoly will expire in two years, have lately issued a new scale of rates for their subscribers. I have heard two explanations offered for the changes they have made, one being that these changes are due to the Post Office authorities, the other that they are due to the desire of the company to acquire the last pound of flesh from their subscribers before finally leaving them. According to the new scale, there are two sets of rates which apply to subscribers in towns. The first applies to "business places and residences," and the second "to residences only." The most important feature of the first rate is that it grants 500 calls for a sum of £6 a year—that is to say, each call costs the subscriber a very small fraction under 3d. The most important feature of the second rate is that it grants an unlimited number of calls for £8 a year.

As you, Sir, also doubtless know, the existing rate up to the present time is an unlimited number of calls for £10 a year.

Now, at first sight, the new arrangement seems to offer an advantage to the medical subscriber; but, Sir—and it is to this point I wish to draw your attention—"doctors' and dentists' residences and premises will be connected at the rates for business purposes only." The result of this is that in future, instead of obtaining an unlimited number of calls for £10, the medical subscriber will receive 500 calls for £6, and for another £4 he can purchase about 1,300 more calls, so enabling him to telephone on an average five times daily.

I would further point out that up to a few years ago medical men on the staff of a hospital were given the special rate of £8 10s. a year for an unlimited number of calls.

I venture to think that such a course of action on the part of a large semi-public body such as the National Telephone Company is not only most unjust to medical men, but is degrading to the company itself as the holders of a great public trust. It is nothing short of scandalous that medical men and dentists should be selected out of the large body of professional men to be told that their residences are "places of business," and must be treated accordingly, and I cannot understand how some of the several bodies who are supposed to look after the interests of medical men have failed up to this to make a protest. In the next place, even assuming, which I do not for a moment consider justifiable, that medical men must submit to such treatment, and may not be allowed the lower rate given to what the company considers "residences," why should their rates be raised, and why should an unlimited service be changed into a fixed service, averaging only five calls daily?

I am afraid the answer is only too obvious—the company know that medical men cannot dispense with the telephone, and they think that the various medical bodies will not bother about interfering in the matter.

May I venture, Sir, to express the hope that in this respect they will be disappointed, and that a vigorous and concerted effort will be made to force the company to recognise that medical men's houses are private residences? If you, Sir, in your influential journal will ventilate the matter, I am most hopeful of success.

In conclusion, may I point out that the new rates are causing universal discontent, and that, as I understand, Parliament is to be asked to appoint a Commission to inquire into them. The time, therefore, is most opportune for prompt action.

I am, Sir, yours truly,
AN OWNER OF A PRIVATE RESIDENCE ALTHOUGH A DOCTOR.

MEDICAL REGISTRATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is very desirable that practitioners should not lose the privileges attaching to registration owing to their names ceasing to appear in the *Medical Register*.

It has been found, however, that many practitioners, not fully appreciating this, especially within a short time of qualifying and registering, fail to give to this office from time to time an address at which official communications will reach them, and they thus incur the risk of their names not being retained on the *Register*. In the interests, therefore, of the practitioners themselves the enclosed notice has been drawn up. I shall be happy to supply you with further copies if they will be of service.

I am, Sir, yours truly,
H. E. ALLEN,
Registrar.

General Council of Medical Education
and Registration of the United Kingdom,
299, Oxford Street, London, W.,
January 31st, 1908.

[The notice quotes the sections of the Medical Act, 1858, referring to the keeping of the Registrar of the Council informed of change of address. It is most important that medical men should bear them in mind.—ED.]

THE FACIAL MUSCLES IN ACHONDROPLASIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. R. L. Jones, of the London Hospital Medical College, has very kindly sent me notes and careful measurements of the facial muscles in two achondroplasic fœtuses, and has compared his results with the condition found in a normal fœtus. His results do not bear out the suggestion made in my letter published last week—viz., that hypertrophy of the facial muscles may be a characteristic of achondroplasia. Mr. Jones' observations were made on specimens in the possession of Dr. Keith.

I am, Sir, yours truly,
A. FRANCIS DIXON.

Medical School, T.C.D., February 13th, 1908.

THE "TIMES" AND QUACK ADVERTISEMENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A leader on Saturday last in the *Times* contains the following passage:—"We must admit that the advertisement sheets of certain publications are continually made the vehicles of statements which can only be described as preposterous; and, frequently, as being false to the knowledge of those who make them. There are advertisers who undertake to make their customers shorter or taller, fatter or thinner, as they may desire, etc., etc."

Astonishing as it may seem it is evident that the editors of the *Times* are quite ignorant of the uses that are now being made of the advertising columns of their own paper. From day to day there are to be seen in the *Times* numbers of quack advertisements of the kind described in this leader. It is impossible they could find admission if the managers would ascertain their true character from one or other of the able medical writers, who, if not on the staff, are constant contributors of editorial matter. Further inquiry would surely convince the managers of the *Times* that the injury to the prestige of their great journal, caused by its descent from its former position of dominating superiority in every respect over all other papers, far outweighs the gain derivable from its present money-making methods. The managers of the *Times* have rendered it impossible for the editors to attack many of the most glaring abuses of the day without stultifying themselves, as on the present occasion, in a manner at once ludicrous and deplorable.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.
February 17th, 1908.

OBITUARY.

GEORGE BRAIDE, M.R.C.S., L.R.C.P.

It is with great regret that we have to announce the death of Dr. George Braide, which took place at Warrington. He had not been quite well for some weeks, but the end came with painful suddenness. Dr. Braide was only 42 years of age, having been born in Liverpool on November 16th, 1865, his father, Mr. Edward Braide, at the time being chief clerk on the London and North-Western Railway at Liverpool. He studied for the medical profession at Owens College, and on obtaining his qualification was appointed to the Manchester Royal Infirmary, afterwards acting as *locum tenens* at Urmston. He went as a ship's doctor for several voyages out to India, finally commencing practice, some 16 or 17 years ago, in Warrington. He secured the appointment of medical officer to the union workhouse. Among other appointments he held was that of medical officer to the Blue Coat School, also of the Warrington district of the London and North-Western Railway Company, and of two or three leading firms and insurance companies. He was held in high repute by his medical *confrères*, by whom his death is extremely regretted. He had passed the chair of the Warrington Medico-Ethical Society, which includes practically all the doctors in the town and district in its membership. Dr. Braide had a host of friends in the town and district, and by these, apart from his many clients, who always had the greatest confidence in his skill and judgment, his loss will be greatly felt and sincerely mourned.

CHARLES ARTHUR AIKIN, F.R.C.S.

We regret to announce the death of Mr. Charles Arthur Aikin, F.R.C.S. He was the only son of Charles Rochemont Aikin, M.R.C.S., by a daughter of Gilbert Wakefield, the well-known scholar, and was born in London in 1821. He was educated at University College School and Guy's Hospital, and he became a qualified medical man on the eve of his 21st birthday. He settled in the district known as Tyburnia, and soon formed a large practice on the north side of the park, where he made many friends, who valued him, deservedly, both for his professional and his personal qualities. In 1858 the Royal College of Surgeons honoured him with its Fellowship. Mr. Aikin retired from practice at about the age of 70, and, after some years more in London, spent the last few years of his life at his sons' residence in North Wales, where he died on Tuesday the 11th inst. His widow and four of his six children survive him.

WILLIAM HENRY REAN, M.D., ST. AND.

We regret to record that Surgeon-General William Henry Rean died at his residence in Oxford Gardens, W., on February 6th, aged 81. He was one of the first pupils of Sir Isaac Pitman, and he used the then new system of shorthand when attending his hospital lectures. After qualifying, he was house surgeon at the Middlesex Hospital, and entered the East India Company's service by competition in 1853, in which year he went to India. In 1857 he served with the Madras Fusiliers in the attempted relief of Cawnpore, and was medical officer on board the small river steamer *Bramaputra*, which was despatched up-stream from Allahabad, and arrived at Cawnpore shortly after the massacre. After the Mutiny he served as senior medical officer in the Andaman Islands for nine years, which position he held when Lord Mayo was assassinated. Before he retired, in 1881, after 33 years' service in India, he was Deputy Surgeon-General at Kampti. In 20 years of retirement, in spite of his long and arduous services in the East, he enjoyed perfect health until December last, when he contracted the sudden illness which prevented him from joining the recent *reunion* of his comrades in the Albert Hall.

REVIEWS OF BOOKS.

FRENCH'S LABORATORY METHODS. (a)

We are glad to find that our prophesy has been fulfilled. We declared that French's "Laboratory Methods" would run through many editions. It is now, after the lapse of two years, in its second. This was only to be expected. The book, though written by one who is comparatively a junior in the profession, is the handiest guide to clinical methods with which we are acquainted. All others are too large and pretentious. The one before us contains all that the average student or practitioner requires for the needs of actual practice. The improvements in the present edition are evident. Much of the text is new, and many new methods have been introduced. A word of warning to the author may be necessary. We trust he will never be tempted to increase the bulk of the volume.

His chapters on the examination of the blood and of the stomach contents are the clearest and simplest expositions the reader can ever hope to meet with. The author's personal work in connection with the examination of the blood is well recognised, and he certainly writes very ably on this particular subject. Many of the illustrations in the book are new, and the coloured ones are specially noteworthy. The binding and also the paper used in the production of this edition are an improvement on the former one. The author and his publishers alike are to be congratulated on the appearance of the second edition of a guide to laboratory methods which is at once a model of neatness and of practical utility.

LIFE ASSURANCE AND GENERAL PRACTICE. (b)

There is at the present moment certainly room for a book dealing with the medical examination of life assurance candidates. The modern developments of life assurance have necessarily entailed changes in the medical aspects of lives, besides the greater experience now accumulated by medical officers to assurance companies and actuaries. The old elaborate forms are giving way to simpler and more practical ones, and the office which teases the life out of its candidates by irritating questions is likely to have fewer and fewer proposers. At the same time we cannot commend the departure of some offices in abrogating medical examination altogether, and applicants under such a scheme are not probably aware that, when their life value is guessed at the office must leave the margin of doubt in its favour. The object, then, of a modern company should be to devise a simple, straightforward scheme which, in the hands of reliable examiners, fixes on the important points. How far does the work before us help the medical practitioner to meet these conditions? On the whole, it is not pedantic and fussy, and that is a great point in its favour, but, on the other hand, it is a little thin and unsatisfying. There is not enough definite information in it to make a standard book, and its value lies more in suggestiveness than in actual pabulum. The difficult questions that one would like to see discussed are skimmed over, and though the author does not commit himself to rash statements, he seldom helps us by authoritative ones. The relation of alcohol to life assurance is talked round rather than tackled; heredity and gout the same. The chapter on syphilis is much better, and those on tuberculosis and the circulatory system are certainly helpful. Albuminuria, the *bête noire* of assurance work, really should have been treated fairly and squarely in a book dealing with this special class of work, and the methods and conditions necessary for exact diagnosis of the origin and significance discussed and described. We are disappointed, too, that so little information as to the assessment of faulty lives is given, and to find no real assurance questions, such as the differentiation of lives according to the suitability under the several tables, discussed. As a handbook to practitioners unaccustomed to this class of work it may be of value.

(a) "Medical Laboratory Methods and Tests." By Herbert French M.A., M.D.Oxon., F.R.C.P.Lond., Assistant Physician Guy's Hospital &c. Second Edition. Pp. viii, 168. With 29 coloured and 59 other illustrations. Crown 8vo. Leather, gilt top. Price 5s. net. London: Bailliere, Tindall and Cox. 1908.

(b) "Life Assurance and General Practice." By E. M. Brockbank, M.D (Vict..)., M.R.C.P., Hon. Assistant Physician, Royal Infirmary, Manchester. London: Henry Frowde and Hodder and Stoughton. 1908.

DISEASES OF THE GENITO-URINARY ORGANS AND THE KIDNEY. (*a*)

WE have perused the pages of this volume with very great pleasure and profit, as it gives a very concise idea of the various diseased conditions of the kidney and genito-urinary tract as studied by the general practitioner and surgeon in the present day. The work runs to 520 pages, with a very copious index, and the subjects treated are divided into thirty chapters, and also contains 292 well-executed illustrations. In the opening chapters much valuable information regarding the general examination of patients is given, as well as practical hints on the subject of endoscopy, cystoscopy, and catheterisation of the ureters. The writers state they do not profess that the book is complete, but it is the conjoint product and effort of a surgeon and a practising physician, and it is thus intended that equal attention should be devoted to both medical and surgical aspects of genito-urinary diseases. Anyone anxious to devote attention to this special branch of surgery will do well to purchase this work.

A MANUAL OF SURGERY. (*b*)

THE author states that this work has been prepared for the undergraduate whose crowded hours demand a manual stripped of verbiage and un-essentials, and for the medical practitioner who seeks a guide to present-day surgery. He further adds his chief desire has been to set down concisely and completely those facts which the student must know, and to make such suggestions in diagnosis and treatment as will best aid the physician in his daily practice, and the aim throughout has been to be brief and practical. The subjects are treated, as a rule, in a thoroughly practical manner, but owing to the anxiety to be brief, and to keep the size of the volume within reasonable dimensions, a few subjects get but a sketchy notice. The work is divided into 31 chapters, and the illustrations, numbering over 500, are very good. To students preparing for an examination this work would no doubt be found to be very useful, and all information given is quite up-to-date.

SQUINT AND OCULAR PARALYSIS. (*c*)

THIS book is the outcome of the author's experience extended over some years, and the attempt, as he tells us in the preface, "to bring into line and compare some of the best practical teaching of the English and foreign schools." Without going very deeply into the subject he nevertheless presents us with a concise and practical description of the various muscular defects of the eye, together with the treatment of the same. Upon the management of convergent strabismus, by orthoptic exercises, he has much to say which is to the point, and if operative treatment is required in children he holds that it is preferable to wait until they are nine or ten years of age. In the section devoted to ocular paralysis, the anatomy and physiology of the extrinsic muscles is discussed fully, and afterwards chapters follow "on general symptomatology of ocular paralysis," and the "etiology, prognosis, and treatment." Heterophoria and heterotropia are subsequently dealt with, and the work concludes with an appendix, descriptive of the use of Rémy's diploscope. The book is one which will be read with interest by all to whom the subject appeals.

MEDICAL JURISPRUDENCE. (*a*)

WE welcome the second edition of Dr. Fred. J. Smith's "Lectures on Medical Jurisprudence," and congratulate the author on having found an appreciative "public." Although in no sense a substitute for the ponderous tomes on the subject, this work will amply supply the ordinary student with all he needs before "facing the music" on the Embankment, and, moreover, he will find the instruction pleasantly conveyed in a chatty and taking manner. Three new lectures appear in this edition, "The Examination of the Person Alive and Dead," "Anæsthetics," and "Death Certification." The question of anæsthetics is much to the fore just now, and Dr. Smith is able to give some excellent suggestions to practitioners who have the misfortune to find themselves before the coroner. We regret that the author has not found room for a few "leading cases," but in a handbook of the dimensions of the one before us we can hardly expect it. It is a common-sense book written by a practical man.

LABORATORY NOTES.

BROMURAL.

MESSRS. KNOLL AND CO. are bringing forward a sedative and mild hypnotic in Bromural. This drug is a bromide of the Valerian group (monobromisovalerianyl-urea). It is obtained by combining urea with bromide of bromino-valerianyl, and stands in its action between the bromides and valerian preparations on the one side, and the hypnotics, such as trional and veronal on the other. Bromural exists in the form of white, almost tasteless, needle-like crystals, which are soluble in hot water, ether, alcohol and alkalies, but with difficulty in cold water. Its melting-point lies at 146° C. Experiments on animals have shown that with very large doses of Bromural it is possible to obtain even deep sleep-producing effects without in any way affecting either circulation or respiration. The sedative and hypnotic action is said to be due, not to the presence of bromine, for the latter does not become split off from it in the organism, but to the isopropyl group contained in the valerianic acid. The action of this group is further intensified by the binding up of the carboxyl group by means of urea and by the introduction of a halogen atom into the methylene group. Bromural is not to cause stupor, but dreamless sleep from which the patient awakes fresh and invigorated. All action by Bromural ceases after from three to five hours, probably on account of its rapid decomposition and elimination by the organism. Bromural is indicated in the difficulty of falling asleep which accompanies some of the milder forms of nervous disturbance, such as hysteria and neurasthenia, and cases where the alkaline bromides cannot be borne or where their action is not sufficiently powerful. It does not produce the desired effect in sleeplessness accompanying organic disease, conditions of worry and excitement occurring at night, hallucinations, and so on.

(*a*) "Diseases of the Genito-Urinary Organs and the Kidney." By Robert Holmes Greene, A.M., M.D., Professor of Genito-Urinary Surgery, Medical Department of Fordham University, &c., and Harlow Brooks, M.D., Assistant Professor of Pathological Anatomy, University and Bellevue Hospital Medical School, New York City. Pp. 536. 292 illustrations. Philadelphia and London: W. B. Saunders Company. 1907.

(*b*) "A Manual of Surgery for Students and Physicians." By Francis T. Stewart, M.D., Professor of Surgery, Philadelphia Polyclinic: Associate in Surgery, Jefferson Medical College, &c. Pp. 778, and 504 illustrations. London: Rebman, Ltd. 1907.

(*c*) "Squint and Ocular Paralysis, with a short account of the Disturbances of Muscle Balance." By G. Lucas Hughes, M.R.C.S., L.R.C.P.Lond. Illustrated by the Author. London: H. K. Lewis, 1907.

(*a*) "Lectures on Medical Jurisprudence and Toxicology." By Fred. J. Smith, M.A., M.D.Oxon., F.R.C.P., F.R.C.S., Physician and Lecturer on Forensic Medicine at the London Hospital. Second Edition London: J. and A. Churchill. 1908.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Multiple Primary Carcinoma.—McConnell reports (*Journal of Medical Research*, July, 1907) a case which he regards as one of primary carcinoma occurring at several sites at the same time. The patient was an aged female, and, according to the clinical history, she developed simultaneously ulcers of the upper lip and of the wrist. Some months later a similar ulcer developed on the cheek. Death occurred, and at the autopsy it was established that the ulcers were epitheliomatous in nature, the structure being that of an ordinary epithelioma with plentiful cell-nests. At the autopsy also it was discovered that there were several ulcers in the stomach, while the gastric glands were enlarged, and tumours were present in the liver. The histology of this group of lesions presented some difficulty, and doubts existed as to whether the condition was one of sarcoma or of carcinoma. If the latter, was it primary in the stomach, or secondary in the tumour of the lip? The microscopic appearance, while not contradicting it, failed to give support to the last suggestion. No trace was found in the gastric or hepatic growths of squamous epithelial structure. There was no formation of nests, there were no epithelial pearls, and no horny degeneration was found. The author, therefore, inclines to the belief that the condition of the stomach was primary, and had no direct relation with the superficial tumours. He believes also that it was carcinomatous rather than sarcomatous in nature. It is interesting to note that the patient exhibited also a fibroid of the uterus. R.

Rhabdomyoma of the Heart.—Wolbach (*Journal of Medical Research*, July, 1907) adds a case of rhabdomyoma of the heart to the very small number of cases already recorded. This makes, according to the reporter, only the twelfth authentic case. These tumours are always congenital, and are associated with general mal-nutrition. The subject of the present report was a child of ten months. The heart was very large, and in the right ventricle, below the posterior segment of the pulmonary valve, was the tumour, spherical in shape, and 1.7 centimetres in diameter. It was attached to, or rather growing from, one of the papillary muscles. Histologically its structure was identical with that of other specimens described, the cells presenting the greatest variations in size, and many of them exhibiting marked vacuolation. This vacuolation is so extreme as to give the tumour a sponge-like appearance when seen under the low power. A very curious, if not unique condition, of the meninges of the brain and spinal cord was discovered. Scattered on the inside of the dura mater, particularly in the cervical cord, but occurring in other regions of the cord and also over the brain, were enormous numbers of small discrete nests of neuroglia tissue. They were quite separate from the cord, and the reporter does not believe that they originated therefrom. He can find no recorded instance of a similar condition. In many of the other cases of congenital rhabdomyoma there was present diffuse cerebral sclerosis; this was absent in the present case. The paper is enriched by excellent microphotographs, and the histology of the tumours is described in great detail. R.

Sarcoma of the Appendix.—Carwardine (*British Medical Journal*, December 21st, 1907) reports a case of sarcoma of the vermiform appendix, a condition of which he can only find two previous cases recorded. He can only find the histories of 42 instances of primary malignant disease of the appendix, and, of these, 37 were carcinoma. In the present case, at operation, the appendix was discovered to be some 3½ inches long, and as thick as one's thumb. It broke with a carrot-like fracture. Microscopically, it consisted of round cells, with little inter-cellular reticulum. The proof that the tumour was primary is hardly complete, as the patient died some nine months later with a large tumour of the ovary. R.

The Speed of Phagocytosis.—Walker (*Journal of Medical Research*, July, 1907) points out a source of error in the usual method of determining the opsonic index, which had not, we think, previously been noticed. In the technique used by Wright, and by most of those who follow him—and they are the majority of opsonic workers—equal proportions of bacteria, of washed leucocytes, and of blood serum, are mixed and incubated for a definite time—usually 15 or 20 minutes. The degree of phagocytosis is assumed to depend on the degree of sensitisation of the bacteria by the opsonins, and if the rate of sensitisation or opsonisation is slow, extending over the period of incubation allowed, then, with a thin suspension of bacteria, we might expect phagocytic indices proportional to the amount of opsonins present. On the other hand, if sensitisation takes place rapidly, and is completed within the first few minutes of the incubation period, the phagocytosis should be complete in all the preparations in the given time, and all the indices should be equal. Moreover, if too few bacteria are present to satisfy all the opsonins of the stronger serum, the weaker one being satisfied, then errors of all degrees should be possible. It was easy to show by experiment that sensitisation was completed very rapidly, and the author discovered that one minute gave as complete sensitisation as 20 minutes. He next investigated whether, if the bacterial suspension contained fewer germs than the opsonin of either serum was able to sensitise, the result would be that each serum would give the same index, bring suspensions of bacteria of graded strengths, and sera, of which one was a half-strength dilution of the other, he found that the phagocytic average increased with each serum equally up to a certain point in the graded series of emulsion, the average being proportional to the number of bacteria in the emulsion. Beyond that point, and presumably where the quantity of bacteria was as great as the opsonins could sensitise, the phagocytic averages were in their proper proportion of 2 to 1. Walker has therefore established that it is necessary to make sure that the bacterial emulsion is sufficiently dense to exhaust the opsonins, or the result will be entirely untrustworthy. R.

The Origin of Rodent Ulcer.—Noon (*Journal of Pathology and Bacteriology*, October, 1907) publishes some observations on the site of origin of rodent ulcer. For long there has been debate as to the nature of rodent ulcer, and the cells from which it originates. Some regard it as a tumour of the hair-follicle, others as a tumour of the sweat glands; while another hypothesis, ignored by Noon, is that it is an endothelioma. Noon, in some of his specimens, was able to trace a definite connection of the tumour with the Malpighian layer of the epidermis, near the neck of the hair-follicle, and with the reflection of this layer which constitutes the outer root sheath. In other cases, however, of clinical rodent ulcer he found an intimate connection with the sweat glands; and it was hard to avoid the conclusion that he was dealing with a carcinoma of the sweat glands. He suggests, therefore, that there may be two pathological entities—epithelioma of the Malpighian layer and carcinoma of the sweat glands—which are grouped together under the clinical term—rodent ulcer. The paper is well illustrated, and the histological descriptions are clear.

Polyarthritis Acuta Nodosa.—Dickson (*Journal of Pathology and Bacteriology*, October, 1907) reports a case of this very rare disease, with a study of the reported cases. The disease is characterised by wasting illness of a couple of months' duration, nervous excitation, followed by semi-coma, being a marked symptom. Pathologically, the typical lesion is a nodule growing on the coats of the small and medium-sized arteries throughout the body. These nodules are due to localised inflammatory, destructive, and proliferative changes in the vessel wall, the most important change being the complete destruction of small areas of the muscular coat. Nothing is known of the cause, but the presumption is in favour of its being a toxin of some sort. Dickson can find no previous case recorded in Great Britain. R.

Secretin and Pro-Secretin in Diabetes.—Bainbridge and Beddard report the result of their observations on diabetic patients (*Guy's Hosp. Reports*, Vol. LXI., p. 161). These observations were directed towards the elucidation of two points:—(1) To determine whether pro-secretin was deficient in the duodenal mucous membrane of patients who died from diabetes, and (2) to determine the influence of secretin administered as a drug in the glycosuria of diabetes. The first series of experiments were carried out with an acid extract of the duodenal mucous membrane of six diabetics, and of nine patients who died from other diseases, the extract being tested by intravenous injection into anæsthetised cats and dogs. The result was most remarkable, as it showed that in five of the diabetics pro-secretin was either absent or present in very small quantities, as compared with the amount present in non-diabetic cases. Pro-secretin was, however, present in normal quantity in one case, and also in a cat a fortnight after excision of the pancreas. That its absence in the five cases was not due merely to acid intoxication seems proved by the fact that artificial acidæmia in a rabbit did not diminish the pro-secretin at all. The second point was investigated by careful observation of the carbohydrate metabolism of three diabetic patients treated by secretin. The drug was given at first subcutaneously, and later by the mouth, and the conclusion arrived at was that the administration of secretin by the mouth had no influence whatever upon the output of sugar in the urine. As, however, Starling has shown that secretin is not absorbed when introduced into the alimentary canal of animals, the writers think that further observations on its subcutaneous administration are desirable. The objection, however, to these is that they are attended by considerable pain. They believe that the results previously reported by Moore were to be attributed more to dieting than to drugs. The same authors have also investigated the livers, blood and muscles of diabetic patients and of depancreatised cats to ascertain whether they possess the normal diastatic ferments, and have found them present in every case. M.

Tetany Associated with Dilatation of the Large Intestine in Children.—Langmead (*Trans. Clin. Soc.*, Vol. XL., page 67) calls attention to a clinical syndrome met with in children, and consisting of the following group of symptoms:—(1) Obstinate relapsing tetany; (2) abdominal distension; (3) offensive, unhealthy motions; (4) a dilated large intestine, as verified by post-mortem, or by laparotomy. He reports four such cases, in two of which the dilatation of the large intestine was general, in one it was limited to the sigmoid flexure, and in the fourth to the transverse colon. He considers that these cases throw some light on the general etiology of tetany, as in each of them considerable toxæmia must have been present, due to absorption from the fermenting fæcal material. Improvement resulted when the bowel was washed out, and also when thyroid gland was administered by the mouth. This last fact suggests that perhaps normally intestinal toxins are absorbed and then neutralised by the thyroid or para-thyroid secretion, and that it is only when they are generated in great abundance that this neutralisation cannot take place, and that tetany results. As a contributing factor, also, there was present in the four cases prolonged malnutrition, a condition which would obviously render the body more susceptible to the influence of a circulatory toxin. M.

Relation of the Pancreas to Diabetes.—Thoinet and Delamere have investigated the pancreas in seven cases of diabetes, with the object of determining which of the current theories deserves most credence (*Arch. de Méd. Expérim. et d'Anat. Pathol.*, 1907, No. 2). These theories are—(1) That diabetes is due to a primary or secondary insufficiency of the cell-islets of Langerhans; (2) that it results from acinar insufficiency. The authors state that they have found most varied changes in the structure of the pancreas, which they group as follows—(1) Interstitial cirrhosis, which spared equally the acini and the cell-islets; (2) interstitial cirrhosis, which involved equally the acini and the islets; (3) in no case was there any special destruction of Langerhans' cells; (4) in some cases both interstitial overgrowth and acinar destruction were present, with special escape of Langerhans' cells. As a result of these observations the writers conclude that it is impossible at present to attribute diabetes to the destruction of any special part of the pancreas. M.

The Relation of the Kidneys to Metabolism.—Bainbridge and Beddard have repeated the experiments of Rose Bradford on the kidneys with the object of determining what effect these organs exert on general metabolism, and more particularly to ascertain whether Bradford's conclusion that they furnished an internal secretion was justified or not (*Guy's Hosp. Reports*, Vol. LXI., p. 149). The experiments were carried out on cats, three of which survived excision of one entire kidney and about two-thirds of the other for several days. Their conclusions are as follows:—(1) Removal of three-quarters or more of the total kidney weight in cats is followed by loss of appetite, wasting and death within a few days or weeks; (2) in such cats an increased output of nitrogen is not of constant occurrence, but is found only in animals that have lost 22 per cent. or more of their initial body weight; (3) this increase of nitrogen output is therefore to be regarded merely as the result of inanition, and is of the same nature as that observed in starving animals; (4) after removal of part of one kidney, and subsequent removal of the opposite kidney, cats are still able to pass a concentrated urine, and the amount of the urine is not necessarily increased beyond the normal. M.

MEDICAL NEWS IN BRIEF.

Visit of the British Association to Dublin.

THE following have been elected by the Council of the British Association to be Presidents of Sections at the meeting of the British Association which is to be held in Dublin in September under the presidency of Mr. Francis Darwin, F.R.S.:—

Section A (Mathematical and Physical Science).—Dr. W. N. Shaw, Director of the Meteorological Office. Section B (Chemistry).—Prof. F. S. Kipping, Nottingham. Section C (Geology).—Prof. J. Joly, Dublin. Section D (Zoology).—Dr. S. F. Harmer, Cambridge. Section E (Geography).—Major E. H. Hills. Section F (Economic Science and Statistics).—Lord Brassey. Section G (Engineering).—Mr. Dugald Clerk. Section H (Anthropology).—Prof. W. Ridgeway, Cambridge. Section I (Physiology).—Dr. John Scott Haldane, Oxford. Section K (Botany).—Dr. F. F. Blackman, Leeds. Section L (Educational Science).—Prof. L. C. Miall, Leeds.

The University of Sheffield.

THE Council of the University have appointed Mr. John L. Annan, M.B., Ch.B.Edin., to the post of Demonstrator in Anatomy. Mr. Annan is at present Demonstrator of Anatomy in the University of Edinburgh, and House Physician in the skin wards of the Edinburgh Royal Infirmary; and to the newly-instituted Clinical Tutorships:—Mr. Miles H. Phillips, M.B., B.S.Lond., F.R.C.S.Eng., Obstetrics and Gynæcology; Mr. Graham Simpson, F.R.C.S.Eng., Surgery; Mr. A. E. Barnes, M.B.Lond., M.R.C.P., Medicine. Mr. Phillips is the Assistant Medical Officer at the Jessop Hospital for Women, and Mr. Simpson Assistant Surgeon at the Sheffield Royal Hospital. Mr. Barnes holds a British Medical Association Research Scholarship, and is at present engaged in research in the Pathological Laboratory of the University.

A Baron M.D.

BARON BRUNO VON HOHNFELDT, M.D., alias Chris. J. Hughes, aged 59, described as a doctor of medicine, living at Star Street, Edgware Road, was charged on a warrant, before Mr. Plowden, with attempting to obtain charitable contributions from Mr. Arthur F. G. Leveson-Gower, of 31 Gloucester Place, Portman Square, with intent to defraud.

The accused, a well-dressed man of gentlemanly appearance, wore a dark, heavy moustache, and carried a silk hat and a pair of kid gloves.

Mr. Plowden inquired if he really were a baron, and he replied that he was.

Detective-Sergeant Draper proved the arrest of the prisoner in Star Street, and stated that when told the charge, he said he had done nothing for which to be arrested.

Mr. Arthur Leveson-Gower stated that in December last he received a letter from a "Mr. Hughes," apparently a medical man, saying that he had in a hospital he was attending a patient named Mr. Edmund Banbury, who had been with him (Mr. Leveson-Gower) at Christ Church, Oxford, and had fallen on bad times. The writer than went on to suggest that the witness should help him in his charitable efforts on Mr. Banbury's behalf. Mr. Leveson-Gower said he consulted a friend about the letter, and subsequently saw Mr. Banbury himself, with the result that a warrant was obtained for the prisoner's arrest. Mr. Banbury, he added, was an acquaintance of his at Christ Church.

Mr. Edmund Banbury, who resides at 16 Hans Place, S.W., was then called, and disclaimed all knowledge of the prisoner.

Other evidence was given that the prisoner arranged for letters to be received on his behalf at a shop in Arlington Road, Camden Town.

Detective-Sergeant Draper said that he found upon the prisoner a memo. bearing a number of names, including that of Mr. Banbury.

Asked as to the prisoner's history, Sergeant Draper stated that he had just completed a term of three years' penal servitude, and before that he suffered four years' penal servitude and a term of twelve months for burglary.

Contaminated Milk.

THE Medical Officer of Health for the City (Dr. Collingridge), in a recent report to the Corporation, states that a further investigation into the condition of the milk arriving in London from the country has just been completed in continuation of four similar inquiries instituted between 1902 and 1906. Twenty-four samples of milk were taken, on delivery at Liverpool Street Station, and submitted to Dr. Klein, F.R.S., for bacteriological examination. Of these, 54.2 per cent. were fairly clean, 8.3 tuberculous, and 37.5 dirty and unsatisfactory. Those results strongly emphasised the extremely unsatisfactory way in which the milk trade was conducted. Two samples containing the tubercle bacillus, and capable of causing tuberculosis in the human being, came from cows suffering from tuberculosis. Practically no precautions were taken either by farmers or by wholesale dealers in London to ensure that their milk was not a vehicle for the conveyance of tuberculosis. As to the samples reported to be impure and dirty, they were accounted for by the dirty condition of the sheds and premises where the cows were kept and the milk stored. The real method of dealing with the milk question was at the actual source—the farm—and there was no real difficulty in getting this effectually carried out on the spot by the local authority. In any case of default by a local authority the Board of Agriculture should take action and charge all expenses incurred against such authority. Other factors conduced to the unwholesome state of the milk on its arrival in London—such as the system of mixing at the railway stations.—*Times.*

The National Maternity Hospital, Dublin.

THE annual meeting of this hospital was held during the past week. The report stated that in the short space of twelve years this hospital has grown to be the third in size in the United Kingdom. The large outlay on the new wing has completely exhausted all the resources of the hospital, which has to depend entirely on the public for support. This wing, which was opened on December 18th, 1906, gave 40 additional beds for the accommodation of patients, as well as rooms for students and nurses. The new operating theatre now being finished will be as fully and efficiently equipped as any in the United Kingdom. The outlay connected with the erection and equipment of the new wing has amounted to £4,000. The expenditure of this large sum has completely exhausted the resources of the institution, but the necessity of this improvement was so urgent that the governors felt it their duty to carry out the improvements, trusting to the generosity of the public to recognise the merits and claims of the hospital. The report was adopted, and also a resolution calling for support for the hospital.

Royal University of Ireland.

AT a meeting of the Senate, held on February 6th, the following medical appointments were made:—

Fellow: A. E. Dixon, M.D., Professor of Chemistry, Queen's College, Cork. Medicine: James A. Lindsay, M.A., M.D.; Joseph F. O'Carroll, M.D. Surgery: Thomas Sinclair, M.D., M.Ch. Pathology: Edmond J. McWeeney, M.A., M.D.; A. E. Moore, M.B., B.Ch., B.A.O.; W. St. Clair Symmers, M.B. Midwifery: Sir John W. Byers, M.A., M.D., M.A.O.; Alfred J. Smith, M.B., M.Ch., M.A.O. Medical Jurisprudence: Patrick T. O'Sullivan, M.D. Materia Medica: Martin Dempsey, M.D.; Sir William Whitla, M.A., M.D. Ophthalmology: Arthur W. Sandford, M.D., M.Ch.; Louis Werner, M.B.; Phrenology: T. H. Milroy, M.D. Diploma in Public Health: Sir Charles Cameron, C.B., M.D.

It was ordered that a meeting of Convocation be summoned for Tuesday, May 12th, at 4 o'clock p.m., to fill the five vacancies which will then have arisen on the Senate amongst the members elected by Convocation.

Conjoint Examination in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

The following candidates have passed the Final Professional Examination, February, 1908:—

P. Blake, W. H. Bomford, F. P. Byrne, T. Fehily, M. J. Glancy, R. de S. B. Herrick, P. J. Holmes, J. Humphreys, P. MacCarthy, J. V. O'Hagan, W. H. O'Riordan, J. R. Talbot.

The following candidates have passed the Diploma in Public Health, February, 1908:—

Martha Adams, M.B., Robert Muschamp, L.R.C.P. and S.Edin., John James Scanlan, L.R.C.P. and S.Edin.

Royal College of Surgeons in Ireland.—Dental Examination.

THE following candidates, having passed the necessary examination, have been admitted Licentiates in Dental Surgery of the College:—Mr. A. E. Weinstock and Mr. B. Wilson. The following passed the Primary part of the examination:—Mr. M. Keogh and Mr. S. R. Macnamara.

IT is announced that the Oxford University Press will publish immediately the Fitz-Patrick Lectures, delivered before the Royal College of Physicians of London by Dr. Norman Moore, under the title "The History of the Study of Medicine in the British Isles." The first of the lectures treats of medical study in London during the Middle Ages; the second deals with the education of physicians in London in the 17th century; and in the third and fourth lectures the history is told of the study of clinical medicine in the British Isles. The volume contains numerous illustrations.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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A Labour Delegate.—We are still puzzling over your effusion. Is it funny? or what? In any case, we cannot publish anything unauthenticated.

L. D. (Bradford).—We have duly forwarded your letter to the Incorporated Institute of Hygiene.

Meetings of the Societies, Lectures, &c.

Wednesday, February 19th.

Royal Microscopical Society (20, Hanover Square, W.).—8 p.m.: Mr. C. L. Curties and Mr. J. E. Barnard: Exhibitions of Slides and Lamp. Mr. E. M. Nelson: Eye-pieces for the Microscope. Rev. E. Tozer: The Life History of a New Protophyte. Mr. F. Chapman: On Dimorphism in the Recent Foraminifer, Alveolina Boscii.

Royal College of Surgeons of England.—5 p.m.: Prof. V. Bonney: A Study of the Connective Tissues in Carcinoma and in certain Pathological Conditions preceding its Onset. (Hunterian Lecture.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. Mackenzie: The Nature of the Symptoms in Heart Failure.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr R. P. Brooks).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

Thursday, February 20th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. T. W. Eden: The Examination of Pregnant Women before Labour.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture:—Mr. W. Edmunds: Surgical Aneurysm.

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Syphilis as it Modifies other Eruptions of the Skin: Symptoms, Diagnosis, and Treatment.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Still: Dyspepsia in Children past the Period of Infancy.

Throat Hospital (Golden Square, W.).—5.30 p.m.: Mr. Rose: Intra-Cranial Complications—Treatment.

Friday, February 21st.

Society of Tropical Medicine and Hygiene (20, Hanover Square, W.).—8.30 p.m.: Fleet-Surgeon P. W. Bassett-Smith: Kala Azar in the Royal Navy (with illustrative cases). Sir Patrick Manson: A Case of Kala Azar ending in Recovery. Dr. J. Cropper: Phenomenal Abundance of Malarial Parasites in the Peripheral Circulation from a Case of Pernicious Malaria in the Jordan Valley.

Society for the Study of Disease in Children (11, Chandos Street, Cavendish Square, W.).—5 p.m.: Dr. G. Carpenter, Dr. E. Cautley, Dr. Whipham, Dr. P. Parkinson, Mr. G. Pernet, Mr. M. Yearsley, Mr. S. Stephenson, and others: Cases. Mr. H. S. Clogg: A Case of Intestinal Obstruction, Resection of a Foot of Gangrenous Intestine, Recovery.

Royal College of Surgeons of England.—5 p.m.: Prof. V. Bonney: A Study of the Connective Tissues in Carcinoma and in certain Pathological Conditions preceding its Onset. (Hunterian Lecture.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. A. Lawson: Clinique. (Eye.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. G. French: Subjective Noises in the Head.

Monday, February 24th.

Royal College of Surgeons of England.—5 p.m.: Prof. Donald Armour: The Surgery of the Spinal Cord and its Membranes.

Royal Society of Medicine (Odontological Section) (20 Hanover Square, W).—8 p.m.: Mr. J. E. Spiller: A Casual Communication, "The Dental Uses of Paraform.". Mr. W. J. Law: Paper:—"Some Investigations of the Nerves in the Teeth of Mammalia" (Illustrated by Epidiascope and Microscopes). Discussion (Adjourned) on Mr. J. F. Colyer's Paper: "The Treatment of Children from a Dental Aspect"

Appointments.

Chisolm, R. A., M.B., B.S.Oxon., Assistant Physician to the North-Eastern Hospital for Children, Hackney Road, Bethnal Green.

Creswell, A. H., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the Cinderford District of the county of Gloucester.

Hall, George, M.D.Lond., B.Sc.Durh., M.R.C.P.Lond., Honorary Pathologist to the Royal Victoria Infirmary, Newcastle-on-Tyne.

Hawes, Ivon Henry Skipwith, M.B., B.S.Durh., Medical Officer and Public Vaccinator for the No. 4 District of the Chipping Sodbury (Gloucestershire).

Hughes, Robert, M.B.Lond., Medical Officer to the School Management Committee, Fenton, Staffordshire.

Morgan, David James, M.D., B.C.Cantab., D.P.H.R.C.P.S., Medical Officer of Health of the County Borough of Swansea.

Race, John Percy, L.R.C.P.Lond., M.R.C.S., L.S.A., Assistant Medical Officer at the Joint Counties Asylum, Carmarthen.

Revie, A., M.B., C.M.Glasg., Certifying Surgeon under the Factory and Workshop Act for the works of Messrs. Grant, Ritchie, and Co., Limited, at Kilmarnock, in the county of Ayr.

Webb, Gilbert L., M.B., B.C.Cantab., Resident Medical Officer at the British Lying-in Hospital.

Vacancies.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

Kent County Asylum, Maidstone.—Male Fourth Assistant Medical Officer. Salary, £175 per annum, with furnished quarters, attendance, coals, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

Catholic University School of Medicine.—The Chair of Medical Jurisprudence and Hygiene. Applications to the Registrar, Medical School, Cecilia Street, Dublin. (See advt.)

Joint Counties Lunatic Asylum, Carmarthen.—Second Assistant Medical Officer. Salary, £160 per annum, with board, lodging, washing, and attendance. Applications to W. Morgan Griffiths, Solicitor, Clerk to the Visitors, Carmarthen.

Nottinghamshire Education Committee.—School Medical Officer. Salary, £300 per annum and travelling expenses. Applications to H. Handford, M.D., County Medical Officer of Health, The Shire Hall, Nottingham.

Metropolitan Hospital, Kingsland Road, N.E.—Casualty Officer. Salary, £150 per annum. Applications to Charles H Byers, Secretary and House Governor.

Royal College of Surgeons of England.—Examiner in Dental Surgery. Application to the Secretary. (See Advt.)

Norfolk County Council.—Medical Officer of Health. Salary, £500 a year. Applications to G. Christopher Davies, Clerk to the Norfolk County Council, The Shirehouse, Norwich.

Barnsley Hall Asylum, Bromsgrove, Worcestershire.—Second Assistant Medical Officer. Salary, £150 per annum, with furnished quarters, board, washing, and attendance. Applications to the Medical Superintendent.

Births.

Hedley.—On Feb. 13th, at 56 Hans Place, London, to Dr. and Mrs. Edward Hedley, a daughter.

Phillips.—On Feb. 16th, at 88 The Avenue, Ealing, the wife of George Phillips, M.D., of a daughter.

Yunge-Bateman.—On Feb. 15th, at 15 Castle-hill-avenue, Folkestone, the wife of Marcus G. Yunge-Bateman, M.R.C.S., of a son.

Marriages.

Heath—Addison.—On Feb. 14th, at St. Paul's Church, Avenue Road, Regent's Park, Philip Maynard Heath, M.S., F.R.C.S. son of the late Christopher Heath, LL.D., F.R.C.S., to Dorothy Mary Rosamund, only daughter of Joseph Addison, of 76, Avenue Road, London.

Deaths.

Gandy.—On Feb. 13th, at Hill Top, Upper Norwood, Surrey, William Gandy, M.R.C.S.Eng., L.S.A., Surgeon-Colonel 2nd V.B. East Surrey Regiment, Divisional Surgeon, Metropolitan Police, aged 67.

McDonald.—On Feb. 14th, Emma McDonald, of 19 Palliser Court, relict of Alexander McDonald, M.D., Fleet Surgeon, R.N., Blane medallist.

Penn.—On Feb. 15th, at 13 Eardley Crescent, London, Agnes, widow of the late William Cecil Penn, M.R.C.S., L.S.A., aged 68.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, FEB. 26, 1908. No. 9.

NOTES AND COMMENTS.

Lord Lister's Birth Place.

West Ham is a district which does not savour very sweetly in the public nostrils at the present moment, for reasons which are as regrettable as they are notorious. It is, however, most unfair to judge a district by the publicly-exposed faults of a few prominent rapacious scoundrels, and to those acquainted with the inwardness of public life, as represented by certain local bodies, it is no secret that the type of fault committed by the late West Ham Guardians is by no means unique. Moreover, West Ham has had peculiar difficulties to face in the construction of local government machinery, for probably no place has grown from a hamlet to a town with such extraordinary rapidity, nor had to accommodate a larger number of poor at such short notice. But we confess that we ourselves, in good company we have no doubt, did not know the great tradition which West Ham is heir to, a tradition which brings it at one bound to the rank of Stratford-on-Avon and Burnham Thorpe. It has remained for Dr. Pagenstecher to point out to the local Town Council that West Ham is the birth-place of the author of antisepsis, and we fancy that a hundred years hence the name Lister, which now has magic chiefly for foreigners, will be recognised by the people of this country as possessing virtue not less than is associated with those of Shakespeare and Nelson, and the flat, unromantic Essex town where he was born will be the object of pilgrimages no less reverent than those which once found their way to Canterbury and Rome. The house, then known as Upton House, where Lord Lister first saw light, is now St. Peter's Vicarage, and faces into Upton Lane, but eighty years ago it was doubtless as plentifully surrounded by trees and fields as it now is by rows of artisan dwellings and chimney-pots. But, thanks to Dr. Pagenstecher, the momentous event which it witnessed is to be commemorated by a tablet placed in its walls, and now that we do not believe in shrines that tablet should act as a lodestone to draw to it for veneration all those who have receeived the benefits which modern surgery is capable of conferring.

Crates for Cradles.

The Government's Children's Bill which we spoke of last week proposes, among other things, to tackle the question of what its draughtsmen are pleased to call "overlaying." Medical men generally will be as much in sympathy with the object of the provision as they will be out of sympathy with the literary solecism by which the offence is described. The confusion of the verbs "to lie" and "to lay" is, if we mistake not, primarily a Cockney, or South country, fault, though it has permeated to districts far removed from the kingdom of Cockaigne, but it is naturally regarded as a shibboleth that marks off certain sections of society from others. To find that the desire to prevent overlaying has so overlaid the intuitive perceptions of a Minister of State that he describes it as "overlaying," cannot but be a shock to the purist, and if this dreadful word finds its way to the Statute Book the error will be stereotyped for all time. The calamity—that is, the physical, not the literary one—admits of a simple remedy, namely, the provision of cots for children, and the financial problem that a cot presents to the poor mothers has been solved by a good lady in Newcastle, who points out that a banana crate, which can be bought for twopence, is capable of being made into an admirable cradle. The family which has nine months to ruminate on the forthcoming advent of an infant to its midst must be poor indeed if it cannot save that modest sum, and now that overlaying is to be made a criminal offence, the alcoholic mothers will be well advised to lay it by against the birth of their next baby.

A Princely Medical Benefaction.

It is not often that the means of medical men are so large, or their professional earnings so bountiful, that they are able to confer benefactions on their fellow creatures, and the good that they do charitably is generally confined to acts of personal service. The offer made by Dr. Henry Maudsley to the London County Council last week ,namely, the gift of £30,000 to found a hospital for acute mental patients, if not unique, must be very nearly so. And it is as enlightened as generous. Mental disease, if one may use the current phraseology, is still regarded by the public as a rare infliction which immediately qualifies the sufferer for segregation from society for the whole or the best part of his natural life. As a matter of fact, it is probably one of the commonest of the ordinary ailments, but as it masquerades under such euphemism as neurasthenia, nervous break-down, or over-strain, its frequency escapes observation. Correspondingly little attention is paid to it, and equally little provision is made for its treatment and study. Residence in a doctor's house, the doctor probably a busy man with many outside engagements, or a nursing-home, the proprietor of which may be kind, but is probably injudicious, enables the well-to-do to escape the "stigma" of an asylum, but the poor usually either stay at home till they commit suicide or drift into chronic disorder, or are consigned to the county asylum, where frequently but little machinery exists for their special requirements. Hospitals such as Dr. Maudsley suggests are badly needed, but it is a little curious that the County Council should have been chosen by him as the authority to administer the scheme. That body could at a stroke of the pen initiate such institutions to-morrow, with the wealth of the London rates at their back.

The Only Way. At the Manchester Assizes last week a very satisfactory result was arrived at. A civil action was brought by the wife of a Darwen weaver, Mrs. Johnson by name, against one, George Hall, of "Dr. Hall's Hygienic Company, Pendleton," for negligent treatment. Her case was simply this: She went to the defendant and consulted him as to a tumour in her breast, and he advised a certain medicine, telling her that an operation would not effect a cure. It was not alleged that the ointment did harm, but it was alleged that it did no good, and that in consequence of the bad advice given her she neglected to consult a surgeon, and that the tumour, which was small at the time of the consultation, had now become so large that surgical treatment was out of the question, and the patient's life could not be prolonged beyond six months or so. After a full trial, the plaintiff was awarded £600 damages, a verdict which gives us the greatest satisfaction. And for this reason: It shows that the machinery of the law as it stands is already capable of providing a powerful instrument against the quack, who by ignorance or mendacity promises more than he can perform. The quack relies upon untruth; he is not content to advise treatment, but promises cure. The medical man does precisely the opposite. Logically, the quack who promises a cure and does not perform it, cannot escape from the conclusion that he has obtained money by false pretences, and if by civil process it is possible for each disappointed patient to obtain heavy damages, the game would certainly not be worth the candle. The case of Mrs. Johnson is the first we remember which was strictly on this line of argument, and we can only hope it will be duly noted by all the disappointed dupes of quack machinations. If so, the knell of unqualified practice has tolled.

The R.C.S. and Members. In the House of Commons, Sir William Collins has obtained from the Prime Minister a statement as to the result of the negotiations undertaken by the Lord President of the Council with the College of Surgeons with a view to obtaining for members some share in the government of the College. The answers given in effect were that the Government sympathises with the members, but that the Council of the Royal College of Surgeons are not amenable to the arguments of reason and justice presented. We cannot but think that the haughty obstinacy in the Committee of the Council of the College could hardly be better shown than by the fact that independent statesmen express sympathy with the members in their desire to have a hand in the management of their own College; at least, the College which has taken their money and treats them as pariahs. But when we say pariahs, that perhaps is going rather farther than circumstances warrant, for the Olympians of Lincoln's Inn Fields have at last so far accepted the suggestion passed at the annual meeting of Fellows and members that women should be admitted to the examinations of the College, that they are about to circularise the members as to its desirability. It is carefully explained that the right of women to become members and Fellows will not admit them to the government of the College, and we think we see clearly now the object of the amenability of the Council to this suggestion. If the poll be in favour of women they will be admitted to the membership, and the question of sex will be made an additional argument against granting representation to members. The Council will be glad of the women's fees, and they will be in a strong position to refuse representation to members. This is excellent business, especially as they seem to be deferring to the sentiment of present members. We trust the fly will not walk into the parlour.

LEADING ARTICLES.

THE MIDWIVES ACT AND MEDICAL FEES.

The Central Midwives Board have at length recognised the inevitable necessity of making terms with the medical profession if the Act they are called upon to adminster is to become permanently successful. This conclusion has been forced upon them as the result of hard experience, and no longer comes, as it might have done long ago, as the graceful and sympathetic recognition of a bounden right. It is true that a thankless function has been thrust upon them, namely, that of instructing midwives to call in medical men in cases of difficulty and danger, while there is no security that the fees of the medical consultant will be paid. Worst of all, the very members of the medical profession who are thus expected to render help of crucial and inestimable value to unqualified women, have to a great extent been deprived by them of a lucrative branch of professional work. The medical profession, as a rule, is poor and struggling, yet it renders year by year an incalculable amount of gratuitous help to mankind. Of late, however, its patience has been sorely tried. Signs are not wanting that the bounteous spring of philanthropic beneficence which has hitherto issued so freely from the medical profession may be in future somewhat seriously curtailed. It is never safe to demand as a right that which men have acceded, however freely and gratuitously, as a favour. That axiomatic principle of social ethics might well be taken to heart by the Legislature, which appears to think it a perfectly natural and legitimate procedure to wring further gratuitous services from a poor profession that is already saddled with many unremunerated yet responsible burdens by the State. Mr. John Burns recently added a particularly obnoxious straw to the gross burden in the shape of a birth notification that is compulsory (under penalty) but is not paid for. If the President of the Local Government Board should by any chance wish to lessen the stigma attached to that unwise act he may to some limited extent do so by making provision for the adequate payment of medical men who are called upon to give personal services that, from the circumstances of the case, demand possibly the highest technical skill and responsibility that could devolve upon the medical practitioner. A short amending Act for that purpose will probably furnish the speediest and most direct way out of the difficulty, and in our opinion

Sir Campbell-Bannerman's Government could not perform an act of more gracious, if somewhat tardy, concession to a class of men whose rights they have treated in various instances with scant consideration. It will be impossible for the letter to the Privy Council which has been drafted by the President of the Central Midwives Board to pass unnoticed. The contents of that communication have not yet been made public, but enough is known to warrant the statement that it deals clearly and forcibly with the question of the payment of medical men called in by midwives, and the difficulties that exist in the working of the Act owing to the lack of such provision. It is to be hoped that the Privy Council will bring pressure on the Government to remedy a serious defect in the working of a measure that would otherwise be a source of unending bitterness and heart-searching throughout the kingdom. Unless the question of remuneration be settled, local authorities, midwives, and medical men will be in a constant turmoil of potential doubt, wrangling and recrimination. Upon an unstable basis of that kind no legislation could ever become permanently established. The flag of revolt has been formally raised already in some places, and the medical practitioners of a whole district have declined to go to the assistance of a midwife except for a large fee. It is all very well for Dr. Champneys to avow that he is not proud of the attitude of the large majority of his fellow members in the medical profession towards midwives: it was neither humane nor natural. The sentiment is sound, so far as it goes, but the President of the Midwives Board must not lose sight of the other side of the picture. Medical men have to live by the exercise of their profession, and it would be to demand the exercise of superhuman virtue to ask them to smile upon the midwives who are taking from their already exiguous incomes even that paying branch of midwifery which they had. Dr. Champneys, in presiding over the penal functions of the Board, must have had his eyes opened to the irregular medical practice performed by many licensed midwives, who are thus fulfilling to the letter the prophecy made long ago to deaf ears when the Act was in the making, to the effect that a bastard kind of unqualified practitioner would be created. The protection of the lives of our mothers and infants, Dr. Champneys rightly remarks, is, and should be, the first consideration of the medical and midwifery professions. Quite so, but in both cases the labourer is worthy of his hire, but it seems as if the Government appeared to think the midwife should have all the fees, while the medical man should be left to look after himself in the matter. Before the hybrid midwife appeared on the scene the humanity of the medical profession sufficed to meet the needs of the nation, and were rendered gratuitously to an extent that the British public has never realised. Now that the State has seen fit to substitute a lower order of skilled attendant in the shape of the certificated midwife, the duly qualified medical man is quite entitled to stand aloof and demand adequate remuneration when called in to supply the highly technical skill required to meet unusual or complicated cases. We wonder if those who were so clamorous for the higher education of midwives ever thought of the damage that would result to the skill of the medical practitioners through the lessened number of midwifery cases they would attend. After all, the presence of an army of midwives would never make up for the lessened standard of skill or for the straitened fortunes of the general medical practitioners of the United Kingdom.

THE AMALGAMATION OF THE HAMPSTEAD AND NORTH-WEST LONDON HOSPITALS.

THE amalgamation of the Hampstead General with the North-West London Hospital has taken place. The fact in itself marks the measure of a small event, but the issues involved have a great significance to the medical profession, the medical charities, and the public. Hampstead had, by the energy and philanthropy of its inhabitants, secured a small, but efficient, local hospital, for which the general practitioners of the district found no difficulty in providing a medical and surgical staff out of their own ranks. The institution, however, was not allowed to abide in peace, and we trust we are not using too strong an expression when we say it ultimately attained the unhappy position of a kind of Naboth's vineyard. The King Edward's Hospital Fund suggested that the Hampstead Hospital should have a staff of consulting surgeons and physicians. A suggestion of that kind comes with overwhelming force from an autocratic body like that of the Fund in question, which is backed with the bulk of the money available for the hospitals of London. Why they should assume the responsibility of practically wiping out the original medical staff of the Hampstead General is somewhat of a mystery. It certainly seems a very arrogant extension of authority on the part of a Fund, the primary object of which was generally assumed to be that of a judiciary trustee and administrator of public charitable money. Were there any appeal against the decisions of the Fund, were there any explicit or declared policy, were its councils composed of representative persons chosen from various ranks of society, there would be less hesitation in accepting the bureaucratic yoke which this Fund is placing upon the hospital world of London. As things go, the fortunes of many medical charities, as well as of members of their medical staff, are at the mercy of any faddist who happens for the moment to have a ruling voice in the policy of the King Edward's Fund. Not content with the change in staff of the Hampstead Hospital, the Fund further suggested amalgamation with the North-West London Hospital. The effect of this policy cannot be reassuring to the main body of the medical profession. The bitterness of class difference has been thrust upon them by an object lesson imposed by the exercise of forces that are absolutely out of touch with the life and aspirations of the general practitioner. The King Edward's Fund have in effect proclaimed to Hampstead that the medical men of the neighbourhood are not of sufficient skill to attend to hospital patients. The Fund can hardly wonder if their work does not in future flourish in the district of Hampstead, where so wanton and unnecessary a slight has been placed upon local practitioners. Were the medical men of the metropolis to rise in a body and protest against the unwarrantable interference of the King Edward's Fund their influence would speedily be felt. Why should not the King Edward's Fund be managed by a representative body like that of the Hospital Saturday Fund? The day of autocratic control of public funds has passed away, and the only methods that can permanently secure the public confidence in this country is that of representative government. The fact that the excellence of aim and the purity of administration of the King Edward's Fund are above suspicion does not excuse the violation of individual rights and the exercise of irresponsible and indeterminate executive powers. Medical men in the provinces will do well to be warned betimes by what is going on in London, and to see that the management of local medical charities does not drift into the hands of autocratic committees.

CURRENT TOPICS.

Influenza in Downing Street.

The atmosphere of the House of Commons, although carefully purified, appears to furnish an ideal foothold for the influenza germ, if we may judge from the huge number of members of Parliament who have from time to time been laid low by this twentieth century scourge. Perhaps, after all said and done, the House is no more a centre of infection than other large buildings where men do congregate, such as theatres, churches, and public halls. The repeated attacks to which Premiers have of late years been subjected, however, suggest that it would be well to look into the smaller environment of No. 10 Downing Street, their official residence. The well-known fact that the site occupies what was once marshy land, or swamp, in no way prevents the erection of a perfectly healthy dwelling on that particular spot. We presume that the Medical Department of the Local Government Board, if it be their duty to do so, have assured themselves that the subsoil drainage of the area is properly planned and efficient. Further, that the foundations of No. 10 Downing Street, are impermeable to damp and to emanations from the surrounding soil. Last, but not least, that Sir Campbell-Bannerman's official residence is fitted with the best modern systems of drainage and ventilation. We have little hesitation in asserting that although influenza may not be forefended by such an obviously simple and necessary line of defence, yet the risk of its invasion may be considerably lessened by a little timely sanitary precaution. Even at this stage of the influenza epidemic, after many years of loss and suffering, medical science is still completely baffled when it comes to the question of prevention or eradication.

Milk-blended Butter.

Last week a question in the House by Mr. O'Shaughnessy drew attention to the question of milk-blended butter. Under the Butter and Margarine Act of 1907 the Board of Agriculture is empowered to sanction the sale of milk-blended butter under various names. It was admitted by Sir E. Strachey that nineteen names had up to the present been officially sanctioned by the Board, and that amongst them was "Peark's Own." If, as appeared to be suggested by the question, butter is sold containing an undue proportion of water, the interests of the consumer demand some further revision of the Act. Butter is butter, and no article should be allowed to be sold under the name which does not conform to a reasonable standard article. Nor should substitutes be enabled to pass in an indirect way so as to mislead the customer under the guise of fancy names of a non-descriptive character. In our opinion, the nature of any butter substitute should be clearly stated on the attached wrapper or containing package, with the name and address of the vendor, and possibly also of the wholesale agent. There are large agricultural interests concerned in the maintenance of a good wholesome standard of butter, and under wise guidance a great national source of income could be rescued from the hands of foreign competitors.

The Salt Water Cure.

The *Pall Mall Gazette* recently gave a full account of the new sea-water cure. The discoverer, M. Quinton, like Pasteur, Curie, Röntgen, and other pioneers, is described as a scientist. The treatment is based upon the simple discovery that our blood and the blood of all living beings is merely sea-water, more or less distilled. Having been impressed with this fact, M. Quinton began to turn it to account for the benefit of humanity languishing for the want of those marine salts known to have so powerful an influence on health. The labours of seven years have enabled M. Quinton to produce his salt-water serum, called officially "plasma de Quinton." Remarkable results have, as we might have expected, flowed from the use of the plasma. Nearly all diseases seem amenable to it. Children in the last stages of pulmonary tuberculosis have shown improvement, even from the first dose; terrible cases of eczema seem to be conjured away as if by magic; and limbs covered with varicose ulcers that only seem fit to be amputated, come back to their normal flesh-tints after a month or six weeks' treatment; whilst we are further assured inactivity of the bowels is rectified by the treatment; not is there any reaction whatever. All these wonders, and a good many more, are described in the lengthy article from which we quote. The article ends with an appeal for £400 or £500 to equip a dispensary in London; and we need not doubt that before long a Quinton Cure establishment will be opened in this country. It will take its place by the side of such great institutions as "The Sandow" and the "Nauheim," which in their several ways are doing so much for the relief of diseases, the origin of which has been hitherto entirely unknown to scientific medicine, and of which the treatment has been in consequence so completely at fault. It is evident that scientists like M. Quinton will end by entirely destroying the *raison d'être* of the medical profession, which has been so largely and undeservedly superseded in every department once entirely its own.

Proposed Abolition of Guardians.

Clearly the interests of the medical profession are closely involved in the problem of Poor-law reform. That the present system is costly, cumbersome, antiquated, and open to abuses in various directions, may be assumed as a fairly well established basis of argument. Recent revelations as to the inner workings of certain London boards of guardians have greatly strengthened the hand of the reformer. So far as the metropolis is concerned, the proposals which will be laid shortly before the Poor-law Commission are stated to be of a drastic and far-reaching nature. Briefly, all boards of guardians will be abolished and their administration taken over by the borough councils, while all central duties will be performed by the London County Council and the City Corporation. The scheme includes transference to those two bodies of: (i.) The powers and duties of the guardians of the poor and the sick asylum district managers with respect to all local Poor-law services, including the maintenance of workhouses and infirmaries, casual wards, and outdoor relief. (ii.) Services of a municipal character, viz.: (1) Assessment, in the six cases where boards of guardians appoint assessment committees. (2) Registration of births, deaths, and marriages. (3) Vaccination. It is further proposed that the powers and duties of the Metropolitan Asylums Board, as regards infectious diseases, hospitals, ambulances, and other health services, should be transferred to the Council, together with the special schools and remand homes. The transference of the Asylums Board to a popularly representative Council is a step we have always advocated. All pauper asylums would also come under the central Poor-law authority for London. The scheme includes other important proposals, such as the care of the Poor-law children of the metropolis. Should it be accepted, it will mark a new departure in Poor-law administration, the effects of which must sooner or later be felt throughout the length and breadth of the United Kingdom.

Infant Mortality and the Public.

Encouraged by her success in rousing interest on the tuberculosis question in Ireland, Her Excellency the Countess of Aberdeen has now inaugurated a movement to lessen the high infant mortality which prevails in Dublin and other Irish towns. It is true this mortality is not as high as in many industrial centres of England, but, nevertheless, when one remembers how few manufactures there are in Dublin which employ married women, there is room for much improvement. The high mortality in Ireland is due almost entirely to ignorance, for the mothers, even in the poorest quarters, are, on the whole, kind and attentive to their children. Moreover, they have shown themselves willing to learn proper methods of caring for their children, when instruction is offered to them, and much good might be done by tactful health visitors. The Dublin authorities, in their apathy to all matters concerning the health of the city, are extremely unlikely to do anything on a proper scale in the matter, and consequently, unless private initiative steps in, present conditions will continue. At present, a series of public lectures on health subjects, oganised by Lady Aberdeen, is being given by various medical men and women, and special prominence is being given to matters relating to the care and welfare of the infant. While wishing every success to the movement, there is one point in regard to which we think some caution is necessary: the urging of the establishment of milk depôts for children. While it is advisable that good artificial food may be easy to obtain where breast-feeding is impossible, there is a danger that too much insistence on the virtues of pure milk depôts may tend to discourage mothers from nursing their children.

PERSONAL.

H.M. the Queen has been graciously pleased to accept the post of President of the Glasgow Maternity Hospital, whose new buildings will be opened next August.

As Grand Master of the German Knights of St. John, Prince Eitel Fritz, on February 20th, received the Tibetan explorer, Dr. von Lecoq, and pinned on his breast the gold medal for life-saving conferred on him by the British branch of the Order for the bravery he displayed in saving the life of Captain Sherer, a British officer, in the Karakorum Pass.

Dr. John L. Annan has been appointed Demonstrator of Anatomy to the University of Sheffield.

Dr. Archibald Leitch has been appointed investigator at the Caird Cancer Pavilion of the Dundee Royal Infirmary.

Dr. W. Lloyd Edwards has been appointed Medical Officer of Schools to the Barry Education Authority, at a salary of £250 a year.

The Lord Mayor presided yesterday at the annual general meeting of the Royal London Ophthalmic Hospital (Moorfields).

On Thursday, March 5th, a discussion on "The Treatment of Pneumonia" will be opened by Dr. Samuel West at the meeting of the Harveian Society of London, Stafford Rooms, Titchborne Street, W.

Dr. Wylie will read a paper on "Foul Breath—Its Cause and Treatment," at the next meeting of the West London Medico-Chirurgical Society at the West London Hospital, Hammersmith, W.

Dr. Athelstane Iliff Simey, Medical Registrar of the London Hospital, has been appointed Physician to Rugby School as from next August. Dr. Simey is himself an old Rugbeian.

The following gentlemen have been appointed "Clinical Tutors" at the University of Sheffield:—Dr. Miles Phillips, in Obstetrics and Gynæcology; Mr. Graham Simpson, in Surgery; and Dr. A. E. Barnes in Medicine.

We learn with great regret of the death of Professor Frühwald, the well-known Austrian Physician for Children's Diseases. Professor Frühwald's books were well-known in England and America.

Dr. Henry Campbell gave an address on "The Therapeutics of Diet" at the *conversazione* of the Therapeutical and Pharmacological Section of the Royal Society of Medicine held at the Apothecaries' Hall yesterday.

It is with the greatest regret—a feeling, we are sure, which will be shared by all medical men—that we learn that Mr. J. Hall-Edwards has had to have his left hand amputated as the result of persistent X-ray dermatitis. We cordially hope that the right hand will yield to medical treatment.

It is announced that Capt. Robert Markham Carter, Indian Medical Service, 36th Gifford's Horse, was slightly wounded in the left arm on February 20th at Chora.

A CLINICAL LECTURE

ON

THE TREATMENT OF PANNUS FOLLOWING TRACHOMA BY INOCULATING THE EYE WITH GONORRHŒAL PUS.

By **VILMOS GOLDZIEHER,**

Professor of Ophthalmology at the University of Budapest.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,—The treatment of pannus trachomatosus belongs to the most difficult tasks of practical ophthalmology. Pannus is the chief complication of trachoma, a complication that is much more serious than the original disease. The integrity of the cornea is one of the principal requirements of good vision. Therefore, to keep it intact or to repair its lost integrity is the spring of the whole trachoma-therapeutics.

It is true that many clinicians held the view that we need not separately interfere with the pannus, because the pannus vanishes, as consequence, if the trachoma, as cause, is rightly treated. This is the opinion of Prof. Arls, the founder of the Vienna school. He says that the pannus heals upon the treatment directed to the eyelids, and therefore it does not need separate treatment. Fuchs teaches that a fresh pannus disappears of itself through the proper treatment of the conjunctivæ; only an old pannus requires special treatment. According to my opinion, these statements are right only between very narrow limits; mostly just the very incipient stage of pannus requires a special treatment, because its further development can only then be stopped with some certainty. Nominally, according to my opinion, the pannus is not a specific product of trachoma, but sometimes it is provoked by the excessively irritating treating methods; it being then a keratitis superficialis vasculosa, which implicitly proceeds further, unless we discontinue the cauterisation of the conjunctivæ; and it disappears without any greater harm to the patient only in case of directing our attention upon the cornea. In such cases we may easily succeed in attaining an entire cure.

However, the treatment of an extensive pannus is ever a difficult task, because the malady is lengthy, obstinate, and it leads to the harmful infiltration of the corneal tissue. The complications are different; superficial ulcers, changes in the curvature, latent iritis, rise of intraocular pressure—shortly, such complications which require the whole art of a skilled oculist.

Amongst the effective methods I have to mention before all the surgical ones, foremost being the application of the galvano-cautery. This interference consists of cutting through every single blood vessel trespassing over the corneal limbus, with a fine glowing platinum sling; or, of the net of vessels were very dense, we cauterise the cornea arch-like parallel to the limbus. I have practised this method with special success, and had pretty good results therewith. However, this method is not only very delicate, but it requires patience and a skilled hand, too. Further on, in cases of a thick pannus, the interference must be repeated several times.

An older method than the galvano-cauterisation is the so-called *circumcisio corneæ*, which consists of the cutting out of the conjunctiva bulbi, a zone running parallel with the limbus. Therewith we do cut the vessels passing in the pannus, not only through, but also out, though only partially; and thus it can be hoped that their peripheral branches, the network of the pannus, become atrophied. Theoretically, only one objection could be brought up against the former operation—viz., the blood vessels of the pannus are connected most probably also with the sub-conjunctival blood vessels, and on this account the desired atrophy of the vessels does not take place. Otherwise, the uncertainty of the result of this procedure is shown by its unpopularity with oculists.

The insufficiency of internal and surgical medication in the severe cases of the so-called *pannus crassus* (carnosus, sarcomatosus) had induced some oculists at about the end of the last century to try the action of the jequirity decoction. Louis Wecker, a Paris oculist, had, by chance, learned that the decoction of the jequirity applied to the conjunctiva causes a violent, purulent fibrous inflammation, after the cessation of which the hyperæmic cornea clears up. This treatment has been widely employed, then; and sometimes good results were attained. I have employed the drug, at first among Hungarian oculists, through the courtesy of Dr. Wecker, and I could only confirm the favourable data given about the jequirity decoction by other oculists. Still, this method of treatment has been omitted, because, according to some oculists, the patients complained of bad consequences, probably from the reason that jequirity has been applied, not only against pannus crassus, but also against the initial stages of pannus. Nay, a few clinicians regarded the jequirity as a "panacea" which was useful in every form of keratitis vasculosa, and in every duskiness of the cornea. Such unjustified application of the jequirity has caused its falling out of favour with oculists on account of the many failures and disastrous consequences arising from its use.

In the latter years—owing to the investigations of Roemer, who succeeded in extracting the acting agent of the jequirity, namely, the abrin—the jequirity treatment came again into vogue. The abrin has the advantageous property of safety, being produced in four strengths, in opposition with the jequirity decoction, the action of which upon the conjunctiva has been pretty uncertain.

However, the application of abrin, too, proved to be unreliable in some cases. It is true that many cases of pannus have healed under its use; still, it seemed that the eye specialists were disappointed with it on account of the harm which arose from its application.

Now I turn to a long-forgotten, quite obsolete method, which can boast at least so much merit that the scientific explanation of the jequirital treatment rests on the successes attained with it. A good many decades ago, in the time when the so-called Egyptian eye inflammation caused a general terror in the time of the Napoleonic war, the doctors had made the experience that if a pannous bulb became blennorrhœic, as the consequence of a direct infection, the vessel-rich cornea not only bore the evil of the intensive purulency, but it even cleared up, too, after its cessation. The transparency of the cornea returned, and it became quite cleared up entirely; the visual power recurred. I do not doubt that—before this fact would have been utilised to therapeutical purposes—the doctors would have ample opportunity of making such observations, because the contagiousness of the Egyptian eye disease had not yet been known then—nay, a considerable number of doctors were inclined to ascribe it to external causes, like dust, heat, and tightly-tied necktie, etc. In this time infectious and non-infectious eye diseases were kept in the same ward, so that infection very easily occurred, thus the opportunity having been rendered to a pannous eye to catch a blennorrhœa and to regain the visual power after the cessation of this. Very probably, on ground of these (by chance) lucky cases, has Frederick Jaeger, the Surgeon-General of the Austro-Hungarian Army, a renowned oculist, regarded the inoculation of blennorrhœa in cases of obstinate pannus as ultimum refugium. As I could elicit from the then literature, Jaeger applied the method often and with marked success. His original communications on this subject appeared in 1870, but these are not obtainable now, to my great sorrow. However, I was successful in finding an epitome of a lecture which was held by Jaeger on this new treatment.

Here I found the following quotation:—"If a case of trachoma terminates unfavourably, with a pannus remaining behind, and when everything that is available has already been tried, nominally ***aqua oxymiriatica***, opiates, regulation of the diet, etc., and the disease is confined to the conjunctivæ, and the internal parts of the eye are devoid of any irritation, then it is advisable to inoculate the eye with the secretion of the lippitudo (blennorrhœa) neonatorum After the cessation of blennorrhœic process, the conjunctiva regains its normal form and function."

It has to be remarked that what Jaeger says, in the last sentence quoted, of the conjunctiva, *i.e.*, that it regains its form and functions, refers to the cornea, because he reckons that the most anterior part of the cornea, in relation to where the pannus exists, is the conjunctiva, which assumption is quite correct and justified from an embryological point of view.

A pupil of Jaeger, T. F. Piringer, chief oculist in Graz (Tyrol), wrote very plentifully on the subject. He is the author of the monograph, "Die Heilung des Pannus dirrch Einimpfung der Blenorrhoe" (the healing of the pannus through inoculation of blennorrhœa). In this book he describes every phase of a blennorrhœic infection, the whereabouts of the infecting agent, its nature and the manner to destroy it. His sayings are based on experiments carried out on human eyes. The ***résume*** of this work is that the inoculation of blennorrhœa for the cure of pannus is as effective a method, as it is devoid of any essential risk on the part of the patient.

From ophthalmological literature I gather that the method has been successfully practised in different countries. Chiefly, the Belgian oculists have declared it "worthy of every praise." As regards Austria, the native country of the method, here we find brilliant names among the friends and followers of the method—Arlt, Stellwag. Arlt says the following in his bulky manual on eye disease:—"Relying on Jaeger's, and particularly on Piringer's statement, I applied the inoculation method in hopeless cases of pannus. In the three cases in which I have done so I had nothing to repent." Similarly writes Stellwag, too, in his manual, although somewhat more reservedly. He says that the inoculation of blennorrhœa is indicated only in the most severe, obstinate, eventually hopeless, cases of pannus crassus.

Since then (the middle of the last century) this method has been quite forgotten. What was the cause of this fact I could not discover. I can only guess that the age of the therapeutic Nihilism, which started out from the Vienna school, has not been favourable for such a method, which, owing to the inoculation of a terrible disease, seemed to be connected with a great danger. However, it is possible that the inoculations had serious consequences on account of negligence in the selection of the cases or in the indications. In the present age of developed bacteriology we would ridicule such an objection as brought up against the method by Saemisch, who said, *ex cathedrâ*, that blennorrhœic inoculations must be avoided for the reason that the inoculated pus may result even in diphtheritis. (Graefe-Saemisch. "Handbuch der Augenheilkunde." I. edition, 4 vol., p. 230.) It is a fact that in the time when the jequirity method became known, the inoculation of blennorrhœa was not practised at all.

The circumstance that the eye section of the St. Rochus Hospital (Budapest) must of necessity admit very severe and neglected cases, which are refused in other hospitals, puts me in front of a very difficult task. Such are the cases of pannus crassus. I encountered several of these desperate cases, where every imaginable treatment was of no use. Then, after having thoroughly studied the literature of the trachoma, I felt myself justified in taking refuge in the trying of the inoculation method; the more so because my patients—in a practical sense of the word—were already blind.

I have the honour to exhibit this patient as a classic example. His case-history is particularly interesting, because it excellently illustrates all the asserted things, and it illustrates also the hard task before which we are standing. The patient, æt. 25, an agricultural labourer, had, as he alleges in 1905, when he became a soldier, entirely good and healthy eyes. Otherwise he is strong and healthy. As a soldier he had infected his eyes, and was for three months attended as an outdoor patient. On July 19th, 1905, he was sent to the Nyitra military hospital, where he has spent 11 months. Here he was treated with every known method, and on June 20th, 1906, he was admitted to our hospital, after being dismissed from the army. His status was as follows:—Photophobia of the highest degree; copious slimy, purulent conjunctival secretion; the conjunctiva tarsi is strongly thickened, with great papillar hypertrophy; among the papillæ there are numerous small nodules, the transitional fold infiltrated, with numerous transparent granules, standing in a straight line. Conjunctival and ciliary injectedness of the highest degree. The cornea was on its whole surface covered with a deep, pink blood vessel network, which was so dense that only the thicker vessel stems could be seen on the limbus. The vision had been reduced to noticing light only. This condition had been uniform in both eyes.

At first I employed the jequiritol treatment, without the slightest result. Later on the condition of the cornæ (especially that of the left one) became so bad that I resolved upon trying the inoculation method. On September 28th I inoculated the left eye with a secretion taken from a blennorrhœic eye. The blennorrhœa broke out on the third day. The patient left the hospital after a month, with an entirely healed blennorrhœa, in order to await at home the clearing up of the cornea. When we saw him again on September 12th, 1907, I noticed a very pleasant change; the cornea was nicely cleared up, although there are fine little spots on its surface; the bulb was devoid of any inflammation; and, what was most surprising, the *tractus conjunctivitis* was sound; there was no trace of the previous trachoma. The status of the right eye has been unchanged; pannus crassus and the succulent trachoma could be seen, the vision reduced to noticing only light. After bacteriological examination of the secretion of the right eye, which revealed no gonoccocci, I inoculated the eye with a gonorrhoeal secretion. The latent stage lasted three days, whereupon a vehement gonorrhoea broke out. The treatment consisted of the cleankeeping of the eye. At present, also, this cornea has cleared up, the conjunctival infiltration has greatly lessened, there is no secretion at all.

From this case and two others already previously treated on similar lines, I can draw the conclusion that the long-discontinued Jaeger inoculation of blennorrhœa can be applied as an ultimum refugium. It is by no means more dangerous than a jequirity-caused ophthalmia. The conclusive indication for its application is the presence of a pannus crassus. It is worthy of special mention that, after the disappearance of the inoculated blennorrhœa, not only has the cornea cleared up, but—in opposition to the results arrived at with jequiritol—the conjunctival tract has also regained its soundness. I intend further to investigate this new field of therapeutics, and from the results of my experiments I will inform you, gentlemen, in due time.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by George F. Still, M.A., M.D.Cantab., F.R.C.P., Physician for Diseases of Children at King's College Hospital, and Professor of Diseases of Children at King's College, London. Subject: "Indigestion in Children."*

LETTSOMIAN LECTURES, 1908.

TUBERCULOSIS OF THE KIDNEY.(a)

By CHARTERS J. SYMONDS, M.S., LOND., F.R.C.S.,

Surgeon to Guy's Hospital.

LECTURE II.

THE Lecturer began by referring to the large, painless, movable, tuberculous kidney as being so well known as to need but a passing reference. In the cases referred to the patients had all given a history of pain of one to three years' duration. In a case operated upon in 1902 there had been frequent micturition in the early stages, then frequent attacks of pain, and as the tumour enlarged, cessation of these symptoms. This patient recovered, and was alive and in excellent health in 1908. The general health of these patients was said to be good, and they were able to work. From a clinical point of view, they resembled pyo- or hydronephrosis in the length of the history, the character of the pain, and the nature of the tumour.

The leading initial symptoms of tuberculosis of the kidney were next passed in review; firstly, renal colic; in many cases it exactly resembled that produced by a calculus, as in Case II., a man of 46, who without any previous symptoms had three attacks of renal colic. Next albuminuria, as an early sign, was commented upon, one of the chief points being the proportion of albumin to the pus, it generally being more abundant than can be explained by the pus. It was pointed out that albuminuria might occur without any other symptoms, and in both that form where the ureter is shut off, as in Case IV., as well as when it is patent. Special atttention was called to the fact that, as miliary tuberculosis is painless, and as extensive destruction may take place without symptoms, an examination for bacilli in unexplained cases of albuminuria was important.

Of hæmaturia as an initial symptom, one case was related; and, though complete demonstration of renal infection was not possible, the man got perfectly well under treatment by tuberculin. Vesical and urethral irritation were shown to be present in a large number of cases without infection of the bladder, and even where vesical tuberculosis existed the irritation was, in some instances, not greater than when the bladder was healthy. The tolerance of the bladder to tuberculous pus was illustrated by several cases. In some the infective material must have entered the bladder for two years or more. This point was thought to be important in view of the danger of such an infection being unduly urged as an argument for immediate operation.

The routine examination of the urine for tubercle bacilli, when small quantities of albumin and pus are found without renal or vesical symptoms, but associated with ill-health and anæmia, will, the Lecturer thought, discover many cases of early tuberculosis of the kidney. The tubercle having been found, the next point was to ascertain the incidence of the disease by means of the cystoscope, segregation, or other methods. He thought, however, that the ureteric orifice would not exhibit characteristic changes until the ureter itself was infected. In the absence of localising evidence, reliance must be placed on hygienic methods and the injections of tuberculin, and by these means he thought there was no reason why early tuberculosis of the kidney should not recover; and he thought that a good many of the cases of albuminuria that did recover had been of tuberculous origin.

How long are we justified in waiting after tuberculosis has been localised in one kidney before operating? That there is no necessity for immediate nephrectomy was shown by the cases recorded in the first lecture. The two principal complications—infection of the bladder and dissemination—are certainly long delayed. He therefore thought that when the bacilli are few, the albumin and pus variable, and where vesical irritation is bearable, the bladder healthy, and the ureteric orifice normal, postponement is justifiable. As to how far complete recovery can be brought about had yet to be ascertained, but he thought that when the ureteric orifice showed positive evidence of disease operation should not be delayed.

He thought that nephrectomy should be performed when the local symptoms indicated progressive destruction of the kidney, as shown by pain, vesical irritation, a lumbar tumour, or the presence of a considerable amount of pus in the urine. These symptoms indicated probably that no recovery could take place in the sense that some renal tissue would be left, and therefore it was better to cut short an illness by removing the kidney. In the absence of the symptoms referred to, he thought the best evidence as to the necessity of nephrectomy was in the appearance of the ureteric orifice.

It was thought that the cases demonstrated that tuberculosis of the bladder was not a contraindication to nephrectomy, especially if the infection was confined to the neighbourhood of the orifice of the infected ureter; and, looking to the well-known recoverability of vesical tubercle, he thought that nephrectomy was justified, even with multiple foci. The question whether slight infection of the other kidney, as indicated by a few bacilli from this side, should contra-indicate nephrectomy when the other was obviously tuberculous was considered, and he thought the question turned upon the distress caused by the obviously affected organ and upon the curability of renal tuberculosis. He expressed the opinion that under such circumstances, where a kidney was causing distress and affecting the health, it should be removed as tending to improve the general health and promote recovery of the remaining kidney. Such a proceeding, he explained, compared with the removal of a suppurating knee-joint with existing phthisis.

(a) Abstract of Lecture II delivered before the Medical Society of London, February 17th, 1908.

The question of whether the ureter should be removed at the same time as the kidney, or subsequently, was next discussed. Cases were quoted to show that a tuberculous ureter might completely recover, even when associated with tuberculosis of the bladder, and that on this ground no strong reason could be given for immediate or subsequent ureterectomy. In one case, however, the ureter had to be removed for a persistent loin sinus and vesical irritation nearly a year after the nephrectomy. It was followed by complete relief. The operation was done in 1897, and the patient was in perfect health at the present time. He quoted another case to show that recovery was more rapid if the ureter were removed at the same time as the kidney. On the whole, he was strongly in favour of this proceeding, provided the patient was able to bear the additional strain; but, looking to the fact that recovery took place when the ureter was left, it was not justifiable to run any risk.

With regard to the method of removal of the ureter, he preferred to separate the muscles, as in the operation for appendectomy, and draw the ureter down. Done at the same time as the kidney, the operation was greatly expedited by the direction given by pulling upon the loin end. He pointed out that the ureter always went up with the peritoneum, and must therefore be sought for on the anterior surface of the wound.

The advantage of preliminary nephrotomy was considered, and was illustrated by Case V., where the general infection was completely relieved, and a successful nephrectomy carried out later. The value of a preliminary incision into the kidney was that it gave an indication of the amount of renal tissue left, that the urine could be collected from the bladder, and the secreting capacity of the other kidney ascertained.

In conclusion, the routine examination of the urine was urged in cases of renal pain and albuminuria; also in all cases of unexplained vesical or urethral irritation and hæmaturia; that nephrectomy should be performed as soon as there was evidence of destruction of the kidney or injection of the ureter; that nephrectomy was not negatived by vesical tubercle nor by slight miliary tubercle of the opposite kidney.

ORIGINAL PAPERS.

GRAFTING OF FIBULA TO TIBIA.

By R. ATKINSON STONEY, F.R.C.S.I.,

Visiting Surgeon to the Royal City of Dublin Hospital.

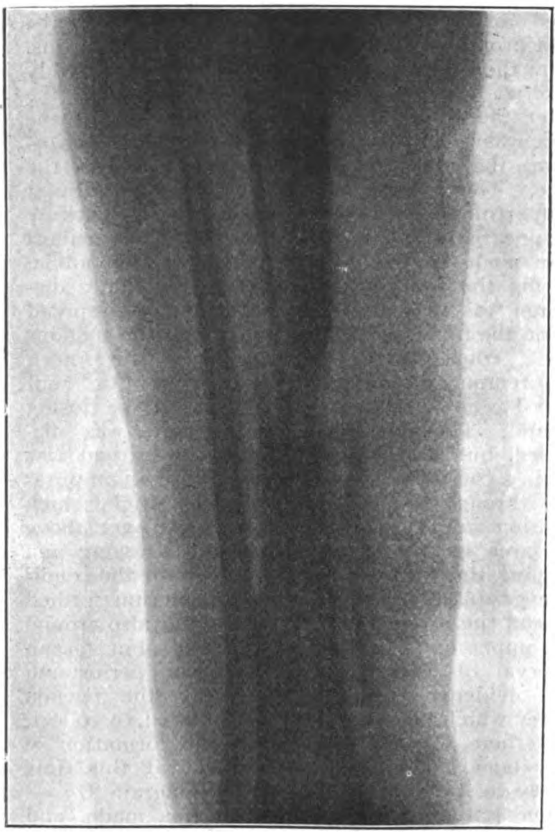
The patient, a boy, æt. 7, was admitted to the Royal City of Dublin Hospital on the afternoon of November 26th, 1904. His temperature and pulse on admission were over 103° F., and 100 respectively. His mother gave a history that he had been ill with pain and swelling of his left leg for some ten days, and also said that he had had an attack of measles about two months previously.

On examination, it was found that the left leg was enormously swollen from the knee to the ankle, the skin was blue and shiny, and fluctuation was well marked. Chloroform was administered and a free incision was made over the most prominent part of the swelling, about 1½ ins. below the knee, and about a pint of pus and shreddy material was evacuated. On introducing the finger the whole length of the diaphysis of the tibia was felt to be bare and denuded of periosteum, the finger passing completely round the bone. The muscles of the anterior tibio-fibular compartment seemed to have almost entirely disappeared. A couple of counter openings were made for drainage just above the ankle. During the following three weeks the daily discharge was very profuse, and suppuration spread up on the inner side of the limb along the tendons for a considerable distance above the knee; the temperature fluctuated between 100° and 104° F., and the patient appeared to be losing ground. The question of amputation was discussed, but it was thought that the patient was not in a condition to stand the shock of an amputation through the upper third of the thigh, which position would have been necessary to get above the area of infection. By careful dressing and keeping the limb in a continuous bath the condition gradually improved; an involucrum formed around the lower half of the tibia and also around the upper end for a short distance; but for an interval of a couple of inches the periosteum had evidently been destroyed by the tension under which the pus had been allowed to collect, and there was no attempt at the formation of new bone. The condition present at this time (early in January) is shown in Skiagram I.

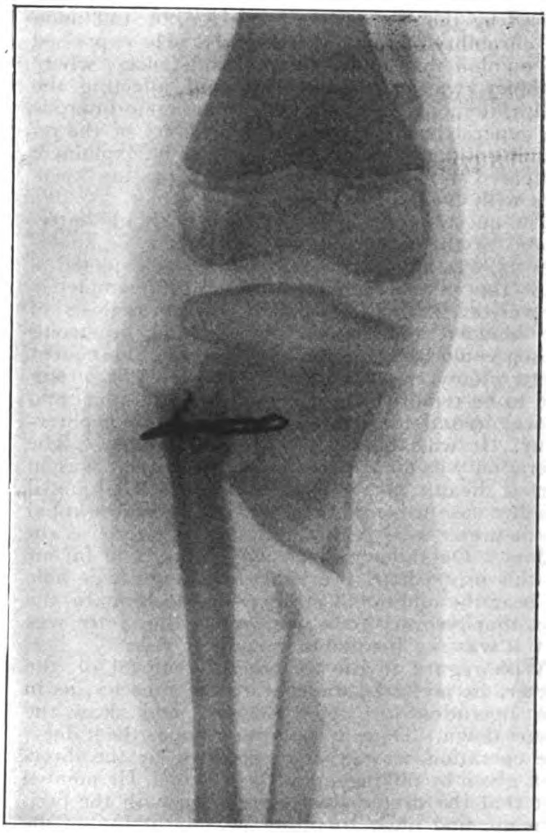
On January 21st an incision was made, and the upper half of the necrosed tibia was removed in one piece. There was no difficulty in doing this as it lay quite loose, without any involucrum surrounding it. The lower half was too firmly fixed to be taken away with safety. Some months later, on the 8th of April, the lower half of the necrosed tibia was removed in several pieces, after making an incision through the involucrum surrounding it. On the 26th of June the sinuses were scraped and several small sequestra were removed. On the 5th of July, after a stay of nearly eight months in hospital, the patient was discharged with the majority of the sinuses healed; but for some time longer he had to attend the dressing dispensary daily.

In the beginning of April, 1906, the patient was re-admitted to hospital with the condition shown in Skiagram II. All the sinuses were soundly healed, the leg was two inches shorter than the opposite one, and there was lateral movement to nearly a right angle at a point a couple of inches below the knee, so that the leg was useless as a means of support or locomotion. On looking at the skiagram it is seen that this mobility was due to a gap in the tibia, about the junction of the upper and middle thirds of the bone; in this interval no new bone had been formed, though it was now eighteen months since the first operation. It can also be seen that owing to the continued growth of the fibula the upper end of this bone was dislocated from the external tuberosity of the tibia and projected up to the level of the knee-joint, forming a marked prominence under the skin.

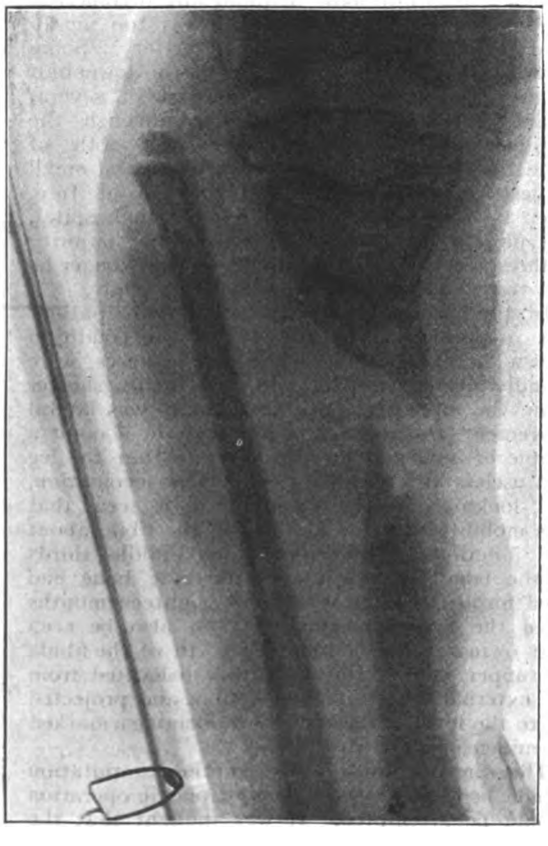
The question arose as to whether amputation should be done, or some form of plastic operation should be attempted. It was thought that the latter would not have much likelihood of success owing to the poor blood supply of the parts, as



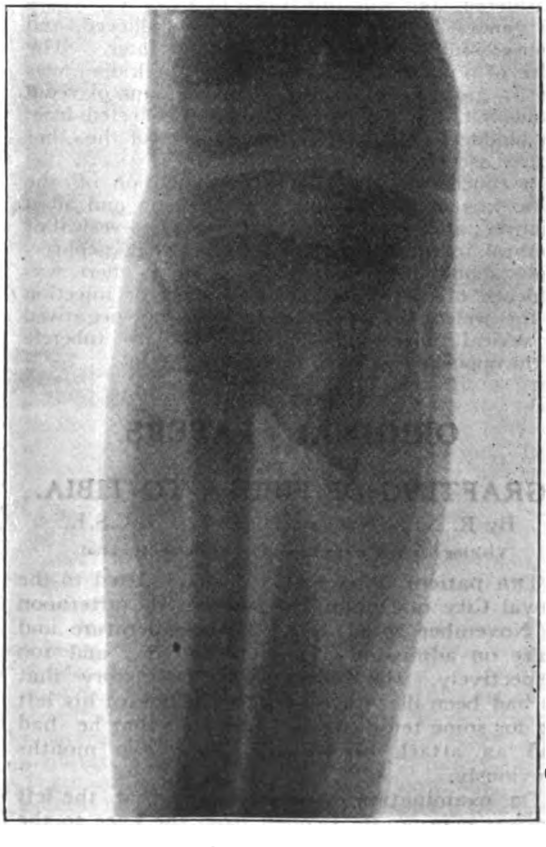
No. I.—Taken Jan., 1905.



No. III.—Taken Oct., 1906.



No. II.—Taken April, 1906.



No. IV.—Taken Oct , 1907.

the upper half of the leg appeared to consist of little more than cicatricial tissue. It was, however, decided to make the attempt.

Several methods suggested themselves :—(1) Removal of a sufficient length of the fibula to allow the two ends of the tibia after freshening to be brought into contact and wired. This would have entailed further shortening of the leg, already considerably too short. (2) The placing of a portion of the fibula or a piece of bone from a recently killed animal between the two ends of the tibia. (3) The transplanting of a piece of the periosteum of the fibula or a slice off the fibula in the gap in the tibia. The great objection to both these methods was the probability that growth and union would not occur owing to the lack of nourishment, as the transplantation would take place in a mass of fibrous tissue, (4) The fourth method, which was that adopted. was to cut across the neck of the fibula just above the level of the lower end of the proximal portion of the tibia, and fix the upper end of the lower fragment of the fibula to the upper piece of the tibia. By this means the graft would retain its own blood supply, and there would, therefore, be less fear of necrosis or failure of union. The idea of this operation was suggested by a case recorded in the *Lancet* of January 13th, 1906, by Prof. E. E. Goldman, of Freiburg, where the upper end of the tibia had to be removed for sarcoma. The operation is a modification of one described by Hahn as long ago as 1885.

The operation was performed on the 7th of April, 1906. Some difficulty was found in bringing the fibula across to the tibia, owing to the fact that the whole of the upper part of the leg was merely a mass of fibrous tissue, showing no trace of muscle. A small cavity was gouged out of the upper fragment of the tibia and the upper end of the distal portion of the fibula was placed in this and fixed in position by a silver wire suture. (see Skiagram III.) Unfortunately some encapsuled mass of sepsis was apparently opened into, for though the surface of the wound healed, an abscess formed around the wire, which had finally to be removed on October 6th. This occurrence of sepsis delayed the union of the bone, but after about ten months spent with the limb in plaster, firm union took place, so providing the boy with a stable column of support for his limb. There is still considerable shortening, due to loss of growth during the eighteen months while the ends of the tibia were not in contact before the plastic operation. Since the operation, however, the limb has been growing at the same rate as its fellow, and the shortening is largely masked by a tilting down of the pelvis and by a talipes equinus which has resulted from the complete destruction of the muscles in the anterior tibiofibular compartment. The patient is now able to walk well, and even to run about without the support of a stick, though there is a considerable limp.

A somewhat similar case is reported in the "Annals of Surgery" for last October, by J. S. Stone But in it there was a much greater failure of formation of new bone in place of the necrosed tibia, so that there was a gap of about eight inches between the two ends. The operation consisted of two stages; the first corresponded almost exactly to that described above, and the second, which was performed some time afterwards, consisted in splitting the lower end of the fibula longitudinally and grafting the inner fragment to the lower part of the tibia.

The condition of the patient last October is shown in Skiagram IV. The plaster had been removed, and the patient was going about. On looking at this skiagram it will be seen that the fibula is fixed to the side of the tibia rather than to its distal extremity; this is partly due to the difficulty that was experienced in drawing the fibula inwards owing to the firm mass of fibrous; cicatricial tissue developed here, and partly to a slipping upwards of the fibula, which occurred as a result of the suppuration which prevented rapid union between the bones. Another point that may be noticed is the great hypertrophy of the fibula which has taken place as the result of having to take on the support of the whole limb. This hypertrophy is very well seen also in the illustrations which accompany both Goldman's and Stone's papers.

ABSTRACT OF A PAPER ON

A RECORD OF A YEAR'S WORK IN THE ROYAL SAMARITAN HOSPITAL FOR WOMEN, GLASGOW.

By J. NIGEL STARK, M.D., F.F.P.S.G.,
Surgeon, Royal Samaritan Hospital for Women; formerly Presiden. Glasgow Obstetrical and Gynæcological Society, &c.

DURING the year 1907 Dr. Stark performed major operations which involved opening into the peritoneal cavity by either the abdominal or the vaginal route on 103 patients. More than 103 operations were actually performed, as on several patients as many as five or six were done. Out of the number three patients died, giving a mortality rate of 2.9 per cent. All three deaths were unavoidable, as can be seen by a study of their causes. It should, therefore, encourage both medical practitioners and patients to know that modern methods of asepsis and the improved technique have in large measure robbed surgical treatment in gynæcology of so much of its former danger, so that sufferers from ovarian or uterine tumours, from chronic inflammatory diseases, from intractable displacements, need not too long hesitate to undergo operation, so far, at any rate, as concerns the prospects of immediate recovery. A large majority of the patients suffered from disease in more than one organ or from injury to several parts. For example, many cases like the following were seen :—Rupture of the perineum, relaxed vaginal walls, lacerated and eroded cervix, endometritis, retroversion and prolapse of the uterus, chronic salpingo-oöphoritis, extensive intestinal adhesions, and even, perhaps, chronic appendicitis. The patients suffering from such complicated and widespread disease were treated at one or two stages. Usually everything was done at one time, and although the series of operations occupied a considerable length of time, yet, with experience and practice, one learns to perform them more rapidly than would at first appear possible. After anæsthetisation, the patient is placed in the lithotomy position, the vagina thoroughly cleansed and disinfected, the cervix dilated—usually to No. 10 Hegar—and the uterus curetted. If the cervix is the seat of chronic hyperplasia and of old-standing lacerations, it is amputated; in less severe cases trachelorrhaphy is performed. Colporrhaphy, anterior or posterior, or both together, follows, and then one of the various methods of perineorrhaphy. The vaginal operations being finished, the patient is placed in the dorsal position; but, after the abdomen is opened, the Trendelenburg attitude is assumed. Adhesions having been separated, the ovaries, tubes, and appendix are dealt with, and ventrofixation or ventrosuspension completes the task, the abdominal wound being sewn up in three layers. It is evident, therefore, that in many patients as many as five or six operations were performed, each of which was absolutely necessary in order to obtain a good result. Bearing this in mind, we may tabulate the operations in the following fashion :—

Operations.			Total.	Mortality.
Hysterectomy (abdominal)	Fibromyoma of body of uterus ...	15	19	0
	Fibromyoma of cervix of uterus...	1		
	Fibrocystic tumour of uterus ...	1		
	Double pyosalpinx and pyometra	1		
	Carcinoma of uterus	1		
Myomectomy	Fibromyoma of uterus—sub-peritoneal	1	2	0
	Fibroma of uterus with pregnancy	1		
Hysterectomy (vaginal)	Carcinoma of the body and cervix of the uterus		2	0
Hysterectomy and Cæsarean section	Carcinoma cervicis and full-term pregnancy		1	1
Ovariotomy	Multilocular ovarian cystoma—			
	Bilateral	2	5	0
	Unilateral	3		
	Gangrenous cyst with twisted pedicle...		1	0
	Papilloma of the ovary		1	1
Salpingo-oöphorectomy	Chronic salpingo-oöphoritis—			
	Bilateral	11	17	0
	Unilateral	6		
	Abscess of ovary		1	0
Salpingotomy	Pyosalpinx—			
	Bilateral	1	3	1
	Unilateral	2		
	Hydrosalpinx, unilateral		1	0
Removal of sessile cysts of broad ligament			3	0
Ventrofixation and Ventrosuspension	Retroversion		11	0
	Prolapse		20	0
Laparotomy for Extra-uterine pregnancy	Full term		1	0
	Tubal abortions and ruptures ...		5	0
Laparotomy and drainage	Purulent peritonitis		2	0
	Pelvic abscess		1	0
Laparotomy	Tubercular peritonitis		3	0
Radical cure for ventral hernia...			2	0
Laparotomy; uncompleted operations	Cancer of ovary, intestines, &c. ...		2	0
			103	3

Hysterectomy for Fibromyoma.—No deaths occurred. One interesting case was that of fibroid of the cervix, already reported in the *Journal of Obstetrics and Gynæcology of the British Empire.* It attained the weight, great for a cervical fibroid, of 17½ lbs. In every case the recoveries were rapid and uneventful, even when there had been serious difficulties in the operations and long-continued previous bad health, and in no other patients did one feel more fully repaid for what one did for them. As the good results continue and endure, it seems unfortunate that even yet there is such a tendency to conservatism on the part of many practitioners, and that so many women struggle on for years, burdened by a fibroid tumour of the uterus, when relief could be given and life rendered more worth living by what is now a comparatively safe operation.

It is impossible to detail cases at length in an abstract of a paper, much as one would like to do so. A most interesting one was that of carcinoma of the cervix associated with pregnancy. The patient was 36 years of age, and in 10½ years had given birth to 9 children. The cervix was converted into an indurated, ulcerated, bleeding mass. Cæsarean section was performed, then panhysterectomy. Fair progress was made until the fifth day, when the temperature was 100 deg. F., and nourishment was being well taken. In the evening sudden faintness and collapse came on, and death ensued in 20 minutes. At the autopsy no other abnormal conditions were found than enlargement and acute fatty degeneration of the liver and fatty heart. A very large number of cases of chronic salpingo-oöphoritis, of prolapse of the uterus, and of retroflexion, associated with disease of the appendages, were encountered, as is to be expected in a large manufacturing city where so many of its inhabitants are the subjects of gonorrhœa, and where so much carelessness and neglect occur during and after childbirth. As a rule, great benefit results to these cases from the stay in hospital, and many leave feeling in better health than they have been for years.

Of the extra-uterine pregnancies, one was at full term—or, rather, had gone beyond full term. The patient was 26 years of age, a multipara. There had been symptoms during the early months suggestive of extra-uterine pregnancy, but these passed away, and later on fœtal movements were felt. A doctor was engaged to attend at the expected confinement. When full term arrived active movements ceased, and three weeks later Dr. Stark was called in consultation. The uterus could be felt empty, and the patient was removed to hospital. At the operation the child was found lying transversely in a sac composed of the layers of the broad ligament, and without any difficulty child and sac were removed along with the placenta which was lying on the breech. The operation was of surprising ease. The child, placenta, and cord were well developed, and, had it been possible to diagnose the condition at an earlier date, a living child could have been removed which would have had a reasonable chance of continuance of life; but the mother had no suspicion that everything was not normal in every respect. The recovery was perfect.

OPERATING THEATRES.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Operation for Imperforate Rectum.—Mr. Arthur Edmunds operated on a male child, æt. 3 days, who had been admitted for persistent vomiting; there was also a history that the child had passed no meconium and no urine. On examination, the little patient was found to be well nourished, though rather a small child. On passing the finger into the rectum an obstruction was felt about three-quarters of an inch from the anus. The abdomen was distended, but not very markedly so, and there was a slight musical bruit over the heart, possibly due to a patent foramen ovale. Mr. Edmunds remarked that this was a comparatively rare condition, although it was very well-known, occurring about once in every 7,000 births. The exact etiology of the condition is by no means as clear as it would at first sight appear to be. Some cases are undoubtedly due to a persistence of the cloacal membrane, a structure which normally consists of two layers of epithelium with a small amount of mesoblastic connective tissue in its anterior portion. It is quite easy to see how an excess of this connective tissue in the cloacal membrane might lead to a persistence of the structure. The obstruction produced by this error of development takes, however, the form of a diaphragm just within the anus which bulges at the orifice and requires merely an incision to give exit to the bowel contents. The case in question probably fell under an entirely different heading. Many cases have been described in which a portion of the alimentary is entirely undeveloped, or is represented by a cord-like structure attached to the free border of the mesentery. In these cases the obstruction may be at any part of the alimentary canal, or even in several situations, normal intestine alternating with patches of completely undeveloped bowel. It is probable that the portion of intestine most commonly affected in this way is the lower portion of the rectum, and in cases of imperforate rectum it is quite common to find the blind end of the gut connected to the anal canal by a fibrous cord, which represents a considerable length of undeveloped intestine. It follows from this that, although the upper blind end may be in actual contact with the termination of the anal tube, the gap between them would be considerable if the intestine were straightened out. In consequence, the peritoneum covers the upper end of the bowel almost completely, so that if a trochar be thrust through the anus into the meconium containing rectum, the instrument will pass across a diverticulum of the peritoneum. At the moment of puncture the two are in apposition, the distended end of the bowel usually filling the pelvis completely. As soon, however, as the obstruction is relieved, the rectum recedes, and its contents then tend to become discharged into the peritoneal cavity. A condition is described and figured in nearly every text-book of surgery in which a diaphragm exists across the bowel about an inch from the anus. This could be treated quite efficiently in the same way as persistent cloacal membrane—namely, by simple incision; but, unfortunately, the condition, if it occurs at all, is extremely rare, and there is no doubt that what he had just described was very commonly mistaken for a simple diaphragm, and attempts made to relieve the patient by thrusting in a trochar. The fact that statistics show that most of these cases die from septic peritonitis is strong evidence that this mistake has been made. In the present case the child was anæsthetised and held in an appropriate position, with the buttocks pointing upwards, by an assistant. As a precaution against shock, an ounce of saline was injected into the right axilla, and a 1-100th of a grain of strychnine administered subcutaneously, both of which measures are much more valuable, Mr. Edmunds said, for preventing shock than for relieving it when it has once become established. An incision was then made strictly in the middle line through the sphincter, dividing the anal canal posteriorly through its whole length and extending backwards to the coccyx. The loose tissue was then separated, and the upper end of the bowel found; this was then cleared as far as possible, care being taken to avoid opening the peritoneum, the reflections of which, from the sides and front of the bowel, could readily be demonstrated. The bowel was opened and sutured with fine catgut to the incision which had been made in the anal tube. The rest of the wound was then packed and dressed. The whole of the operation, from the making of the first incision to the application of the dressings, lasted ten minutes.

The child bore the operation well, and although convalescence was hindered by acute abscesses in the neck, no trouble was expected as a consequence of division of the sphincter when the patient leaves the hospital. The failure of urination was found to be, as suspected, an error of observation.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held Thursday, February 13th, 1908.

The President, Dr. Herbert Spencer, in the Chair.

OVARIAN DERMOID WITH SECONDARY CYSTS CONNECTED WITH THE OMENTUM.

A paper on this subject was read by Dr. Martin Randall, including a pathological report by Mr. T. W. P. Lawrence. The author described the case of a young woman who had a pelvic tumour the size of a hen's egg situated in the right posterior quarter of the pelvis, rather high up. There were symptoms of inflammation, and the tumour was opened in the right iliac region, and purulent-looking fluid with some vernix-like material escaped. The cavity was drained, but subsequently the cyst was removed by operation. The omentum was observed to be studded with a large number of small cysts containing cheesy material and hair, and a large piece of this structure was removed. Mr. Lawrence reported that the main tumour was a dermoid of the right ovary. As many as fifty minute cysts were found in the omentum. They were for the most part lined with cubical epithelium and contained sebaceous material. The patient made a good recovery, but died a year later with symptoms of apoplexy.

The **President** (Dr. Herbert Spencer) thanked the authors for their valuable and interesting paper. He thought there was little doubt that the fluid at the first operation was sebaceous and not purulent. He had been surprised to find how frequently some operators met with "suppurating dermoids." The explanation he thought was that the sebaceous material, fluid at the temperature of the body closely resembled pus to the naked eye, although it solidified at a lower temperature. In his experience suppuration rarely occurred in dermoids. A practical deduction from the paper was the importance of removing these and other ovarian tumours entire, if they were not large. This had been his practice for many years. He did not go so far as Mr. Bland-Sutton, who removed all tumours, however large, entire, sometimes making an incision extending from the ensiform cartilage to the pubes; such a long incision certainly to some extent increased the risk of omental and intestinal adhesions and of hermia.

Dr. **Galabin** said that he had met with a somewhat similar case in which there had been a further development of the metastases than in any of these collected by Dr. Randall. An unmarried lady, aged between 40 and 50, came with a large tumour, the history of the duration of which was quite indefinite. She said that her abdomen had been large for as long as she could remember. An ovarian tumour was diagnosed. At the operation it turned out to be a dermoid and was removed with difficulty on account of universal adhesions. Among the adhesions and over the peritoneun were scattered very numerous thin-walled cysts containing sebaceous fluid like that in the main cyst. These existed also in the cellular tissue of the abdominal wall and pelvis, so that a number of them were divided in the abdominal incision. No skin-like structure was seen in the secondary cysts. Those on the peritoneum were thin-walled, but in the cellular tissue no definite cyst wall could be detected. A good deal of sebaceous matter had to be left unremoved, but the incision healed well in the first instance. After some weeks, however, it broke down again, and a discharge of oily fluid began, which later became semi-purulent. The patient remained ill many months, and it was feared the condition might run a malignant course, but eventually the sinus closed, she recovered completely, and was well after several years. He agreed with the President that it was desirable, if possible, to remove a small or medium-sized dermoid cyst entire.

Dr. R. H. **Hodgson** remarked on the fact that some of the cases had died with septic symptoms. He suggested that they might have been saved had hexamethylene-tetramine been used. He had experimented with it in large and small quantities in many and varied diseases, and had found it most valuable in septic diseases, but it needs to be used with great caution. The kidneys afford the first and most marked signs that the drug is in excess. He strongly suggests its use to those who have much operative work on the peritoneun.

Dr. H. **Macnaughton-Jones** said there must have been some thousands of ruptured dermoid cysts, and yet but the cases mentioned have been recorded. It did not appear, therefore, that there was any great danger of metastasis or implantation in the case of simple dermoids. No matter how extensive the incision, in some cases of dermoids, and with every case, rupture would occur.

The following specimens were exhibited:—

Dr. Herbert Spencer:—Caseating carcinoma of the corpus uteri.

Dr. H. Macnaughton-Jones :—Hæmato-salpinx complicating a myomatous uterus.

Dr. Eardley Holland :—A melanotic tumour of the vulva.

Dr. Amand Routh :—A placenta diffusa.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 31ST, 1908.

The President, J. M. REDMOND, in the Chair.

PROGNOSIS AND TREATMENT OF NEPHRITIS.

THE PRESIDENT of the Academy opened the discussion on the above subject by calling attention to the wide range of the subject and its vast importance in the realms of surgery and obstetrics as well as in medicine, and the interdependence of prognosis and treatment, so closely were they related to each other. He limited his remarks entirely to those inflammations included in the varieties—(*a*) acute nephritis due to toxic influences or exposure to cold ; (*b*) sub-acute or chronic parenchymatous nephritis ; and (*c*) chronic interstitial nephritis. He pointed out, however, that in every variety of nephritis there is more or less diffuse inflammation involving the glomeruli, the parenchyma, and the interstitial tissue. He then proceeded to discuss, with a view to forming a sure basis for prognosis and treatment, three principal features to be found in these cases—(1) Albuminuria, (2) dropsy, (3) the uræmic syndrome—and laid stress on the importance of taking a wide and comprehensive view of them, and of avoiding attaching too much significance to any one group by itself. On this point he called attention to the possible harm which may be done to a patient's prospects in life by rejecting him for insurance or admission to a post in the public services on account of albuminuria, pointing out that the condition may be due to adolescence or the result of temporary weakness of the heart. He indicated some errors to be avoided in this condition, such as testing a chance sample of urine instead of the water of 24 hours, the comparing of the albumin of one specimen with that of another when the variations may be entirely due to some change of diet or diminution of the liquids ingested ; and he quoted von Noorden's statement that "albumin is a conclusive index only in acute nephritis, as its reduction points to improvement, its increase to exacerbation." It is not so reliable in chronic parenchymatous nephritis, in which "it is liable to fluctuations, and an attempt to base a prognosis on or to estimate the effect of treatment by such a criterion is fallacious." On the other hand, their significance must never be under-rated when they point in the same direction as the other changes in the general condition of the patient. As to the possibility of treating albuminuria by medicine, he considered it was as little encouraging as in using hæmostatics in the hæmaturia of renal inflammation. The indications for treatment were to save the kidneys—to place them in physiological rest—by cutting off all proteid diet, as meats, soups, beef extracts, eggs, etc., by feeding the patient at first with starvation diet when the inflammation was acute, the urine bloody and very scanty, and then allowing a very restricted diet of milk and starchy foods, with cream and sugar. The amount of liquid permissible at first must not exceed two pints in 24 hours, as the oliguria is due to renal inefficiency, and it is as harmful as well as unscientific to try to produce diuresis by copious libations as it is by diuretic medicines. As soon, however, as the kidneys show recovery by secreting more water, it is then most beneficial to flush them with water, or lemon and water with a small quantity of cream of tartar. This treatment by deprivation of liquids is especially necessary when the oliguria is accompanied by dropsy, local or general. The second indication for the treatment of acute nephritis is to save the kidneys by calling the bowels and the skin into activity, and thereby eliminating the poisons and the water which the inefficiency of the renal epithelium causes to be retained. A daily morning dose of pulv. jalap co., or concentrated doses of magnesium sulph., will meet the one, and poulticing, leeching or cupping over the loins will effect the other. In some cases of acute nephritis where uræmic symptoms are early developed in a previously healthy and vigorous patient, it is right to bleed to 15-20 ozs. from the arm, or, as Baccelli suggests, from the dorsal vein of the foot. One such case was reported where venesection apparently saved the patient's life. In addition to local or general depletion, the use of hot air baths, hot pack, or hot baths was insisted on, and in most acute cases of albuminuria or of dropsy this treatment alone will be followed by diuresis. On the subject of anasarca, reference was made to the opinion of Straus, von Noorden and Senator as to the non-elimination by the secreting epithelium of the chlorides being one of its chief causes, and of the therapeusis of withholding salt from the diet, and to the statement of many German and French writers that the amount of dropsy can be gauged by the retention or the excretion of chlorides in parenchymatous nephritis, more especially when uræmic symptoms are present. This question does not arise in the chronic interstitial nephritis, as in it the chlorides are freely discharged. While the prognosis and treatment are more closely related to the state of the heart and the arteries, in these oft-times very chronic cases, lasting for years, the diet should be more generous and contain more proteids than in the other forms of kidney inflammation ; the prognosis as to cure is very bad, but much may be done to prolong life. The state of high tension of the arteries may be reduced and regulated by a systematic use of nitroglycerine, trinitrites or sodium nitrite for weeks and months, as under their use tension is reduced and the left ventricle is enabled to recover from a state of dilatation to the normal state of hypertrophy present in cirrhosis of the kidney. Should a case be complicated by an attack of acute nephritis, the treatment already detailed for that state must be used for a comparatively short time, and should uræmic headache or coma or convulsions set in, active treatment of the bowels and the skin should be instantly commenced and strenuously carried out, while full doses of chloral must be administered by mouth or rectum, and aided, if necessary, by inhalation of chloroform. Reference was made to the valuable effects of hypodermics of morphia in this form of disease, and when carefully administered and its effects watched, they will be found invaluable in stopping the convulsions, limiting the status epilepticus, relieving the headache, and arresting the vomiting. Another drug of great value is the iodide of potassium, which should be given for weeks and months at a time, since it diminishes the risks of hæmorrhage into the brain or retina, while, if bleeding has already taken place into the latter it causes its limitation and absorption.

PATHOLOGY OF NEPHRITIS.

Dr. **EARL** read a paper on the above subject. He confined his attention principally to three main points —(1) The etiology of nephritis ; (2) the classification of the varieties ; (3) the changes in the cardio-vascular system.

Dr. **TRAVERS SMITH** said it was a good thing to bear in mind that, taking a comprehensive view of the subject, nephritis was not altogether a destructive process. Nature did not stand by and allow the body to fall a victim to the disease without making a fight against it. She had two lines of defence. The first was high arterial tension and hypertrophy of the left ventricle, by which the kidneys had a greater supply of blood sent to them and more rapidly passed through them, this making up for some of the deficiency in the action of the kidney. The second line of defence was œdema, which, however they might regard it, took out of circulation certain toxic substances. Looking upon œdema—as well as upon high arterial tension—as conservative processes, he thought there were certain cases of extremely severe uræmic symptoms where it was a good thing to induce œdema. He had been struck on several occasions with patients who died of severe uræmic symptoms without ever having been in the least œdematous, and he thought that, if œdema be a conservative process, they might have been saved if they could have been made œdematous. He had given a man, who had been for some time in uræmic convulsions and coma, sodium chloride, with the result that at the end of 24 hours he became markedly œdematous, and made a good recovery from all his symptoms. He thought, therefore, that these two conservative processes should not be treated directly unless they were doing harm *per se*, and they should watch for cases in which the production of œdema might do good.

Sir **John Moore** said he concurred with the view put forward by Dr. Travers Smith as to the beneficial influence of œdema in cases of chronic renal disease, with regard to which he had read a paper before the British Medical Association at the Oxford meeting. The general view in regard to the pathology of nephritis was that increased arterial tension was the cause of the hypertrophy of the left ventricle of the heart, but recently the view had been put forward that the high arterial tension was the result of the forcible action of the heart caused by the circulation in the blood of an increased amount of nitrogenous compounds, such as urea and its allies. He could not go with Dr. Finny in dissenting from the view that water should be given freely in some forms of nephritis. He looked upon water as a valuable eliminant in cases of nephritis; it acted on the bowels and on the skin, and it was very desirable to keep the skin active in all forms of toxæmia, but the water should be soft water. They should not be too strict in dieting chronic nephritics; milk was sometimes very distasteful to them, and was not easily digested, and sometimes they died of starvation if kept off an animal diet. It was, moreover, just as necessary to treat nephritis in fresh air as tuberculosis.

Dr. **Finny**, in reply, said he did not take the view that œdema should be looked upon as a conservative process, when the materials which were stored up in the fluids in the cavities of the body were a constant danger of infection. It was well known that the presence of a great deal of dropsy might be compatible with good health, but it would hardly be looked upon as a conservative process saving the patients from some other danger. The subject, however, was open for consideration. High arterial tension was a compensating force, but at all times was a matter of great danger; at any moment there was the risk of rupture, and the treatment should really be to lower the tension.

HARVEIAN SOCIETY.

Meeting held Thursday, February 13th, 1908.

The President, Mr. D'Arcy Power, in the Chair.

Mr. **Maynard Smith** read a paper on

THE DIAGNOSIS AND TREATMENT OF ABDOMINAL INJURIES.

The symptoms resulting from these injuries were described in detail, and their relative importance in diagnosis was pointed out. The difficulty in distinguishing the general shock following the injury from the collapse associated with the rupture of an important abdominal organ, such as the liver or bowel, was fully dealt with. The signs associated with free fluid or gas in the peritoneal cavity were carefully discussed. The symptoms suggestive of a grave abdominal injury, such as the general appearance of illness of the patient, the increase in pulse rate, the presence of vomiting, and distension of the abdomen, were described, and the importance of noticing the advent of these at the earliest possible moment was insisted upon. The question of operative treatment was carefully considered. The whole paper was illustrated by the records of 124 consecutive cases of abdominal injury which had been under treatment at St. Mary's Hospital, and reasons for the views expressed and of the treatment advised in different abdominal injuries were in many cases supported by the results of these cases which formed the basis for the paper.

The paper was discussed by the President, Mr. Crisp English, Mr. Lawrence Jones, Dr. Aitken, Mr. Campbell Williams, and Dr. Spilsbury.

Dr. **Carmalt Jones** read a paper on

THE TREATMENT OF BRONCHIAL ASTHMA BY INOCULATION WITH A BACTERIAL VACCINE.

A brief review was given of the methods employed in the treatment of disease by the opsonic method. The method of the isolation of the organism, of its growth, the preparation of the vaccine, and the estimation of the quantity and frequency of the dose, by determination of the opsonic index of the patient after inoculation were fully described. In some cases of bronchial asthma a specific organism had been isolated from the sputum, and a vaccine prepared from this was used for inoculation of the patients suffering from the disease. Twenty severe cases of bronchial asthma were treated by the special vaccine prepared, and definite improvement occurred in 16 of these cases, a marked improvement in 11. The cases chosen were severe cases which had resisted the usual methods of treatment, and the patients themselves were convinced of the marked freedom from attacks, which they had experienced since undertaking treatment by inoculation. Dr. Carmalt Jones showed several of the cases which he had been treating.

The paper was discussed by the President and Dr. Willcox.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

The President, Dr. Walker Downie, in the Chair.

Dr. **Arnold Lorand**, of Carlsbad, delivered a very instructive and illuminating lecture on diabetes. His clinical researches were based on observations on over 700 cases of diabetes, and he had experimented on animals. According to Dr. Lorand, diabetes is brought about by morbid changes in the ductless glands, the thyroid, pancreas and adrenals. He pointed out that lesions in the brain very seldom give rise to true diabetes, although glycosuria is common. He maintained that Claude Bernard's famous puncture of the fourth ventricle of the brain gave rise only to glycosuria, and not to diabetes proper. He did not deny the influence of mental shock in producing diabetes. He thought it was a common cause, but it acted through its influence on the ductless glands. He pointed out analogies between Graves' disease and diabetes. Graves' disease was due to exaltation of the functions of the thyroid gland, and that when the gland atrophied, it was followed by myxœdema. Even in advanced cases of diabetes, myxœdematous symptoms may arise. The *rôle* of the liver he thought of secondary importance; that changes in that organ were secondary. Glycosuria could be distinguished from diabetes by a test meal of beef, rice and honey. Any very decided quantity of sugar in the urine indicated diabetes, but small quantities, like a half per cent., did not. In the genesis of diabetes he was strongly of opinion that large meat-eaters were specially prone to the disorder; indeed, a meal of meat and carbo-hydrate brought out the latent tendency to diabetes better than a purely meat or carbo-hydrate diet. Children of diabetics often showed their morbid tendency when tested in this way. Extirpation of the whole of the pancreas was followed by diabetes. In the treatment he advocated meat to be given once a day, and allowed a moderate quantity of carbo-hydrate. He allowed green vegetables and certain fruits like oranges and apples, also cream and sour milk. The great danger, he considered, in diabetes was not the sugar in the urine, but acetone and diacetic acid. He had found very beneficial effects from thyroid extract in removing diacetic acid from the urine. He thought the serum or milk of goats, whose thyroid had been extirpated, might prove of benefit. At all events, such milk had very decided soporific properties, and a dog living on such milk was practically useless, as it was always falling asleep.

An interesting demonstration of cases was given by the staff of the Glasgow Royal Infirmary to the members of the Glasgow Medico-Chirurgical Society.

Dr. T. K. **Monro** showed a patient suffering from syphilis of the nervous system, and an Icelandic fisherman who was recovering from an attack of beri-beri associated with a cutaneous eruption.

Dr. **Cowan** exhibited a patient suffering from syringo-myelia; casts from a case of aero-megaly; and a series of blood charts.

Dr. **Harrington** showed microscopical specimens of the blood from a case of pernicious anæmia; the irregular size of the corpuscles was very evident; and the hæmoglobin index was high.

Dr. **Hunter** showed a case of Banti's disease.

Dr. **M. Crorie** and Dr. **Campbell** gave a magnificent demonstration of micro-organisms. Beautiful specimens of the parasite of sleeping sickness, ague, filaria sanguinis hominis, bacillus pestis, the coccus rheumaticus, leprosy, and many others.

Dr. **James R. Riddell** showed 15 patients. Several were cases of lupus vulgaris healed, and others in the process of healing; two cases of tubercular disease in bone which had got well; one case of keloid also healed; two cases of exophthalmic goître, both of which were greatly improved; in one case the improvement had been maintained, and the treatment had been stopped for a year; the pulse had dropped from 109 to 80. The exophthalmos was much less, and all symptoms had practically disappeared. Two cases of rodent ulcer, one healed and one almost well; all these had been treated by X-rays. In the cases of goître, X-rays were used on account of their known power of destroying epithelial tissue and their degenerating action on glandular structures. One case of rodent ulcer was shown illustrating the use of ionised zinc; the ulcer, which had been rather larger than a shilling, was completely healed. Three cases were shown illustrating the beneficial action of X-rays, which may sometimes be got in the more serious forms of malignant disease; one patient had a recurrence of cancer in the scar after removal of the breast. This case had come under treatment in November of 1904, at that time there was an ulcer on the scar about the position of the nipple the size of a crown piece, pain and hæmorrhage were prominent symptoms; there were six or seven small red nodules on the skin scattered along the edge of the scar, and in the axilla was a mass, not well defined, about the size of a pigeon's egg or less. In three months time the ulcer had quite healed, the axillary mass was practically gone, as had also most of the nodules in the skin. The œdema in the arm, which had been a marked feature, was much less. Patient had occasional treatment chiefly to axilla until early in 1906, when treatment was suspended altogether. Lately the axillary mass has increased, and treatment is resumed. The second was a case of epithelioma on the dorsum of the foot. A small tumour had appeared in January, 1907. It had enlarged and broken down, leaving an ulcerating mass the size of a florin. Treatment began in November, and by this date the ulceration was entirely healed and the tumour gone. The third case was one of round-celled sarcoma in the naso-pharynx. Towards the end of 1903 the patient began to have a discharge from the nose. In a few months his nose became blocked, and blood was occasionally present in the discharge. Headaches, sleeplessness, and progressive loss of weight were present. Treatment began on June 7th, 1904, when patient's weight had fallen to 8 st. 2 lbs. By January, 1905, the tumour had disappeared entirely. Sixty applications had been made, and the patient had put on about 2 st. weight. At this date, after three years, the naso-pharynx appears quite normal. Among other appliances those for producing temporary complete epilation by one measured dose of X-rays (for treating ringworm, etc.) for ionisation, for exact localisation, a stereoscope for radiograms, etc., were shown, as were also radiograms illustrating fractures, dislocations. Early tubercular disease in lungs and bones, abscess of bone, cancer of bone, the examination of the bowel after a bismuth meal, urinary calculi, etc., etc.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, February 13th, 1908.

The President, Mr. T. H. **Bickerton**, in the Chair.

Dr. **Crace-Calvert** read a note on

THE TREATMENT OF HÆMOPTYSIS BY NITRITE OF AMYL.

He stated that till recently the treatment of hæmoptysis had not been satisfactory, and that nearly all drugs except morphia had been described as useless. Dr. F. W. E. Hare had called attention to the use of the nitrite in checking hæmorrhage, and pointed out that it acted partly by causing a marked reduction in the arterial blood pressure, and partly by producing an intense anæmia of the lung parenchyma, and so gave time for clotting to take place. Dr. Crace-Calvert had tried it in about 25 attacks of hæmoptysis—many of them profuse—and always found that it checked the bleeding almost instantly. Afterwards, if there were excitement of any kind, he gave a quarter of a grain of morphia. He considered that nitrite of amyl was the drug *par excellence* to be used first, as it saved the patient unnecessary loss of blood, and prevented large accumulations of blood in the air-passages. It was especially useful in sanatorium work, where the patient was seen at the beginning of the attack.

Sir **James Barr** congratulated Dr. Crace-Calvert for pointing out the value to be obtained from the use of nitrite of amyl, and such other agents in cases of hæmoptysis. We often hear of blood pressure in numerous diseases without the observers having any clear idea as to what is meant by blood pressure. Is it arterial pressure, capillary pressure, venous pressure, or the pressure within the arterioles? Those who talk so glibly on the subject generally mean arterial pressure, and in this case the reference must be to the systemic arterial system, because the pulmonic system is very poorly supplied with any regulative mechanism in the form of vasomotor nerves, and damming back of the blood in the pulmonic system must be due to heightened pressure within the arterial system. Blood pressure is purely a relative term, and what might be considered a very high blood pressure in phthisis would be a low pressure in renal disease. In phthisis the heart is small and weak, and a comparatively small resistance is more than it can cope with; therefore, any slight rise in the arterial pressure in cases of phthisis is very apt to dam back the blood in the pulmonic system. The great advantage of the use of morphia, or morphia and atropine, in cases of phthisis, arises from the fact that they generally stop the cough, and thus prevent any rise in the arterial pressure. Personally, he has for many years used nitro-glycerine in cases of hæmoptysis, and, as a rule, he prefers it to nitrite of amyl because of its more lasting effect. If the blood is deficient in lime salts, it is very important that lime salts should be administered.

Dr. **Nathan Raw** could not agree that nitrite of amyl had any specific action in the control of hæmoptysis. Whilst one occasionally met with an overpowering hæmorrhage which was rapidly fatal, the fact remains that the great majority subside spontaneously with care and rest. He could not agree that hæmoptysis was due to increased blood pressure, but rather to erosion of some small blood vessel. He advocated absolute rest in the recumbent posture, a hypodermic of morphia, ice to suck, and cold turpentine applications to the chest. He had seen excellent results from adrenalin chloride in long-continued but small hæmorrhages from the lungs. By lowering the blood pressure it was possible that nitrite of amyl was occasionally useful.

Dr. **W. B. Warrington** said it had long been recognised that a hypodermic injection of morphia was the most satisfactory drug in the treatment of hæmoptysis, and for some years past nitrite of amyl, in addition, had been the routine treatment at the Northern Hospital.

Dr. **A. G. Gullan** said that there seemed to be varied opinions on the blood pressure of phthisis, and he believed that in many cases it was lowered. Yet everyone was well acquainted with the excited and strong action of the heart and the strong and quick pulse, which arose on the sudden occurrence of a serious hæmoptysis. The arterial blood pressure was then undoubtedly greatly increased, and it was in this condition that the amyl nitrite was beneficial as a rapid means of lowering it. At the same time such good results had been obtained by rest, morphia, and purgatives in the past, and, moreover, these methods were invariably used in conjunction with amyl nitrite, that he felt too much credit for the good results obtained should not be given to that drug.

Dr. **R. J. M. Buchanan** drew attention to the fact that cases of phthisis associated with good blood pressure generally did well, and that hæmoptysis more often occurred in chronic and relatively favourable cases. The hæmoptysis was in a large majority of cases the result of raised blood pressure in the systemic arteries, and Nature pointed out a method of treatment in that the hæmoptysis itself lowered pressure, and thus arrested hæmorrhage. Taking the lesson from Nature, the use of nitrite of amyl, acting in the same way, was a rational therapeutic measure, and the results justified its administration. Dr. Buchanan advised a course of sodium nitrite afterwards to prevent recurrence at any time when from a marked rise of pressure hæmoptysis was to be feared. He did not advocate worrying the patient at the time of the hæmorrhage with purgatives. Dr. Buchanan related a case of recurrent hæmoptysis without any pulmonary lesion always associated with high blood pressure due to tobacco smoking, and always arrested by the exhibition of nitro-glycerine and nitrite of soda.

The note was also discussed by the President, Drs. Bushby, Bradshaw, and Abram, and Dr. Crace-Calvert replied.

Dr. W. **Blair Bell** read a paper on

SOME OBSERVATIONS ON THE PHYSIOLOGICAL IMPORTANCE OF THE CALCIUM SALTS.

These observations which had been made incidentally during the work he is at present engaged upon in reference to the calcium metabolism in menstruation and pregnancy, he considered of sufficient importance to bring forward, as he himself could not carry them any further. His method of calcium estimation, described in the *British Medical Journal* for April 20th last, had been largely employed in the investigation. The diurnal variations and the value to be attached to the blood index and the interpretation thereof were fully described. He discussed what he described as the reparative function of calcium salts, and stated that he considered there was always a determination of these salts to an injured or a diseased region. He also thought that there was no such thing as calcareous degeneration *per se*, but rather calcification—a reparative process—in diseased structures. The effect lime salts had upon involuntary muscles was next mentioned, and Dr. Blair Bell alluded to the work of Ringer and others in this direction. He went on to describe the attempts made by himself to discover the regulating factors in the calcium metabolism, and discussed his experiments and observations in regard to the thyroid, pituitary, and other ductless glands, which he considered acted in association, anabolically or catabolically, in connection with the lime salts. The question of calcium and the coagulability of the blood was discussed, and he brought forward evidence to show that the reduction of the coagulability of the blood on the administration of an excess of lime salt was due, not to an excess in the blood, but to an active resistance or immunity on the part of the subject, or increased excretion brought about probably by thyroid interference. The power the leucocytes possess of absorbing calcium probably in solution, and conveying it for the processes of repair and for other functions, was considered, and evidence adduced to show the probability of this property. Lastly, Dr. Blair Bell described some interesting observations upon gelatin and the contained calcium. He illustrated the fact which he had discovered, that if calcium is precipitated from gelatin, it will no longer coagulate by passing round a control and a specimen prepared several days before.

Sir **James Barr** said that he considered this one of the most important papers that he had heard for a long time. He has himself been using calcium in disease for many years, and therefore feels very grateful to Dr. Blair Bell for giving a more accurate method for estimating the amount of calcium in the blood. Hitherto, we have had to go by the coagulability of the blood, and in such a disease as pneumonia by the amount of the adhesiveness of the secretion. In cases of pneumonia it has a very great value, especially in those cases in which the secretion is liquid or hæmorrhagic. *Cæteris paribus*, the more scanty and viscid the expectoration in pneumonia the better the prognosis, hence in such a disease he had condemned the use of expectorants for many years. The calcium salts have a wonderful effect, not only in increasing the secretion, but in toning up the vessels. The variable amount of lime salts in the blood at different periods of the day scarcely affects the diseased conditions, because in the infective process the calcium is thrown out of the blood into the tissues, and in such cases there was always a tendency to a deficiency. The important effect of the calcium salts in maintaining the heart's action has been well-known since the observations of Sidney Ringer. The reparative action of the calcium salts has been shown by Dr. Blair Bell, but in many chronic diseases they are apt to accumulate in the blood where there is defective excretion, and become deposited in the walls of the vessels. Now, although the salts under these circumstances are fairly insoluble, yet by maintaining a high alkalinity of the blood by the use of citrates these salts can be withdrawn from the tissues. The observation of Dr. Blair Bell on the presence of calcium in the leucocytes is exceedingly interesting. The great increase in the blood of a cat where the thyroid had been removed was interesting, because Sir James Barr has found that in cases of exophthalmic goître the lime salts are nearly always defective, and great amelioration of the symptoms can be produced by their administration. He hoped that Dr. Blair Bell would pursue his interesting investigations by which the profession generally will derive much benefit.

Dr. R. J. M. **Buchanan** considered Dr. Blair Bell's method of calcimetry by the use of the hæmocytometer sufficiently accurate for clinical purposes, and stood on a par with erythrocytometry and leucocytometry in abnormal blood states.

Dr. P. **Hick** said that although the total calcium of the blood was not precipitated by Dr. Blair Bell's method, all the "ionised" calcium was, and that it was in this state that the calcium took part in such active processes as the clotting of blood, and the method gave a measure of the available calcium. Also that calcium chloride and calcium lactate given by the mouth occasionally gave no rise in the calcium content of the blood, which seemed to show that in these cases inorganic Ca salts or the Ca salts of the simpler organic acids were not capable of absorption. Sir A. E. Wright having previously arrived at the same conclusion, by showing that these salts so administered in such cases produced no increase in the coagulability of the blood, Dr. Hick suggested that the disappointing results obtained with gelatin by some observers were due to using only a 2 per cent. solution which contained only a comparatively small amount of gelatin.

Dr. **Gordon Little**, whilst endorsing the remarks as to the interesting character of the paper, emphasised the necessity for verification of the method employed by strict chemical analysis. It was absolutely necessary that clinicians should exercise the greatest care, especially when they attempted work in the domain of physiological or physical chemistry. In the past, objection had been taken—and rightly taken—by high authorities to the unreliable methods by which some eminent authors had obtained their results, and upon which far-reaching theories had been set up, only to be discounted later. He pointed out that the method of Dr. Blair Bell was a comparative method, and that by it only a proportion of the calcium in the blood could be estimated—viz., the free or ionised calcium. There was, in addition, the masked or absorbed calcium in combination with proteins which this method did not touch, and which in a metabolic sense was the most important. He also drew attention to the artificial standard of comparison and the impossibility of measuring by means of crystals formed in an aqueous solution, even of known strength, those formed in a complex colloidal medium such as blood. The process of crystallisation went on in the two media under totally different conditions. Attention was called to Dr. Blair Bell's results in reference to reconstruction and the diminished calcium content of the blood during that period, as illustrating the relationship of calcium to gout. It might tend to explain why women suffered less frequently from the disease than men. He also pointed out that, owing to the frequent variations that went on almost from hour to hour, the idea of establishing a so-called "calcium index" was next to impossible, without any prolonged series of observations. He also remarked that the subject of calcium was not so new as had been suggested. As an empiric remedy it was among the oldest and best authenticated, as in the waters of well-known springs—*e.g.*, Contrexéville, Buxton and Bath—and mentioned the names of modern workers, especially Ringer in this country and McCallum in America, who, with a number of others, had done much to prove the importance of this element in the human economy. In regard to calcium as a factor in the setting of gelatin, its essential importance was disputed. Reference was made to a paper by Mörner, in the *Zeit. fur Physiolog. Chemie.* (28, p. 471, 1899) on the coagulation of gelatin. Mörner showed that ash-free preparations of gelatin show very little difference in the time of coagulation when formed into aqueous solution as compared with ordinary gelatin containing 0.4—3.1 per cent. of ash, and as the result of a long series of well-conducted experiments states:—"Solutions of gelatin rich in ash do not in the very least surpass the solutions of ash-free gelatin preparations in regard to ease with which they coagulate," and further shows that the addition of neutral salts greatly increases the time required for the coagulation of gelatin solutions, although this is in no way due to a chemical change, but is purely a physical effect.

The President discussed the paper, and Dr. Blair Bell replied.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Feb. 23rd, 1908.

CANCER OF THE STOMACH.

THE medical treatment of gastric cancer cannot, naturally, be otherwise than palliative, but, when intelligently applied, it can prolong life to almost the same extent as that obtained by surgical interference without exposing the patient, as in the case of operation, to death in a third of the cases.

Certain drugs have been supposed to possess certain anti-cancerous virtues. Although such is not, unfortunately, the case, they render good therapeutic service, says Prof. Robin, a well-known authority on disease of the stomach.

Leaving aside the different anti-cancerous serums so much vaunted in past years, it is well to study those agents of which the palliative effect is certain.

Condurango gave to Friedreich excellent results that were not obtained by other authors. In reality it is a good tonic, and can be prescribed under the form of tincture, 10 drops before meals, or as follows:—

Condurango bark (white), ½ oz.
Water, 10 oz.

Reduce by boiling to 6 oz. A tablespoonful half an hour before each meal.

Chlorate of soda, recommended by Brissaud, only temporarily improves the appetite. Albuminuria constitutes a counter-indication.

Fressenger proposed some years ago the treatment with bihydrochlorate of quinine. Although it does not possess more curative value than the preceding drugs, it retards notably the development of the disease and improves some of the symptoms. It can be given by the mouth, the rectum, or hypodermically. By the mouth it fatigues the stomach, by the rectum it produces tenesmus, and under the skin it is sometimes painful. Prof. Robin alternates the three methods in the folowing manner: During eight days he injects beneath the skin of the epigastrium the contents of one and finally two hypodermic syringes of the following solution:—

Bihydrochlorate of quinine, 6½ dr.
Sterilised water, 14 dr.

The following eight days he gives in a wafer 10 grains of the quinine fasting, and the same amount in the evening as a suppository, when he returns to the injections, and so on.

Two drugs help the action of the quinine salts—methyl arseniate of soda and bromide of gold. The arrhenal is given in 5 per cent. solution at the dose of 10 drops twice a day during five days. During five days more a tablespoonful of the bromide of gold solution—

Bromide of gold, 1 gr.
Water, 10 oz.

As to the *régime* which materially aids the treatment, it depends on the tolerance of the stomach. Generally the milk diet alone is prescribed, but there are some patients who cannot support milk. However, in cases of pyloric stenosis, hæmatemesis, or an insurmountable repugnance for food of any kind, milk alone is tolerated. In all other cases the patients can and ought to eat, but the *régime* must be regulated according to the condition of the intestines. If there is diarrhœa, meat must be suppressed and vegetables alone allowed; otherwise a mixed diet adapted to the capacity of the stomach may be prescribed.

But, in order that the patient should eat, he must be given an appetite, and here persulphate of soda succeeds admirably—

Persulphate of soda, 30 gr.
Water, 10 oz.

A tablespoonful half an hour before the two principal repasts.

Metavanadate of soda acts similarly—

Metavanadate of soda, ½ gr.
Water, 12 oz.

A tablespoonful half an hour before meals.

When the patient has eaten, digestion must be facilitated by hydrochloric acid and digestive ferments—

Hydrochloric acid, 35 drops.
Water, 1 quart.

A wineglass or more to be drunk during the meal. In the midde of the repast one of the following wafers—

Pepsin, 15 gr.
Maltine, 2 gr.

After the meal, two pills of pancreatin (2 gr. each).

Fermentation will be treated by fluoride of ammonium—

Fluoride of ammonium, 5 gr.
Water, 10 oz.

A tablespoonful towards the middle of the repast.

If the flatulence causes more or less pain, the following mixture may be prescribed:—

Subnitrate of bismuth, 1 dr.
Phenic acid 15 drops.
Spirits of chloroform, 2 dr.
Water, 4 oz.

If the suffering is intense:—

Cocain, 1 gr.
Codeine, 1 gr.
Lime water, 5 oz.
Spirits of chloroform, 2 dr.
Water, 5 oz.
A teaspoonful after meals.

The substitution of milk diet for the diet that had been allowed alternates the pain by diminishing the irritation produced by the food on the gastric mucous membrane.

It relieves also the vomiting, which can also be checked by giving before each absorption of milk 4 or 5 drops of the following mixture:—

Picrotoxin, 1 gr.
Proof spirit to dissolve, q.s.
Hydrochl. of morphia, 1 gr.
Atropine, 1-6th gr.
Ergotin, 15 gr.
Cherry laurel water, 3 dr.

If the gastric intolerance is absolute, recourse should be had to nutritive enemata.

Such is the treatment recommended by Prof. Robin, and if the lives of the patients are not prolonged very much, it at least relieves their sufferings and allows them to entertain more or less hope. It is only where relief cannot be obtained by medical means that gastro-enterostomy is justifiable.

GERMANY.

Berlin, Feb. 23rd, 1908.

AT the Medizinische Gesellschaft, Hr. E. Klebs gave a report on some

EXPERIMENTS WITH BLINDWORM TUBERCLE BACILLI —*i.e.*, tubercle bacilli that had had their origin in the human subject, but had passed through the body of the blindworm. From these he made pure cultivations. He injected equal quantities of sputum containing tubercle bacilli into the anterior chambers of both eyes of rabbits. An emulsion of the culture bacilli was injected afterwards into the left orbit of the rabbits. The left eye at first remained sound, whilst the right eye was soon destroyed by tuberculous panophthalmitis. It was only after an interval that a white nodule formed slowly on the iris of the left eye. The speaker further took sputum containing tubercle bacilli, mixed it with the blindworm bacilli, and placed the mixture in the incubation chamber for three days. He injected some of this mixture likewise into the anterior chamber of a rabbit's eye, and obtained nothing from it but a staphyloma of the cornea, which only appeared after the lapse of 40 days. There appeared, therefore, to be an antagonism between human bacilli and those of cold-blooded animals, which was the more remarkable, as the blindworm bacilli originated in the human subject, and only had their biological characters changed by passing through the body of the blindworm.

Hr. Sticker showed

A Tumour of the Brain of a Dog Experimentally Produced.

He had trepanned the skull of a dog, and had implanted a remnant of round-celled sarcoma, frequently used by him, into the left posterior lobe of the brain. After this the dog remained well for a long time; no visible changes were seen even in the fundus oculi. Convulsions first appeared on the 163rd day, then maniacal movements, and afterwards a deep sleep; the following day there were ataxic movements, a condition of sopor and death. The tumour was the size of a cherry.

Hr. Borchardt showed

A Student, Æt. 24, from whom he had Removed the Talus

five years before for sarcoma. In 1901 he was unsuccessfully treated for tuberculous disease of the ankle-joint, until, two years later, Röntgen illumination showed a tumour of the talus. This proved to be a giant-celled sarcoma. The patient had been permanently cured by the operation, and could walk as with a normal foot. It was the first reported case of permanent cure of sarcoma by conservative treatment, without amputation.

Discussion on Hr. Casper's Paper on Recurrences of Papilloma of the Bladder.

Hr. Mankiewicz alluded to the similarity between papilloma of the urinary tract and the same disease in the respiratory tract, particularly the larynx. Here recurrences were seen after intra-laryngeal operations as well as after laryngotomy. It had been thought that a malignant metaplasia might take place after operation, but the attempt to prove this had failed. He mentioned the case of a patient who had suffered from vesical hæmorrhage for two years, and had also two papillomata at the orifice of the ureters. The patient declined operation. When the speaker saw him two years later the growths had entirely disappeared. Spontaneous cures of papillomata did take place, therefore, even if rarely. It was equally certain that papillæ existed in the normal individual in a certain number of cases, the precursors of papilloma.

He next referred to the distinguished effects of arsenic on papillomata, and suggested its use in bladder affections.

Hr. M. Borchardt had removed quite a number of papillomata of the bladder by the high operation, but had seen no recurrences. Even conceding that a certain number of his patients had gone elsewhere, the number must still be small. Where recurrences did take place, some very small ones were probably overlooked. A great deal could be said in favour of the high operation as regarded certainty of diagnosis and completeness of the operation.

Hr. Sticker referred to the papillomata of dogs that had a malignant nucleus, and suggested that in the cases in which recurrences took place, small ones could easily be overlooked.

Hr. Israel summarised the discussion, and afterwards reverted to the case of the patient that Casper had made the basis for his paper. This man had suffered from vesical hæmorrhage for 12 years before he came to himself (the speaker), and in 9½ years he had then been operated on by Nitze nearly 60 times, and he had been repeatedly admitted into hospital for serious hæmorrhage. The value of intra-vesical operation should not be over-estimated, therefore.

In his reply, Hr. Casper mentioned a tenth case that had come under his notice of a man who had already had the high operation performed four times, with recurrences constantly taking place. The endo-vesical was a less serious operation, and the general condition was but little affected by it, and death had never taken place from hæmorrhage. If the bleeding would not stop, the sectio alta could still be carried out as before.

AUSTRIA.

Vienna, Feb. 23rd, 1908.

Lymphatic Leucocythæmia and Chylothorax.

At the "Gesellschaft für Innere Medizin," Strasser presented a patient who had been brought to hospital for weakness, diarrhœa, and general debility with enlarged glands. On February 4th, 1907, her report is: Cachexia, glandular enlargement of neck, axillæ and groin, while the spleen projected three finger breadths below the ribs, associated with stertorous breathing, enlargement of abdomen, and firm resistance over the epigastrum, with the feeling of a distinct tumour in the umbilical region with an irregular surface. The erythrocytes were 4,000,000, leucocytes 43,700, hæmoglobin (Fleischl) 74 per cent. The white corpuscles contain 0.5 of polynuclear cells. The Röntgen rays were applied, and improved the blood considerably, but the lymphocytes still remained abnormally high. The spleen receded below the margin of the ribs, while the other lymphatic glands were decidedly reduced, but the hard tumour in the umbilical region remained unchanged. In July the patient complained of great pressure in the thorax, associated with shortness of breath. Closer examination revealed dulness on the right posterior surface of the thorax, about 9 ctms. above the fourth rib. Respiratory breathing and pectoral fremitus were quite absent over this region, but the tumour in the abdomen was unchanged, and the margin of the liver could not be defined. The leucocytes were now 2,500 and the hæmoglobin 70 per cent. It was resolved to continue the Röntgen rays, which were applied constantly till the beginning of November when the leucocytes were then found to be 5,930, of which 15.5 per cent. were polynuclear, while the exudation in the chest had increased with the dyspnœa. The right side was aspirated, and 2,000 grammes of a white milky hæmogenous fluid was extracted, which was found to be chylous.

Three weeks later 2,400 grammes were drawn off, and the analysis gave the same chylous result. After the second aspiration the fluid was longer in collecting, and the third extraction was performed the day before the patient was presented, and 1,000 grammes of the same fluid were drawn off.

The etiology of the case is somewhat enigmatical, but the chylothorax appears to be due to the compression and subsequent bursting of the ductus thoracicus, probably the result of the sarcomatous growth in the abdomen.

Decastello applied the Röntgen rays to this case, and affirms that the radiation of the long bones had no effect on the blood pressure. After radiating the lymphatics and spleen there was a sudden fall in the number of leucocytes, which within one week fell from 402,000 to 127,000, and after a month to 51,000.

Offer remarked that the fluid extracted gave Ehrmann's reaction, *i.e.*, one cubic centimetre of the fluid counteracted 0.01 of a mg. of adrenalin when applied to a dilated pupil.

Strasser remarked that the tests for glycosuria were negative.

Epiploitis.

Reitter showed a case he had to operate on after herniotomy for epiploitis five weeks after the first operation. The patient suffered for some time from bilateral inguinal hernia, which was successfully corrected, but five weeks after fever, pain, swelling, and fluctuation indicated some recurrence. After warm applications and rest the tumour, about the size of a child's head, was opened, and found to be an inflammation of the epiploica, which had been caught in the stitches when closing the herniotomy.

Tubercle in Brain.

Flesh presented a patient in whom he diagnosed tubercle in the right pedicle of the brain. There was tubercle in the apex of the left lung, with Calmette's reaction of the conjunctiva after 24 hours.

There was spastic alternating hemiparesis with the characteristic paralysis of the oculomotorius. This combination pointed to a lesion in the right peduncle. This form of paralysis has gone under the name of Weber's paralysis or hemiplegia alterans superior since 1863. The lesion in the lung is excellent confirmation in this case.

ALGIERS.

Mustapha Superieur, Feb., 1908.

So many places have sprung into existence of late whose promoters have placed in the forefront very extravagant claims for the patronage of English physicians, their patients, and the travelling public, that it is somewhat difficult to describe the special attractions of an ancient town like Algiers within modest proportions. It is, however, too well-known to need reference here to its past history, and I will therefore refer briefly to it as it affects the profession in search of a change for health's sake for themselves or their patients, and the impressions made on a stranger like myself visiting it for the first time during the present month in search of that necessity of life—health. The first thing that occurred to me was the absolute serenity of its atmosphere, the extraordinary distances the eye could compass, and the cloudless African sky.

Hemmed in, as Algiers is, by a horseshoe range of hills, the climate appears to be comparatively uniform, and one does not experience that sudden drop of temperature at sunset which is peculiar to many of the Mediterranean stations. The air is of that balmy sweetness which is so soothing to jaded nerves on a fine May morning in England, and should prove of signal service during the winter months to those predisposed to pulmonary affections, cardiac or renal troubles. Rheumatic subjects should also do particularly well there, inasmuch as they can safely spend nearly the whole day in the open air under an unclouded sun. I have not as yet seen rain, but am informed that the rainfall averages about the same as in Paris or London, but that, when it descends, it is much heavier, and therefore shorter in duration.

Mustapha Supérieur, situated on the upper slopes, amid an environment of orange, lemon, olive and palm trees, is the residential quarter of Algiers, whereat reside one or two English and several eminent French physicians (on some of whose tables I was glad to see copies of The Medical Press and Circular). There is a large civil as well as a military hospital, and a cottage hospital for British subjects. On behalf of the latter a bazaar is being held this week under the patronage of H.R.H. Princess Beatrice (Princess Henry of Battenberg), who has been staying with her son for some months past at the Hotel Continental. Algiers cannot boast of the palatial hotels that are found along the Riviera. All are comparatively small, but home-like and comfortable, the principal being, in addition to the Continental, the St. George, the Alexandra, and the Oriental, all at Mustapha Supérieur, and the Hotel de la Regence and the Excelsior down in the town.

Those whose soul is accessible to the picturesque will find here in the Arab quarters thousands of Moors, Kabyles, Jews, and other native races, whose splendour and misery afford much food for contemplation; whilst lovers of art will find their leisure fully absorbed in the study of ancient monuments of Algerian grandeur, and the present attempts at modern greatness.

There are, of course, many ways of getting to Algiers, the quickest from England being the overland route by the P.L.M. lines through Paris to Marseilles, thence by Transatlantique Company's steamer (25 hours) to Algiers; but to those for whom the sea has no terrors, I would advise the voyage from London to Marseilles by one of the magnificent floating palaces of the P. and O. Company. These are so huge that, even in rough weather, motion is greatly minimised, and any tendency to sea-sickness lessened thereby. As to the health-giving properties of "life on the ocean wave," I need not here refer, and the pleasure of a call at Gibraltar will decidedly enhance the pleasure of a sea voyage.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Appointment of Dr. Clouston's Successor.—The directors of the Royal Edinburgh Asylum have appointed Dr. George M. Robertson, M.B., C.M., F.R.C.P., Superintendent of the Stirling District Asylum, Larbert, to be Superintendent of Morningside Asylum. Dr. Robertson's whole professional career has been devoted to work in connection with mental diseases. He was for six years an Assistant Physician at Morningside, under Dr. Clouston, whence he was promoted to be Superintendent of Murthly Asylum. In 1899, on the appointment of Dr. John Macpherson to a Commissionership in Lunacy, Dr. Robertson succeeded him at Larbert. His tenure of office there has in every way been an unqualified success. He is an excellent organiser, and has effected large economies in the management of the institution, while at the same time the general standard of comfort throughout the Asylum has been raised. His chief work, however, has been in connection with the introduction of improvements in nursing. In place of the old system of charge attendants, he has succeeded in placing the nursing of the patients, both male and female, under the control of fully-trained hospital nurses. His system of nursing has attracted much attention among alienists, and his example has been followed in several quarters, while Larbert Asylum has been visited by many American and Continental experts desirous of seeing for themselves the details of the admirable system of nursing in operation there. Though his principal strength is as an administrator, Dr. Robertson has not neglected the scientific aspects of insanity. Within late years he has equipped a laboratory in connection with the Asylum, and has secured the appointment to the staff of the Asylum of a trained bacteriologist, by whom investigations are being made on the etiology of general paralysis and the acuter forms of insanity. Dr. Robertson has had considerable experience in teaching students, having for eight years been a Lecturer on Mental Diseases in the School of Medicine of the Royal Colleges. He was employed by the Edinburgh District Lunacy Board as medical expert to report on the plans of the village Asylum at Bangour.

Infant Life Protection Act.—A case which well illustrates the inadequacy of the legislation concerning boarding-out of infants was tried last week before Sheriff Mackenzie, Glasgow. A midwife named Russell was indicted under the Act for having on four occasions failed to report to the authorities that she had received into her custody children for whom she had been paid money. The Criminal Officer to Glasgow Parish Council testified that when he visited the accused in March, 1907, she denied receiving infants for adoption. Towards the end of December he received information that prisoner had adopted a child named Davidson. By that time prisoner had changed her residence, and in her new house two children had been born and died. The Parish Council did not receive notice of the deaths as required by the Act. The accused was apprehended on board an American liner bound for New York, having taken a passage under a false name. Evidence was given by four young mothers as to the handing over of their infants to the accused, and the payment of money—from £5 to £7—on the understanding that homes were to be found for them. The Sheriff found the respondent liable to forfeit the four sums received by her, with the alternative of 21 days' imprisonment for each offence. She was also fined £10 for having failed to notify the Procurator-Fiscal of the deaths of two of the children under her care. A case such as this, involving the deaths of four young infants, strongly enforces the necessity for further legislation, and the more effective supervision of persons carrying on the practice of adopting infants for gain.

British Medical Association.—The usual conjoint meeting of the Scottish branches was held in the Royal Infirmary, Edinburgh, on February 21st, when a long programme was successfully carried through. A large number of instructive cases were exhibited, among which may be mentioned Dr. F. Gardiner's patients suffering from sycosis and furunculosis illustrating the vaccine treatment of these diseases; fracture of the patella treated under lumbar anæsthesia with tropacocain, and removal of half of a tongue, division and wiring of the jaw under local anæsthesia (cocain), shown by Mr. Caird; a patient, æt. 3, suffering from epispadias with incontinence treated by transplantation of the ureters into the pelvic colon. There is now no incontinence; the urine is almost clear, and generally passed independently of the fæces. This patient was shown by Mr. Stiles, who also demonstrated (1) a child of 15 months two months after operation for a complete branchial fistula. A silkworm gut suture introduced into the external opening could be passed upwards until it finally emerged through the nostril of the corresponding side. (2) A male, æt. 36, after pylorectomy for a sarcomatous tumour of the muscular coat. The condition found at the operation reminded one of congenital hypertrophy of the pylorus. (3) A child, æt. 5, operated on for obstruction at the pylorus was also shown; the condition here, also, resembled that of congenital hypertrophy of the pylorus. Dr. Fleming showed a case of spastic diplegia with athetoid movements occurring in a man of 43. Mr. Cathcart, among other surgical cases, one of colostomy for idiopathic dilatation of the colon. Dr. Chalmers Watson showed a series of cases illustrating the features of chronic inflammatory or degenerative changes in the pancreas, demonstrating the clinical value of Cammage's pancreatic reaction. Mr. Scot Skirving showed several cases of surgical interest, including one of the now rare disease—popliteal aneurysm, treated by excision of the sac. Dr. Russell showed a case of filaria loa, and others. Dr. John Thomson showed a case of congenital obstruction of the bile duct, an early case of pseudo-hypertrophic paralysis with wasting of the pectorals, and to contrast with this a case of congenital defect of the pectoral muscles. Patients were also shown by Dr. Edwin Bramwell, Dr. Sinclair, Mr. Miles, Mr. George Chiene, Dr. Thompson, Dr. Dunlop, Dr. Cairnhill, Dr. Low, and Dr. Byrom Bramwell. Another feature of the meeting was the museum, in which Dr. Low's beautiful exhibit of casts of skin diseases, Dr. Lauder Thomson's exhibit of specimens illustrating cerebro-spinal meningitis, and Miss Taylor's demonstration on the opposite reaction of the meningococci from London and Edinburgh cases of meningitis, and Mr. Wade's series of preparations of the appendix may be mentioned; and Dr. James Ritchie's demonstration of opsonins, in the College Laboratory. The meeting was pronounced a complete success, and was terminated by the members dining together in the evening.

LETTERS TO THE EDITOR.

"A SURREY DOCTOR" AND VACCINATION.

To the Editor of The Medical Press and Circular.

Sir,—Pray who is Mr. West, of Bradford-on-Avon, who, in your issue of February 12th, complacently asserts, without any hint as to how he arrived at his conclusion, that every medical man who has "ever" studied the subject is opposed to vaccination, adding, and that "they are legion"? This may be so, but it hardly admits of proof or disproof, so that Mr. West is trading on our gullibility when he asks us to accept his unsupported statement.

Again, who is Mr. West that he should declare bleeding, blistering, and sundry other therapeutical procedures to be "admittedly false remedies" in apparent ignorance of the unquestionable, and for the matter of that unquestioned, fact that they are in daily use under certain specified morbid conditions? It would be an impertinence on the part of a recognised medical authority to write in this strain, and for an obscure individual to do so is to expose himself to the imputation of ignorance if not rank stupidity.

Of course Mr. West may be a man of considerable scientific attainments, but even so that does not dispense him from the obligation of substantiating his assertions before making them the ground on which to declare our "ineptitude" to learn from experience

Admitting that vaccination is inseparable from danger, as stated by the "packed commission," so is trimming one's nails or picking one's teeth, but while the latter are cosmetic procedures vaccination has saved, and is saving, millions from a terrible disease, if the ordinary rules of evidence are to be accepted in proof—and if not what criterion is left except unsubstantiated and, on the face of them, foolish statements by Mr. West and others of his class.

It is a noteworthy fact that the Arabs, who are constitutionally opposed to treatment of any kind greedily welcome vaccination now that they have had a few object lessons on the subject, and this undeterred by Mr. West's platitudes.

I am, Sir, yours truly,

Alfred S. Gubb, M.D.

Algiers, February 18th, 1908.

CHRISTIAN SCIENCE.

To the Editor of The Medical Press and Circular.

Sir,—Mr. Sewill's last letter states his position in terms it is more possible to discuss.

Mr. Sewill now says that the spread of Christian Science "must lead to a vast increase in the amount of human pain and misery," and he bases this statement on the evidence at the inquest on the late Mr. Darlington. Now Mr. Darlington was a brilliant thinker and scholar who deliberately accepted a form of treatment which Mr. Sewill describes as "nonsensical"; he was a member of a great Christian sect who turned to what Mr. Sewill describes as a "blasphemous cult," and I venture to suggest that, both as a thinker and a Christian, his opinion was at least as valuable as that of Mr. Sewill. Finally, he was in the last stages of an incurable disease, a disease attended by considerable pain. It was shown at the inquest, not only that this pain had been practically destroyed, but that, in the words of one of the witnesses, himself the treasurer to a hospital, and consequently surely unbiassed, the patient "received spiritual, mental, and physical relief from suffering by treatment of the kindest, sweetest, and most beautiful kind." It would surely have been difficult to find a frailer foundation on which to base a charge of increasing human pain and misery.

No Christian Scientist has ever denied that the members of the medical profession are devoting their lives and energies unsparingly to the battle with disease and pain; on the contrary, they are repeatedly emphasising it. But that does not constitute an admission that they do not think there is a better way, a way based on the eternal fact of spiritual health instead of on the examination of physical disease.

In turning from Mr. Sewill's particular instance to his general principles you are confronted, as I have already said, by a colossal begging of the question. Because a certain number of physical experiments produce results approximating to some law of cause and effect, it does not in the least prove that this law is an expression of materialism and is inexplainable from an idealistic standpoint. Berkeley never maintained that if you put your finger ten thousand times into the fire you would not burn it ten thousand times, nevertheless he maintained there was "no substance of matter." Professor Ostwald has never said that if a man fell into the sea he would not be drowned, nevertheless he has said that "matter is only a thing imagined, which we have constructed for ourselves."

"If the hypothetical substance of mind is possessed of energy," Huxley wrote, "I, for my part, am unable to see how it is to be discriminated from the hypothetical substance of matter." Of course, it cannot be, and that is why Mrs. Eddy said, forty years ago, "Mortal mind and body combine as one." But she did not fall into the mistake of explaining matter as a mental phenomenon by recommending tar-water as a remedy, and so become, like Berkeley, "a mired logician." She pressed straight forward to the conclusion that mortal mind or energy was itself nothing but a negation of Divine principle, and that healing must be effected in consequence by the recognition of the fundamental fact of the allness of God.

"The phenomena of disease," writes Mr. Sewill, "are the outward show of solid concrete facts, the result of the action and reaction of matter and force." In other words, as I have already said, he adopts a definition of science limited to his own argument, and declares that anyone who applies the word science to anything beyond this is advocating "pernicious nonsense."

The day when it was possible to argue against Christian Science on such a basis as this is gone for ever. The one little Boston church has given place to the great building seating 5,000 people, and filled at every service. A thousand churches and societies, an innumerable number of meetings, are spreading like a network over the globe. Northward in Alaska and Norway, southward in the Transvaal and Australia, eastward along the Persian Gulf and the Chinese littoral, westward by the great lakes to the Pacific slope. Every week, from a thousand testimony meetings, there goes out the story of sin and disease of every description mastered and destroyed. The answer comes, as it came in Jesus' time, in a copious stream of denials, and when that will no longer do, in charges of hypnotism.

At the same time the evidence of Christian Science healing is much more definite than is commonly supposed. No one, I imagine, would maintain that cancer, epilepsy, and consumption could be destroyed by pretending; yet all these diseases are being destroyed by Christian Science every day. In the pamphlet entitled "Christian Science and Legislation," a copy of which I enclose, instances of the cure of these and many other types of disease are given, and, if anything was to be gained by it, such instances might have been increased indefinitely. The evidence in support of these cures is irrefutable, and has satisfied Judge Clifford Smith, a man trained by years of experience to sift and weigh evidence of every kind.

It is true that the Christian Scientist is to-day very much of a child. He cannot walk in furnaces or upon the water, but he is learning, as his Master taught him, with the finger of God to cast out the devil of sorrow, and sickness and sin. In hundreds of thousands of cases this is being done. And so long as it continues to be done there is no human power which can overthrow Christian Science, "lest haply it be found even to fight against God."

I am, Sir, yours truly,
Frederick Dixon.

Christian Science Publication Committee,
23 and 24, Clun House, Surrey Street,
Strand, W.C.,
February 21st, 1908.

SCIENCE, ITS OWN REWARD.

To the Editor of The Medical Press and Circular.

Sir,—In the House of Commons last week a member asked Mr. Haldane whether he was aware of the public service rendered by a Commission of the Royal Society in discovering the cause of Malta fever, from which many hundreds annually of our soldiers and sailors on that island till recently suffered; and whether, in view of the importance of this discovery, inasmuch as at the present moment the disease had been entirely stamped out, he would consider the desirability of giving the thanks of the Government to the Royal Society for this instance of the successful application of British scientific research?

In reply, Mr. Haldane said he was aware of the great service rendered by the Commission in question. Its recommendations had been followed by the practical disappearance of Malta fever from the garrison of the island. The Royal Society was well aware how genuine was the appreciation of the Government. The results illustrated the enormous importance of bringing science into our business of government. This is all very well so far as it goes, but it does not go very far. There is not the smallest suggestion of any intention to reward as they deserve the labours of the men of science—all medical men—who have performed this service to humanity. There is no suggestion of appropriating a suitable sum—say, at least, £100,000—to be divided among Col. David Bruce and his colleagues, through whose researches the results were brought about. Col. Bruce has won the F.R.S.; has gained wide scientific distinction; and with such honours he and all workers like him must at present be satisfied. The money value of his discoveries to the nation in preservation of the health of its soldiers alone represents a capital sum of not less than some millions; but no material return is offered for this. Material rewards are not gained by science; science, like virtue, is its own reward. Money rewards, and often wealth beyond the dreams of avarice, are reserved for the fraudulent concoctors of quack medicines, and for the army of impostors allowed and encouraged by the laws and by the newspaper Press to prey upon suffering humanity. By their individual labours in the investigation of disease, and by their work as the sole pioneers of national sanitation, the medical profession have performed an enormous service to the State, and, by improving the national health, have at the same time deprived themselves of great part of their income. Their only reward so far has been, so to say, the approval of their professional conscience—an asset not very tangible as a contribution to a livelihood, not very consoling to the crowd of practitioners who find it impossible under present conditions to live upon their scanty professional incomes.

I am, Sir, yours truly,
A Surrey Doctor.

February 20th, 1908.

ROYAL COMMISSION ON WHISKY.

To the Editor of The Medical Press and Circular.

Sir,—In the *Times* of to-day are published the names of the Royal Commission on Whisky and other potable spirits. The Chairman is Lord James of Hereford, and the seven other distinguished members include no less than four to whose names are appended the letters F.R.S. The terms of reference are, to inquire into and report whether, in the general interests of the consumer, or in the interest of the public health, it is desirable to place restrictions upon the preparation of Scotch or Irish whisky, or any spirit described as whisky, and to require declarations to be made as to the materials and processes of manufacture, or age of any such spirit, etc., etc. This Commission has been granted virtually at the request of the whisky trade.

The public are now spending nearly three millions annually on quack medicines. It is possible to demonstrate scientifically, and in most cases by simple chemical analysis, that at least 95 per cent. of these compounds are frauds. They rarely contain any potent drug, and when such is present it can be proved, as a rule, that it is either useless or harmful in the disease for which it is intended. It can be proved that the intrinsic value of quack medicines is always nominal, and that at the least the traffic in them is an organised system of pocket-picking and plunder. It can be proved that reliance upon worthless nostrums in cases where serious disease exists often allows pathological processes, which might have been cured in an early stage, to pass into an incurable phase. It can thus be proved that the quack medicine trade involves the infliction of a vast amount of unnecessary suffering and misery, and is truly murderous as well as fraudulent. All these things can be demonstrated beyond the range of controversy. Is it to be believed that if the medical profession were to exert themselves as much as the whisky trade have done, were to force their case to the front, they could fail in obtaining an authoritative inquiry not only into the nefarious traffic in quack medicines and apparatus, but into the whole question of quackery and practice by fraudulent pretenders. Does anyone who knows the facts doubt that the exposure which would be thereby effected would be followed by remedial legislation? Does anyone dispute that it is the pressing duty of the profession to throw their energies into this question, if not for their own sakes, for the sake of suffering humanity, who in this matter, unfortunately, can look with confidence for assistance in no other direction.

I am, Sir, yours truly,
REFORMER.

February 19th, 1908.

THE LONDON INTER-COLLEGIATE SCHOLARSHIPS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The London Inter-Collegiate Scholarships Board will hold a combined examination for twenty scholarships and exhibitions tenable at University College, King's College, and the East London College, on May 12th and following days. No candidates will be admitted to the examination unless they have passed the London University Matriculation, or an equivalent examination, and are under the age of 19 on October 1st, 1908. The total value of the scholarships offered exceeds £1,700. Full particulars and forms of entry may be obtained from the Secretary of the Board (Mr. Alfred E. G. Attoe), University College, Gower Street, London, W.C.

Thanking you in anticipation,

I am, Sir, yours truly,
ALFRED E. G. ATTOE,
Secretary to the Board.

February 18th, 1908.

OBITUARY.

R. S. W. WILSON, L.R.C.P., L.R.C.S.Ed.

MUCH distress was caused on February 18th throughout the district of Rossendale by the sudden death of Dr. Robert S. Walmsley Wilson, of Church Street, Newchurch. On the previous day he was about as usual, and appeared in the best of health. He retired at his usual hour, and in the morning, when a servant entered his bedroom, after knocking in vain, he was found dead in bed. Very few men were better known in the district than Dr. Wilson, who was 54 years of age. He was unmarried, and was a Liberal in politics. Educated medically at the University of Edinburgh, he qualified L.R.C.P. and L.R.C.S.Ed. in 1879.

RICHARD GORST, M.R.C.S., L.S.A.

WE regret to record the death of Dr. Richard Gorst, an event which severs a link which locally bound the present with the first generation of the past century. Born in Cheshire, in 1823, Dr. Gorst was able to say that he had lived under four monarchs, George IV. having been only recently proclaimed at the birth of the subject of this memoir. He was in his ninth year when William IV. and Queen Adelaide ascended the throne, and in his seventeenth at the marriage of Queen Victoria. He was educated at Edinburgh University, and qualified M.R.C.S. as long ago as 1848, taking the L.S.A. ten years later. Dr. Gorst was one of the best-known practitioners in South-West Lancashire, residing first at Prescot and then for many years at Huyton. Up to within two or three years of his death the deceased gentleman, although in his eighty-fifth year, enjoyed robust health, for which his love of fishing, shooting, and other outdoor sports, associated with regular habits, largely accounted.

ROBERT SYDENHAM FANCOURT BARNES.

WE regret to announce that Dr. R. S. Fancourt Barnes, Consulting Physician to the Royal Maternity Charity, died on Thursday at Sunningdale, West Worthing, at the age of 59. He was son of the late Dr. Robert Barnes, Consulting Obstetric Physician to St. George's Hospital, and studied for his profession at Aberdeen and St. Thomas's Hospital, taking the M.B. and C.M. degree at Aberdeen in 1875, being elected a member of the Royal College of Physicians, London, in 1877, and proceeding to the M.D. degree in 1878. Dr. Fancourt Barnes had devoted much study to the subject of midwifery, and besides being Consulting Physician to the Royal Maternity Charity, had been Consulting Physician to the British Lying-in Hospital, Obstetric Physician to the Great Northern Central Hospital, Physician to the General Lying-in Hospital, Senior Physician to the Chelsea Hospital for Women, etc. He was a Fellow of the Royal Society of Edinburgh and of the British Gynæcological Society, and of various learned societies of the Continent and America, and he had been editor of the *British Gynæcological Journal* and on the staff of the *British Medical Journal*, and was the author of several medical works.

JOHN HENRY REGINALD PIGEON, L.S.A.

WE regret to record the death of Dr. J. H. R. Pigeon, of Stapleton Road, Bristol. On Monday week he was attending to his professional duties, when he fell a victim to the prevailing epidemic of influenza. Pneumonia afterwards set in, and about 10 p.m. on the Wednesday he was conveyed by the ambulance to the Bristol Royal Infirmary, at which institution he had received his training. When admitted, he was in a delirious state, and passed away about 2 o'clock the next morning. At one time the deceased acted as assistant to Dr. W. G. Grace, and was attached to the same sport as the veteran cricketer, in addition to being a keen fisherman. Dr. Pigeon went on some voyages as ship's surgeon before settling down to practice.

DR. CONNOLLY NORMAN.

WITH deep regret we announce the death of Dr. Conolly Norman, Resident Medical Superintendent, Richmond Lunatic Asylum, Dublin, which occurred with painful suddenness on Sunday last. About 4 o'clock in the afternoon Dr. Norman left his residence, St. Dympna's, North Circular Road, Dublin, for a short walk, but after going a few hundred yards he became ill, and collapsed on the pavement. He was quickly removed to his home, but he died almost immediately. He had been unwell for some months past, the result of influenza followed by bronchitis, and his heart was also affected. As the sad news of his death only reaches us as we are going to press, we are only able to publish this brief notice, but in our next issue we hope to refer to his long career as a distinguished alienist.

LABORATORY NOTES.

FORMAMINT.

WE have received samples of Formamint from Messrs. Wulfing and Co., who introduced the preparation to the profession. Formamint is a chemical combination of formic aldehyde and milk sugar, having the formula $5\ \mathrm{C\ H\ O\ H}\ C_{12}\ H_{22}\ O_{11}$. Its combination has deprived the formic-aldehyde of its irritative effect on the mucous membrane of the mouth and throat. Experiments with formamint show that it has no internal effect, such as that due to the administration of pure formic-aldehyde, such as formalin. Its composition is .01 gram formic aldehyde in every gram tablet of formamint. The tablets are allowed to dissolve in the mouth. The action of the saliva sets free the formic aldehyde in a nascent condition; this has an immediate bactericidal action, with the result that Formamint is indicated in all cases demanding asepsis of the oro-pharyngeal regions, the saliva containing Formamint being carried into every crevice of the mucous membrane lining the mouth and throat. Among the conditions in which its use has been favourably reported on are pharyngitis, quinsy, follicular tonsillitis, mumps, otitis media, pyorrhœa alveolaris, scarlet fever, diphtheria, measles, and thrush; also in streptococcal infections, erysipelas, and erythema nodosum. We venture to think that Formamint is already widely known in the profession.

THE following Bill was presented and read a first time in the House of Commons on February 19th:—Sir J. Tuke (Edinburgh and St. Andrews Universities).—Bill to prohibit joint stock companies from acting as physicians, surgeons, or medical practitioners.

REVIEWS OF BOOKS.

MANUAL OF BACTERIOLOGY. (*a*)

WHEN the first edition of this manual appeared ten years ago, it at once sprang into popularity as a thoroughly reliable practical treatise on bacteriology, and with each successive issue it has strengthened the position it then took. The fourth edition now before us has been thoroughly revised, and is as fully representative of the contemporary status of bacteriology as its predecessors have been. During the four years which have elapsed since the third edition appeared, many advances of first-rate importance have been made, and, in consequence much new matter has been incorporated, without, however, materially increasing the size of the volume. We have only space to refer to a few of the alterations, but it ought to be stated generally that the authors, in re-writing their book, have adhered to their former plan of giving special prominence to the clinical aspects of their subject. The introductory chapters on methods have been thoroughly brought up to date, and now include, among other novelties, descriptions of Gordon's fermentation tests, the newer eosin-methylene blue stains, Graham Brown's chamber for anærobic hanging drops, and descriptions of the various forms of pipette, etc., which we owe to the ingenuity of Sir A. E. Wright and his collaborators. The account of the meningococcus rheumaticus is ample, and Beattie's work in this connection is referred to. The section on Weichselbaum's meningo-coccus has been considerably amplified, and mention is made of Flexner's researches, as well as Houston's work on its opsonic and agglutinative properties. Under tuberculosis the relations of bovine and human tuberculosis are discussed, and the findings of the Royal Commission, issued only a few months before this volume appeared, are alluded to. Recent discoveries in connection with the transmission of Malta fever and of plague are discussed, and there is a good description of present opinion on paratyphoid fever. Some of the chief additions concern the protozoal diseases. The spirochæte of syphilis is described, but, pending more exact knowledge of its biological condition, the writers have retained the disease, as also relapsing fever, among those due to bacteria. Protozoal diseases proper are fully dealt with in the appendix. Schaudinn's proof of the non-identity of the amœba coli and the amœba dysenteriæ is given, and the study of the life cycle of the malaria parasite has been much enlarged. There is a full description of the pathogenic trypanosomes, mention being made of Schaudinn's work on the hatteridium; an account of the parasite of kala-azar, and of the piroplasmores is also included. There is a very valuable chapter on immunity, which is both a most lucid and thoroughly up-to-date exposition of this difficult subject. This brief sketch of a few of the changes which have been made is enough to show that to a large extent the volume has been re-written, and we can confidently recommend it as a most excellent and readable treatise, admirably adapted to the study of all who wish to keep abreast of modern bacteriological research.

KEEN'S SURGERY. (*b*)

THE second volume of this excellent work deals with the various lesions of the bones, joints, muscles, lymphatics, skin, and nervous system. There are 13 chapters in all. The first four deal with diseases of and injuries to the bones and joints, and are contributed by Nichols, Eisendrath and Lovett. Then follows a chapter on the surgery of the muscles, tendons and bursæ by J. F. Binnie. The three succeeding chapters deal successively with orthopædic surgery, by R. W. Lovett; the surgery of the lymphatic system, by F. H. Gerrish; and the surgery of the skin, by J. A. Fordyce. The last four chapters deal with the surgical disorders and the surgery of the nervous system, and include a chapter on "Surgery Among the Insane and the Surgery of Insanity." These chapters are written by W. G. Spiller, G. Woolsey, F. X. Dercum and J. C. Da Costa.

The chapters on the surgery of the bones and joints take up quite half the book, and are very valuable contributions to surgical literature. The chapter on fractures is especially excellent, and is profusely illustrated. We are glad to notice that amongst the descriptions of the different fractures a full description is given of the fracture of the thumb metacarpal, described by the late Professor Bennett, of Dublin.

The surgery of the nervous system is also very full, and particularly good illustrations are given of the various operations on the nerves of the face. We hope that the importance attached to the description of hæmatoma auris amongst lunatics is not indicative of the frequency of that condition in American asylums. It has four pages devoted to it, and so lengthy a description in a work on surgery coming just after a very unpleasant description of the methods adopted in certain American asylums (which description lately appeared in the columns of the general Press), makes one rather suspicious. There are still three more volumes of this important work to appear, and if they are up to the same standard of excellence as their predecessors the book will be very hard to beat.

NEURASTHENIA. (*a*)

NEURASTHENIA is one of the diseases of modern life. The fact that Dr. Savill's admirable monograph has passed through three editions since its first appearance in 1899, is significant. Both the medical profession and the nervous public are concerned in the study and management of this prevalent and distressing malady. Dr. Savill's work will doubtless be read by representatives of both these classes. It is a comprehensive, suggestive and reliable treatise which, while dealing with the subject in a thoroughly scientific manner, is also practical and helpful. The form of the clinical lecture is followed throughout. The lectures dealing with diagnosis, pathology, and treatment have undergone considerable amplification for the present edition, and a new lecture has been added on etiology and prognosis. Dr. Savill believes that in all cases of neurasthenia there exists some degree of weakness of the nervous system, inherent or acquired, which renders the nervous system vulnerable to a number of disturbing influences, such as overwork and mental strain. He holds, however, that the gastro-intestinal symptoms, often regarded as a part of the disease, are really indicative of an antecedent causal gastro-intestinal derangement. In an analysis of the author's cases about 80 per cent. were found to be the subjects of some kind of auto-intoxication. A specially commendable feature of the work is the very serviceable and up-to-date bibliography prepared by the author's wife, Dr. Agnes F. Savill. We commend the volume to all physicians and medical advisers of latter-day valetudinarians.

McISAACS' NURSING TECHNIQUE. (*b*)

THIS little handbook is written for first-year nurses. The authoress, Miss McIsaac, is clearly well acquainted with the subject. Speaking from the basis of a fairly wide acquaintance with books upon nursing, we can confidently say we know of none which occupy quite the same place as this little volume. The essential point is its practical nature, and, so far as we have tested its pages, the information given is sound and accurate. The ground covered by the writer embraces a vast variety of surgical and medical technique, some of which, such as gastric lavage, we should have imagined somewhat beyond the field of action of a nurse in her first year. The price of this excellent little book is 3s. net.

(*a*) "Manual of Bacteriology." By Robert Muir, M.D., Professor of Pathology, University of Glasgow, and James Ritchie, M.D., Superintendent, Research Laboratory, Royal College of Physicians, Edinburgh. Fourth Edition. Edinburgh and London: Young. J. Pentland. 1907.

(*b*) "Surgery, its Principles and Practice, by various authors." Edited by William Keen, M.D., LL.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Vol. II. Pp. 920, with 572 illustrations and 9 coloured plates. Philadelphia and London: Saunders and Co. 1907.

(*a*) "Clinical Lectures on Neurasthenia." By Thomas D. Savill, M.D.Lond., Physician to the West End Hospital for Diseases of the Nervous System, London, &c. Third (revised and enlarged) edition. Pp. xvi, 216. London: Henry J. Glaisher. 1906. Price 7s. 6d. net.

(*b*) "Primary Nursing Technique." By Isabel McIsaac. New York: The Macmillan Company. 1907.

MEDICAL NEWS IN BRIEF

Claim by a Medical Man.

Dr. John Wilson, Cheltenham, at Gloucester Assizes, on February 18th, sued Mr. Hugh Baird for £732 for professional services rendered to the defendant and his wife between July 13th and November 20th, 1906.

Defendant paid £380 into court.

Paintiff's counsel said the circumstances were very exceptional, rendering special medical charges necessary. Mr. Baird suffered from chronic alcoholism, and was almost a dipsomaniac. Sometimes plaintiff was in attendance all night, and he had charged as much as £20, £30, and £50 a night, as defendant on these occasions required the whole of his attention and was very troublesome.

Mr. Baird alarmed the house and terrified the servants. On one occasion defendant was in the grounds in pyjamas, and was going to attack plaintiff, when his wife put her thumbs in his mouth, as a bit, and controlled him.

Plaintiff's charges for the period mentioned included £232 for day attendances, sometimes going three times a day, at one guinea per hour, and £500 for 14 night attendances.

Plaintiff said he was specially requested to get defendant fit for a garden party in his grounds, and did so, but next day he was as bad as ever. Defendant secreted spirits in all sorts of places. Once he threatened to throw himself out of the window, and plaintiff told him if he did his insurance money would all go, and what would be the use of that? That brought Mr. Baird to his senses. Plaintiff considered the charges were fair under the exceptional circumstances.

Medical evidence was called on both sides, and the jury eventually awarded plaintiff two guineas extra for each of the 14 nights, besides the £380 paid into court.

£30,000 for a Special Hospital for Mental Diseases.

An offer of £30,000 towards the cost of a special hospital for mental diseases has been made to the London County Council by Dr. Henry Maudsley. The offer was conveyed to the Council in a letter to the Chairman, which was read at last week's meeting. The following are the important features of the proposal, as outlined in Dr. Maudsley's letter:—

"As a physician who has been engaged in the study and treatment of mental diseases for more than half a century, I have been deeply impressed with the necessity of a hospital, the main object of which would be (1) the early treatment of cases of acute mental disorder, with the view, so far as possible, to prevent the necessity of sending them to the county asylums; (2) to promote exact scientific research into the causes and pathology of insanity, with the hope that much may yet be done for its prevention and successful treatment; and (3) to serve as an educational institution in which medical students might obtain good clinical instruction. The outline of the scheme is that the hospital should be for 100 patients suffering from recent and mostly acute insanity."

The Vice-Chairman of the Council (Mr. Stuart Sankey) proposed a hearty vote of thanks to Dr. Maudsley for his generous offer. Captain Hemphill (Deputy Chairman) seconded, and the motion was adopted, the letter being referred to the Asylums Committee for consideration and report.

Viewing the Body.

The text of the Bill to dispense with the compulsory viewing of bodies on the holding of coroners' inquests was published last week. The proposed measure is presented by Mr. Higham, supported by Mr. Luke White, Mr. Arthur Henderson, Mr. Summerbell, Mr. Toulmin, and Mr. Cameron. It is proposed that it shall not be necessary for either the coroner or jury at any inquest to view the body, unless the coroner, or at the first sitting of the inquest a majority of the jury, shall deem a view necessary. The Bill also seeks to amend the form of the oath of a coroner's jury by the omission of the words "of whose body you shall have the view."

Irish Medical Schools' and Graduates' Association.

The thirty-first annual general meeting of the Association will be held at the Hotel Great Central, Marylebone Road, London, on Tuesday, March 17th, 1908, at 6.30 p.m., when it is particularly requested members will make an effort to attend. On the same evening the members of the Association will dine together at the Hotel Great Central, at 7.15 for 7.30 p.m., the President, Sir Charles Cuffe, K.C.B., in the chair. The Rt. Hon. Sir Edward H. Carson, P.C., and Professor Windle, President Queen's College, Cork, will be the guests of the Association.

Royal College of Surgeons of England.

At an ordinary meeting of the Council, held at the Royal College of Surgeons of England, the following were admitted members of the College:—

A. C. Anderson, C. E. Anderson, A. G. Atkinson, T. R. H. Blake, H. Blakeway, S. L. Brimblecombe, J. P. Buckley, W. A. Burr, H. J. B. Cane, E. P. Carmody, A. J. W. Cunningham, S. T. Davies, B. Day, A. F. W. Denning, A. Dixon, J. McD. Eckstein, J. Everidge, A. L. Foster, H. Gall, E. W. Gandy, E. G. Gauntlett, W. Gilliatt, H. D. Gillies, G. R. Girdlestone, A. E. Gow, A. Hamilton, C. T. Hawkins, C. A. Holburn, N. W. Jenkin, G. Ley, E. L. M. Lobb, D. Loughlin, A. T. McCaw, D. Macrae, C. H. Marshall, J. B. Martin, T. M. Miller, R. J. G. Parnell, E. M. Parsons-Smith, H. Pinto-Leite, H. J. D'A. G. Price, R. B. Price, J. F. E. Prideaux, E. J. J. Quirk, P. C. Raiment, R. W. Rix, H. T. Rossiter, Mulk Raj Sawhney, F. C. Searle, L. W. Sharp, F. H. Stephens, H. Stott, G. F. Syms, W. R. Taylor, E. W. Toulmin, N. H. Vakeel, C. F. Walker, A. G. Wells, E. G. Wheat, J. N. Wheeler, E. B. C. White, W. C. Wigan, C. O. O. Williams, R. R. Williams, J. S. Williamson, W. L. R. Wood.

Royal College of Surgeons in Ireland.

Fellowship Examination.—The following candidates, having passed the necessary examination, have been admitted Fellows of the College:—B. P. Banaji, L.M. and S., Bombay Univ.; P. T. Carpenter, M.R.C.S.Eng., etc.; M. D. Healy, L.R.C.S.I., etc.; H. L'Estrange, L.R.C.S.Edin., etc.; T S. Reddy, L.R.C.S.Edin., etc.

The following passed the Primary part of the examination:—H. G. P. Armitage, Student R.C.P. and S.I.; K. K. Chatterji, L.M. and S., Calcutta University; W. Doolin, Student Roy. Univ. Irel.; A. Foley, Student R.C.P. and S.I.; E. W. O'G. Kirwan, Student Roy. Univ. Irel.; A. M. Lanphier, Student R.C.P. and S.I.; J. S. Pegum, Student R.C.P. and S.I.; R. H. Weir, Student R.C.P. and S.I.; R. White, Student R.C.P. and S.I.

Society of Apothecaries of London.

The following candidates passed, February, 1908, in:—

Surgery.—H. M. Jones (Section II.), F. B. O'Dowd (Section II.).

Medicine.—C. F. Curtis (Sections I. and II.), M Fisher (Sections I. and II.), O. C. H. L. Moll (Section I.), E. H. Paterson (Sections I. and II.), L. G. Powell (Sections I. and II.), W. W. Stacey (Sections I. and II.), N. C. Wallis (Section II.), H. F. Wight (Section I.).

Forensic Medicine.—C. F. Curtis, H. W. E Danaher, F. S. Hawks, L. G. Powell, H. C. Simpson, S. Speelman.

Midwifery.—L. G. Powell, H. C. Simpson, W. W. Stacey, S. H. Sugden.

The Diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—C. F. Curtis, F. B. O'Dowd, E. H. Paterson, and W. W. Stacey.

There are at present 23 patients suffering from cerebro-spinal meningitis in hospital at Belfast. During the week six fresh cases and three deaths occurred in the town.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Non-Filarial Chyluria.—Dr. Hertz presents a study of a case of chyluria occurring in England (*Guy's Hosp. Reports*, Vol. LXI., p. 857, and a short review of the previously recorded cases. The patient was a sailor, æt. 66, who had last visited the Tropics in 1886, and who was admitted to hospital in October, 1907, with pain in the loins, loss of flesh, and marked chyluria. A careful search for filariæ in both the blood and urine, at different times of the day, yielded no result, and as there was no eosinophilia, it was concluded that the case was due to some other cause. The fat in the urine was in extremely minute particles, resembling the molecular basis of chyle; a few leucocytes, some fibrin and albumin were also found, but no casts nor dextrose. From time to time the chyluria disappeared, as in other recorded cases, without apparent cause. The amount of fat varied directly with the fat taken in the food, and was found to increase steadily every hour up to the fifth after an ordinary breakfast or dinner. Exercise, especially of the lower extremities, definitely increased the amount of fat and albumin present, while posture independent of exercise did not appear to have any effect. A cystoscopic examination undertaken with the object of ascertaining whether the chyle entered the urine above or within the bladder did not yield any definite result. The patient died from an attack of acute bronchitis, and at the post-mortem examination an obstruction was found in the thoracic duct about 7 c.m. above the receptaculum chyli. Injection of the abdominal lymphatics failed to show any enlargement of those from the kidneys and ureters, but those on the right side of the bladder were very much enlarged and anastomosed freely with the intestinal lymphatics. From this fact the author concludes that a leakage most probably took place from these enlarged lymph channels direct into the bladder. It was not possible to drive mercury through them into the bladder cavity, but this, he thinks, may be explained by the fact that the chyluria had ceased for some days before death.
M.

Aspiration of a Pneumothorax under the X-Rays.—Fawcett reports a case of pneumothorax successfully treated by aspiration (*Guy's Hosp. Reports*, Vol. LXI., p. 49). The patient, a man, æt. 22, was admitted with the typical symptoms and signs of a right-sided pneumothorax. The cause was unknown, the only recent illness being an attack of pneumonia two years previously. There was no cough, expectoration, or hæmoptysis, and the tuberculo-opsonic index was normal. There was slight fever at first, but this soon subsided, without, however, any expansion of the lung taking place. Accordingly, after 19 days, it was decided to aspirate, and a trocar and cannula were introduced into the sixth intercostal space. The tubing of the cannula was then connected with a sterilised Winchester bottle, from which the air had been partly exhausted, and on turning the tap air was found to pass from the pleural cavity into the flask, while at the same time the lung was found to expand. The cannula was withdrawn, and a dressing placed over the punctured wound. The patient was kept on the couch for some time, and the lung was found to remain expanded and to move with respiration. The patient finally left hospital twelve days later, quite well.
M.

The Blood and Urine of New-born Infants.—Biffi and Galli have investigated the blood and urine of newborn children, and report as follows (*Journ. de Physiol. et de Pathol. Génér.*, IX., 5, p. 723):—(1) The red blood corpuscles continue to increase after birth, and reach a maximum on the second day. They remain at a high level for a week, and then gradually begin to diminish in number. (2) The volume of the red cells, estimated by a sedimentation method, varies directly with their number, and is greatest also on the second day. (3) The number of white cells falls after birth, and reaches a minimum about the seventh day of 12,000 cells per c.m. This number then remains constant for about a month. (4) During the first week the neutrophile cells preponderate, but after this the lymphocytes begin to increase. Nucleated red cells disappear after the sixth day. (5) The coagulation time is lengthened, the first formation of fibrin being noted nine minutes after the blood is drawn, and full coagulation only in about 20 minutes. (6) The urine during the first few weeks contains a colouring matter, similar to what is found in the blood plasma, and which appears to be bilirubin.
M.

New Test for Lactic Acid.—Thomas employs as a test for lactic acid the brown colour which is produced on treating this acid with a solution of chromic acid (*Zeitschrift f. Physiol. Chem.*, Bd. 50, S. 540). The colour is not given by acetic acid, butyric acid, hydrochloric acid, or acetone. The reaction is obtained by treating 6 c.c.m. of gastric contents with 3 or 4 drops of a 33 per cent. solution of chromic acid in a water bath for ten minutes. A bright yellow colour is first produced, which changes gradually to a reddish brown. The test is so fine that it detects .01 per cent. of lactic acid. The addition of a few drops of peroxide of hydrogen causes the colour to appear in the cold after a few minutes.
M.

Review of Five Years' Experience with HCl Treatment of Gout.—Falkenstein (*Berlin Klin. Woch.*, Dec., 1907) reviews the work of Pfeiffer, van Loghem and Lilbergleit, Brugsch and Schittenhelm on the effect of large doses of HCl in gout. He agrees with their results, but does not believe that gout is due to a faulty nuclein metabolism. He lays most stress on the fact that in the stomachs of gouty persons, according to most observers, there has been a lack of HCl. In the last five years he has treated 390 cases of gout with HCl, including himself. He himself is taking about 60 gtts. of concentrated HCl per diem, well diluted. Most of his cases, whether early or very marked, have had relief from attacks, or the severity of the attacks has been lessened. Colchicin, aspirin, and many other remedies recommended for gout have had a certain amount of influence on the course of the acute attack, and have alleviated pain, but have not influenced the course of the disease, which the author claims may be arrested by the continued use of HCl.
D.

The Heart Reflex and the Mechanism of Angina Pectoris.—(*Adams' Med. Record*, Dec., 1907.) The heart reflex is a contraction of the myocardium of varying duration, brought on by reflex irritation. Irritation of the skin in the præcordial region brings out this reflex, but it is also elicited by irritation of more remote regions, *e.g.*, of the nasal, œsophageal, gastric and rectal mucosæ, by percussion of the muscles, vertebral concussion and by psychic irritations. That it is a true reflex is shown by the fact that it does not appear when the mucous membrane becomes anæsthetic by cocain. This reflex is best observed by the X-ray. It is more manifest in the left than in the right ventricle. In some individuals it may be scarcely perceptible, while in others the heart's outlines may recede more than 2 c.m. In persons with dilated hearts the reflex is especially evident and much more prolonged. As a rule the duration is over two minutes. When the reflex is in evidence, the heart is practically inhibited. Inasmuch as the factors precipitating a paroxysm of angina are equally operative in inducing the heart reflex, viz., emotion, muscular exertion, etc., the writer is led to the ingenious conclusion of the connection between the two conditions. The coronary arteries in his theory are passive agents. The heart is inhibited and contracted; hence a claudication ensues which explains the symptoms. D.

Migraine and Epilepsy.—Gordan (*Therapeut. Gaz. Detroit*, Dec., 1907) reports ten cases to illustrate the principle that migraine due to morbid metabolism has an undoubted relationship to a faulty thyroid function. Migraine patients with migraine are usually free from the affliction during pregnancy, during which period there is functional hyperactivity of the thyroid. Of course, not all cases are directly ascribable to this source, but the therapeutic test by thyroid feeding is at the same time diagnostic as regards pathogenesis That there is a relation of the seizures of essential epilepsy to a faulty chemistry of the organism is now generally admitted. The six patients who were studied with special care for a long time all showed signs of hypothyroidisation. When the thyroid treatment was instituted a remarkable change took place, first, in the general condition, then the epileptic seizures became rare. There is a certain class of epileptics whose seizures are in direct relationship with a disturbed function of the ductless glands, particularly the thyroids. In such cases the failure of the usual treatment lies in the want of thyroid feeding. D.

Intestinal Arteriosclerosis.—Cheinisse (*Semaine Med. Paris*, Dec., 1907) reviews the scanty literature on arteriosclerotic changes in the intestinal vessels and the symptoms which they elicit. Abdominal pain, in persons past 40, occurring in paroxysms, generally after physical exertion or emotional stress, should suggest intestinal arteriosclerosis, he states, especially if the pain comes on when reclining. The mechanism of the disturbance is similar to that of intermittent limping—the ischæmia of the intestinal vessels causing painful cramp with transient paralysis of some segment of the intestine and consecutive meteorism. The trouble has been called "intermittent ischæmic dysperistalsis" and "intermittent arteriosclerotic intestinal dysphagia." Dubious cases may be differentiated by giving tincture of strophanthus, from 5 to 8 drops three times a day. Narcotics and other measures to soothe the pain are generally useless, but drugs that control angina pectoris may prove effectual, especially strophanthus and theobromin. Jaquet has reported excellent results from the use of potassium iodide or potassium nitrate combined with sodium nitrate, the combination recommended by Sir Lauder Brunton for chronic arterial hypertension. D.

Ætiology of Infantile Eczema.—Hall (*Brit. Journ. of Dermat.*, 1908) gives the result of the examination of 100 consecutive cases of eczema occurring during the first year of extra-uterine life. He finds that about four-fifths of the cases occur during the first four months of life, and that male children are much more commonly affected than female, the proportion being 78 to 22 per cent. The disease is much more common during the colder months of the year than during the summer, only 7 of the 100 cases began during the months of June, July and August. He finds no evidence of vaccination as an ætiological factor, the number of cases in which it follows that operation being less than one-third of the whole. In over four-fifths of the cases, also, the first dentition had not begun when the rash first appeared. The primary site of the eruption is almost always on some part of the scalp or face, and it always becomes bilateral and usually symmetrical. The disease is usually most severe in or about the region of the primary site. Hall is of opinion that "such a uniformity of primary situation at least suggests a diminished local resistance to the ordinary external irritants of daily life." There does not appear to be any particular local irritant, but "the fact that only 7 per cent. of the cases began during the summer quarter seems to support the view that exposure to cold winds may be the common external irritant." K.

Veronal Dermatitis. — Ormsby (*Cleveland Med. Journ.*, Jan., 1908) reports a case of this rare form of drug eruption. Only some eight or nine cases have been recorded since the drug was introduced by Fisher in 1903. In some of these cases the eruption was vesicular or pemphigoid, and in others consisted merely of an erythema. Ormsby's patient was a woman, æt. 54, suffering from varicose veins of the legs. She was ordered two 5-grain doses of veronal in the day to procure sleep, and about five days later became feverish, and had some itching of the skin, especially between the fingers and toes, and on the dorsal surface of the hands and feet. The fever continued, and she became delirious. The dermatitis spread to the arms, legs, trunk and face, and was accompanied by considerable œdema, redness and itching, but there does not appear to have been any development of vesicles or bullæ. The whole condition of the patient resembled that of an acute attack of general erysipelas. The inflammation generally subsided, and had entirely disappeared in six days, but was followed by extensive desquamation. The nails also became black and brittle, and were eventually shed. K.

Lack of Gastric Mucus and its Relation to Hyperacidity and Gastric Ulcer.—Kaufmann (*Amer. Journ. of the Med. Sciences*, Feb., 1908) contributes an interesting article on this condition, which he considers a very important factor in the production of diseases of the stomach. In order to recognise the absence of mucus from the gastric secretion, it is necessary to examine the contents of the stomach after a test breakfast. The absence of mucus may then be recognised macroscopically by finding the particles of bread more or less finely divided, distinctly separated, and forming a flour-like layer from which the watery constituents of the test meal quickly separate. This finding can be confirmed by staining with Lugol's solution, which does not mix with the mucus. If mucus is absent, all the starch grains and yeast will be stained, but if mucus be present in normal quantity, most of these particles are protected from the stain. The mucus is to be looked on as a protection to the gastric mucosa. If the gastric juice is of low acidity, the lack of mucus will not cause any symptoms, but if the acidity is normal or increased, severe symptoms of gastric irritation will follow. In this way Kaufmann explains those cases which present the symptoms of hyperacidity, but in which the gastric secretion shows no excess of acids. Treatment by lavage with solutions of silver nitrate quickly relieves the symptoms of hyperacidity, but in many cases so treated it was found that after the symptoms had completely disappeared the hyperacidity of the gastric juice was not really lessened. A marked increase in the mucus present was, however, always found in such cases after the treatment. Kaufmann concludes that, "without sufficient covering of mucus the gastric mucosa becomes more easily injured by the many insults to which it is constantly subjected. When once injured, even though slightly, the damaged part becomes more prone to the invasion of bacteria and to the digestive action of the gastric juice. Again, the thinner the layer of protective mucus the easier will these secondary deleterious insults to the injured mucus membrane take effect. Under such conditions the digestive activity of the gastric juice must be particularly pronounced when hyperacidity is present. It is probable that such occurrences are the primary disturbances in the development of gastric ulcer. The majority of cases of gastric ulcer give a history of a more or less prolonged period of suffering from so-called hyperacidity symptoms." K.

The Army and Navy Male Nurses' Co-operation (which is under the patronage of Her Majesty the Queen, and was founded by Miss Ethel McCaul) has taken the Caxton Hall, Westminster, for the purpose of holding "The World's Jumble Sale" on May 22nd and 23rd next. This will afford an opportunity to all, and especially the women of the country, of assisting this most deserving Institution, and this they can do by presents of second-hand articles useless to themselves but of great value to those organising the sale. The Sale Secretary (Miss I. Crowdy) will be most pleased to send a collecting sack for such presents on receipt of a card desiring her to do so, addressed to the offices, 47b, Welbeck Street, W.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.**

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

H. G.—The Paris Courts recently decided that no legal responsibility rests upon a medical man in respect to warning a patient to whom an anæsthetic is about to be administered that, in a certain number of cases, a fatal result ensues from the anæsthesia.

As Influenza (so-called) is now so prevalent, a few lines on the subject from a victim might be found appropriate:—

A VICTIM'S EXPERIENCE OF INFLUENZA.

When your sitting in your tub, only gruel for your grub,
And your head feels like a beehive all the time,
And you cannot sleep a wink,
And you think, and think, and think,
And imagine you are punished for some crime!
And you wonder what comes next,
And with everything you're vexed,
And you're thinking what the deuce is wrong with you,
And your eyelids feel like lead,
And you're bound to stay in bed,
You've got a jolly dose of what's *called* "Flu" ! A. D.

C. B. T., M.D.—We are sorry about your letter, but do not remember receiving it, and can find no reference to it. We think you will admit that the views you support are not those of the bulk of the profession, nor are they our own. And we hope that we are not unfair, even when we think it right to speak emphatically.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 26TH.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Prof. D. Armour: The Surgery of the Spinal Cord and its Membranes. (Hunterian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. L. Mummery: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. L. Paton: The Retina in Albuminuria.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Outpatients Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

THURSDAY, FEBRUARY 27TH.

CHILD STUDY SOCIETY, LONDON (Parkes Museum, Margaret Street, W.).—8 p.m.: Sir Edward Brabrook: Introductory Address.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. F. Taylor: Leukæmia.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappell). 4.30 p.m.: Lecture:—Dr. A. G. Auld: Asthma, its Pathology and Treatment.

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Baldness, its Causes and Treatment.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Mr. Fairbank: Surgical Treatment of Paralyses.

THE THROAT HOSPITAL (Golden Square, W.).—5.30 p.m.: Mr. Parker: Chronic Inflammatory Affections: Treatment.

FRIDAY, FEBRUARY 28TH.

ROYAL SOCIETY OF MEDICINE (EPIDEMIOLOGICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Mr. R. C. Punnett: Mendelism in Relation to Disease.

ROYAL SOCIETY OF MEDICINE (ELECTRO-THERAPEUTICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Dr. L. Jones: The Principles and Practice of Ionic Medication.

ROYAL SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m.: Dr. J. S. Haldane: The Removal of Dust and Fumes in Factories (Shaw Lecture on Industrial Hygiene.)

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Prof. D. Armour: The Surgery of the Spinal Cord and its Membranes. (Hunterian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Dr. J. Horne: Clinique. (Throat.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. C. Beale: Ulcerative Endocarditis or Cases of Interest in the Medical Wards.

MONDAY, MARCH 2ND.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Prof. F. C. Shruball: The Physical Antropology of the Pigmy and Negro Races of Africa.

THE THROAT HOSPITAL (Golden Square, W.).—5.30 p.m.: Mr. Faulder: Diseases of the Perceptive Mechanism: Acute.

Appointments.

CURTIS, HENRY, B.S., M.D.Lond., F.R.C.S.Eng., Assistant Surgeon at the Branch Seamen's Hospital, Royal Albert Dock, E.

LEITCH, ARCHIBALD, M.B., Ch.B.Glasg., Investigator into Cancer in connexion with the Dundee Royal Infirmary.

SHAW, JOHN EDWARD, M.B., C.M.Edin., Honorary Consulting Physician to the Bristol Royal Infirmary.

SIMPSON, GRAHAM, F.R.C.S.Eng., Clinical Tutor in Surgery at the University of Sheffield.

SMITH, E. ARCHIBALD, M.B., F.R.C.S.Eng., Honorary Surgeon to the Western General Dispensary, Marylebone Road, London, N.W.

TURTLE, GODFREY DE BEC, M.D., B.S.Durh., M.R.C.P.Lond., Physician to the Public Dispensary, Drury Lane, W.C.

WETHERALL, PRITZLER SIM BATTEN, L.R.C.P.Lond., M.R.C.S., Medical Officer for the Weymouth Workhouse.

Vacancies.

Liverpool Dispensaries.—Assistant Surgeon. Salary, £100 per annum, with board and apartments. Applications to the Secretary, 56, Vauxhall Road, Liverpool. (See Advt.)

County Borough of Middlesbrough.—Education Committee.—Medical Inspection of School Children.—Assistant to the Medical Inspector of School Children. Salary, £300 per annum. Applications to J. S. Calvert, Secretary, Education Committee, Municipal Buildings, Middlesbrough.

Barnsley Hall Asylum, Bromsgrove, Worcestershire.—Second Assistant Medical Officer. Salary, £150 per annum, with furnished quarters, board, washing, and attendance. Applications to the Medical Superintendent.

Lanark County Council.—Bacteriologist. Salary, £250 per annum. Applications to the County Medical Officer, Hamilton.

Plymouth Education Authority.—School Medical Officer. Salary, £250 per annum. Applications to E. Chandler Cook, Secretary, 18, Princess Square, Plymouth.

Manchester Royal Infirmary and Dispensary.—Honorary Assistant Gynæcological Surgeon. Applications to the Secretary. (See Advt.)

Metropolitan Asylums Board, London.—Assistant Bacteriologist. Salary, £300 per annum Applications to the Clerk, Metropolitan Asylums Board, Embankment, London, E.C.

Births.

BUCKNALL.—On Feb. 20th, at 16 Devonshire Street, Portland Place, London, the wife of Rupert Bucknall, M.S., M.D., Lond., F.R.C.S., Eng., of a son.

HERRINGTON.—On Feb. 21st, at 18 Lorrimore Square, Kennington Park London. the wife of Edmund W. Herrington, L.R.C.P., M.R.C.S., L.S.A., D.P.H., of a daughter.

STRATFORD.—On Feb. 20th, at 210 Worple Road, Wimbledon, the wife of Howard M. Stratford, M.R.C.S., L.R.C.P., of a son.

Marriages.

BRERETON—BAKER.—On Feb. 20th, at Manchester Cathedral, John Neville Brereton, N.M.A., to Florence May Baker, younger daughter of the late Benson Baker, Esq., M.D., L.R.C.P., of London.

DARTNELL—GILMOUR.—On Feb. 22nd, at St. Michael's, Mickleham, Surrey, Staff Surgeon Louis E. Dartnell, R.N., to Margaret Ethel, third daughter of the late David Gilmour and Mrs. Gilmour, Mickleham Downs, nr. Dorking.

FELCE—STRATTON.—On Feb. 21st, at Christ Church, Winchester. Gilbert Carlyon, youngest son of Stamford Felce, M.R.C.P., M.R.C.S., of Cope Hall, Newbury, to Hilda, daughter of Frank Stratton, J.P., of Manningford-Bohnne, Wilts.

Deaths.

BARNES.—On Feb. 20th, at Sunningdale, West Worthing, Robert Sydenham Fancourt Barnes, M.D., F.R.S.E., of 15 Chester Terrace, Regent's Park, aged 59.

BELL.—On Feb. 22nd, at 17 West Southernhay, Exeter, Blanche Noble, the beloved wife of Charles E. Bell, M.R.C.S., L.R.C.P.

HARLEY.—On Feb. 21st (suddenly), Robert William Harley, M.D., of 31 Pembroke Road, Dublin, aged 67.

NORMAN.—On Feb. 23rd, at his residence, S. Dymphna's, N.C. Road (suddenly, of heart failure), Conolly Norman, F.R.C.P.I., Resident Medical Superintendent Richmond Asylum, fifth son of the late Rev. Hugh Norman, aged 54.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MARCH 4, 1908. No. 10.

NOTES AND COMMENTS.

The Licensing Bill.

THE question that medical men will set to themselves about the Licensing Bill introduced in the House of Commons last week, will be: Is it a measure that will make for the increased sobriety of the nation? If they are able to answer it in the affirmative, the Bill will be very welcome; but if they conclude the measure is mere "window-dressing" it may well be left to fight its way through the stormy arena of politics. Drunkenness and drinking are the prime cause of, and constitute the most important ancillary features in, an enormous number of diseases, and it is within the truth to say that national longevity would be prolonged, illness much more infrequent, and many diseases entirely banished, if there were no such thing as alcohol. It is, however, one thing to recognise a disease and another to prescribe a remedy. There is much to be said for the view that is is impossible to legislate a man into temperance if he is alcoholically inclined, and quite a body of opinion in favour of Dr. Archall Reid's suggestive, but pessimistic, theory that a people has to pass through a stage of energy and drunkenness before it reaches one of nonentity and sobriety. In our view, drunkenness is a symptom expressing social unrest and discontent, that is to say, alcohol is used as an anæsthetic for the woes, physical and mental, of life, and the indication is to deal with the causes lying deep in our system of civilisation which produce the symptom. The Licensing Bill, if it passes, will provide an experiment which will be watched nowhere with more interest than in the out-patient departments of hospitals and among those who attend many of the poor.

The L.G.B. and Carlisle.

WE have had occasion lately—and good occasion—to criticise the attitude of Mr. John Burns in regard to the medical profession, namely, when he, himself a staunch Trade Unionist, imposed an invidious obligation on medical men, and urged them to rise higher than their Trade Union. It is, therefore, with all the more pleasure that we notice an act of his which shows an appreciation of the services of medical men to the public health. The Town Council of Carlisle recently determined to have a whole-time Medical Officer of Health, and offered the ambassadorial salary of £400 a year to the successful applicant. The President of the Local Government Board, however, promptly wrote and intimated that the Board would not sanction the arrangement unless a salary of £500 were supplied, because it is necessary to secure for medical officers "such a position as will enable them to perform their duties impartially and independently," and also because it is desirable that they should not be regarded as holding "an inferior position as compared with other medical men." This is wholesome doctrine and from the right source.

Penny Wisdom.

THE evolution of the Public Health Service is slow, and it certainly is not taking place altogether in the right direction. Sanitary authorities, it is true, are inclining more and more to the "whole-time" principle, which is the only logical one for a medical officer to hold if he is to be independent and impartial, but the salaries offered are so small that these posts cannot continue to attract the best class of man. It is hardly to be expected of human nature that the most intellectual and energetic men in the profession will continue to apply for posts, mostly held on uncertain yearly tenancies, and all without pension, when they can earn £1,000 a year and upwards in general practice. Young men may take the smaller sum when there are prospects of promotion, but the tendency is for £600, £700, or £800 a year to be made a top price. If counties and large towns do not offer more than those sums, the result must be that men will see how little there is to hope for in the public health line, and only mediocrities, or those below even that standard, will apply. Considering the paramount necessity for thorough development of public health administration if the community is to prevent the many evils of civilisation, money laid out on the best advice may be regarded as the best investment Society can make, and is it really asking too much to suggest that the Medical Officer of Health should be paid not less than the Town or County Council Clerk?

Vaccination Fees.

THE revised scale of vaccination fees is being put into force by various Boards of Guardians, and a good deal of discontent is naturally evinced by public vaccinators. We confess to considerable sympathy with them. The question is not one of the efficacy of vaccination, or the policy of primary vaccination for infants, but simply one as to whether the fees are sufficiently liberal to remunerate practitioners holding the appointment of public vaccinator. It is merely stupid to expect vaccinations carried out with elaborate precautions, and done at a patient's home, to be paid for on anything like the old scale when "stations" were in vogue, and a vaccinator could vaccinate a score or two of children in an hour or so a week. The idea is even more preposterous when the elaborate book-keeping and correspondence entailed by the new plan is taken into account. The benefits now received by the public must be paid for, and naturally the cost of vaccination has risen considerably, to the chagrin of the noisy section which hates vaccination and all its works. It is, however, but fair to remember that the accidents of the operation are reduced to minimum by the new plan, and it is essential in the interests of the community that this high level of efficiency should be maintained. Moreover, a public vaccinator is always a private practitioner, and the demands made upon him in his official capacity vary enormously. He is not allowed to vaccinate by deputy, at least to any considerable extent; and in periods of threatened epidemic the whole of his private practice is dislocated by the rush of applicants for vaccination. One man is only capable of doing a certain amount of work, and what he receives in fees from the guardians he probably loses in private connection. Cheese-paring boards must take these facts into consideration.

Free Medical Advice.

IT would be interesting, but presumably impossible, to obtain an authoritative census of the number of people who obtain their doctoring for nothing, and of those who obtain it for nothing in all cases of serious illness. The *Newcastle Journal* the other day pointed out that in that city there were no less than thirty institutions for the relief of the sick poor, and propounded the question, "How many fewer than two-thirds of the Newcastle sick get medical aid for nothing—medical aid at the expense of the ratepayers and the charitable?" Like Pilate's query of old, we fear this question is likely to remain possessed of a higher suggestive than intrinsic value; but it is interesting that a lay journal should have been so much struck by the phenomenon of wholesale medical relief as to submit the proposition to its readers. No one grudges gratuitous medical help to the genuinely unfortunate in the battle of life, and it is certainly better that a few rogues who can afford to pay should be seen for nothing than that a deserving case should be unattended. But there are limits to the time of medical men and economic limits to the practice of seeing all applicants who put in an appearance at hospitals, and the probability is that there is a very small percentage of the poor who could not make some definite provision for sickness, if it were brought to their knowledge that they were expected to do so.

A Needed Inquiry.

IN London the Prince of Wales has been well advised to decide on appointing a committee to inquire into the "system" of admitting and treating out-patients at the various hospitals, for there is probably no city in the kingdom where more abuse takes place, and where the working classes contribute so little to the hospitals. The actual appointment of the committee is postponed till the Royal Commission on the Poor Laws has reported, for it is thought with good reason that otherwise a good deal of the work of the two bodies would overlap; but we warmly welcome the idea of such a committee, and we are sure it will have the support of all hospital reformers. The utter chaos existing in the hospital world is a reproach to civilisation. Anybody goes to any hospital at any time, and demands relief on the spot, knowing that he cannot be refused treatment, even if the injury is a pinprick or flea-bite. If hospitals were attached to certain areas, and only people living in that neighbourhood were entitled to relief, there might be a chance of eliminating the unworthy, but as things stand now there is no satisfactory method of dealing with impostors, and some, as is well known, make the tour of the hospitals getting for considerable periods medicine from all and a bed at some. It is much to be hoped that the committee will report in favour of out-patient departments being made purely consultative, such as is the case now at the Belgrave and Bolingbroke Hospitals, except, of course, in the case of emergencies. And even the "emergency" consultation is liable to many abuses. There is no reason why a workman or butcher who cuts his hand should have it dressed for nothing at a hospital. All works at a distance from hospitals have their own "first aid" men, and it is the obvious duty of those near to make similar provision. There is a greater want of comprehension as to the function of hospitals than of almost any other public institution.

LEADING ARTICLES.

QUACKERY IN AUSTRALIA.—No. 1.

UNDER all climates and in all races there is to be traced a community of intellectual habit that probably springs from a single ancestral origin. One of the many interesting problems that presents itself to the philosophical student of sociology is the universal patronage bestowed by mankind upon quacks and quackery, no matter how well supplied they may be with medical practitioners duly qualified and equipped with the best modern knowledge. The man in the street, whether in London, New York, Cape Town, Yokohama, Pekin, Madrid, St. Petersburg, or where you will in scores of nations, prefers the confident assurance and promises of the quack to the guarded probity of the responsible medical man. It seems doubtful whether the general spread of education will remedy this defect in human judgment. Some of our greatest philosophers have been given over to the toils of the nostrum vendors, and it is well known that in the House of Commons it would have been hopeless to introduce legislation against irregular practice during the lifetime of a notorious bonesetter who departed this life some years ago. In the United Kingdom for some time past, Mr. H. Sewill, adopting the policy for many years advocated in THE MEDICAL PRESS AND CIRCULAR, has strongly advocated the appointment of a Royal Commission to ascertain the nature and extent of the evil of quackery. This certainly appears to be a necessary and logical step which will furnish both legislators and citizens with a mass of trustworthy evidence upon which a sound opinion may be based. Australia has been before us in this matter, as we are reminded by the appearance of the first volume of the Report of the Royal Commission on Secret Drugs, Cures, and Foods. The scope of the inquiry is stated to be: (*a*) The manufacture, importation, announcements, offering for sale, sale, and use of preparations commonly known as patent or proprietary medicines and of drugs, alleged curative agents, medicinal preparations, toilet articles, foods, and drinks, the composition of which is not disclosed, and which are alleged to have medicinal or remedial qualities; (*b*) the effects or consequences of the use of such articles; and (*c*) the legislation and administration in Australia and elsewhere relating to any of the aforesaid matters. The subject under investigation has been divided into six chapters or divisions, namely, prevention of conception and fœticide; infanticide; injury and death to the adolescent; injury and death to adults; advertisements, and legislation. An immense mass of matter has been collected under these various headings, and in many instances the advertisements themselves are produced in facsimile. To attempt anything like an analysis in a leading article would, of course, be out of the question, but in future articles we shall hope to deal with further details. Speaking of drink cures, the Report observes that drunkards, like other afflicted persons, are choice game for swindlers. Many fraudulent secret cures are herein set forth, and a host more are thrust forward upon the public, or, rather, upon the self-denying friends of the inebriates, thus causing much grief and ruin. The pith of the matter is arrived at in the terse proposition that, "if there be merit in the cures there should be no secrecy; if there be secrecy it is incredible that there should be merit." "Drink cures" have always been strongly attacked in our own columns, so that the emphatic condemnation offered in the Australian Report comes with an exceptional claim upon our attention. The cruelty of many of these preparations, specially aimed at women, lies in the fact that they are largely made of cheap white spirit, and are consumed by way of private debauchery. One form of bitters, for instance, is made up with spirit to half the strength of whisky. It seems almost incredible that a preparation which has a wide sale as a cure for kidney disease should have nine-tenths of the strength of whisky. The Bile Bean case is fully discussed, and some astonishment is expressed that, after the unsparing condemnation of that preparation by Lord Ardwell in the Court of Session of Scotland, in 1905, there is no suggestion for stopping the sale, no suggestion that the State should cease to participate in the total receipts by its average share of one-eighth, no suggestion, as a matter of course, that any punishment should follow. It is to be noted that most of the secret preparations exposed and condemned by the Australian Commission flourish in the United Kingdom. If the General Medical Council be in earnest in their recent pious resolution with regard to quacks and quackery, they will find an immense quantity of material at their hands in the Australian report. It is shown therein that every range of therapeutic knowledge has been ransacked. At the end of a long classification it is added naïvely: "The foregoing list is incomplete in itself, and to it must be added—an interminable series of quack secret cure-systems, which is being ever augmented. These embrace everything conceivable in health and in disease under like trickery, treachery, humbug, and fraud. They are not subject to preliminary examination, license, and inspection. Though these humbugs are notorious and often ridiculous, prosecutions are either rare or entirely absent." In our next issue we propose to deal with some of the conclusions and recommendations presented in this important Report. It is to be hoped that before many years have elapsed a similar volume may be issued by the legislature of the United Kingdom.

THE TUCKER ASTHMA CURE AGENT FINED.

Hardly have the reverberations of the recent libel case, Tucker *versus* Wakley died away, than the agent (or proprietor) of that "cure" again figures prominently in the public gaze. This time he has been prosecuted for selling "certain poisons, to wit, cocaine and atropine, contained in a bottle bearing the words 'Nathan Tucker, M.D., specific for asthma, hay fever, and all catarrhal diseases of the respiratory organs,' which bottle, when sold, was not distinctly labelled with the word, 'poison,' and with the name and address of the seller." In support of this precise, if not elegantly worded charge, Mr. Thomas Tickle, public analyst, stated the fluid in the bottle contained 3.6 grains of cocaine, and .91 grains of atropine. It appears that the purchaser went to the house of Mr. Augustus Q. Tucker, at Herne Hill, and asked him for a bottle of his specific. He further explained, in answer to a question, that he wanted a one-ounce bottle, which was handed him by the defendant without further ado, paid for, and the customer walked away. Medical evidence showed that the contents of the bottle, if swallowed, would probably cause death. The bottle appears to have had no label or attached directions. For the defence it was alleged that it was Mr. A. Q. Tucker's practice to send out the bottle with minute instructions that it was to be used only as an inhalant. The defendant, through counsel, further stated that until quite recently, he was totally unaware of the ingredients of the specific, which represented an extremely valuable professional secret, the discoverer being his brother, Dr. Tucker, a distinguished American physician, for whom he acted as agent in this country. In the upshot, a fine of £5 and £5 5s. costs was inflicted. The result will serve as a reminder to all concerned in combating the evils of the patent medicine trade, that there are various methods by which action can be taken. Where the ingredients of such preparations contain deadly poison, a prosecution can always be undertaken, unless the word "poison" is printed legibly across the label. The presence of such a precautionary warning would certainly render many persons more chary in resorting to a palpably dangerous remedy. The glimpse behind the scenes afforded by this prosecution, apart from its serious significance, is worthy of the pen of a Dickens. An American gentleman, one of whose Christian names we understand, is "Quackenbusch," drives a huge trade in an American specific for asthma. In the United Kingdom there is a stringent Poisons Act for the protection of citizens. A number of active poisons are carefully scheduled, and a customer wishing to purchase any of these poisons must go to a qualified chemist, and satisfy him as to *bona fides*, and have careful entries made as to the details of the transaction in a book kept specially for that purpose. The American nostrum agent, however, is not hampered by any considerations as to the possibility of collision with the Poisons Act. By his own confession he does not even trouble to inform himself as to the nature of the drugs which he is distributing broadcast, for it has been shown in evidence that a large trade existed in this American "specific." The irony of the whole situation is evident to the medical profession, who know that asthma is a symptom due to various causes, for some of which it would be hopeless to expect cure from powerful drugs applied to the nasal mucous membrane. That aspect of the question was taken up rigorously by the *Lancet*, who have had to pay the penalty for their assumption that the law would demand that the vendor of a nostrum should substantiate scientificially the therapeutic claims advanced by him on behalf of his specific. We fear that our distinguished contemporary will glean but cold comfort from the reflection that it has been a generation in advance of the times. On the other hand, its public-spirited action has earned the sympathy and respect of all interested in the true welfare of legitimate medical science.

CURRENT TOPICS.

Bravery and Hypnotism.

THE Westminster Coroner recently had occasion to eulogise in the warmest terms the promptitude and bravery shown by a lady doctor. A cook in a certain house had the misfortune to set fire to her clothing, which a carpenter and a manservant tried in vain to extinguish. At that point Dr. Ettie Sayer appeared on the scene, threw the unfortunate woman down on the ground, and promptly extinguished the flames with the aid of a rug. The subsequent inquest revealed the fact that the cook was dressed in the fatal flannelette. A neighbouring medical man, who was called in, applied hypnotism without avail, for the poor woman died soon afterwards as the result of her injuries. We do not recall the use of so unusual a therapeutic agency as hypnotism under similar circumstances, nor could it be imagined that such a proceeding is likely to meet the approval of the medical profession generally. Were similar treatment to be applied by an unqualified person he or she would be liable to prosecution. As to the flannelette its use for articles of dress should, in our opinion, be forbidden. As to Dr. Ettie Sayer, she deserves honour at the hands of the profession as well as of the public. We should be pleased to organise a testimonial.

Chemist as Medical Man.

THE Cardiff Coroner, Mr. W. L. Yoratto, certainly has the courage of his convictions when called upon to deal with unqualified medical practise. A plumber's wife of the town took her three-year-old child to the shop of a chemist, where an assistant said the sickness was influenza, and gave a bottle of physic. As a matter of fact the disease was diphtheria, which proved fatal a few days later. As every medical man knows, the early recognition of diphtheria is essential to any fair chance of cure. On the other hand, it is well-nigh impossible to diagnose influenza in a baby, so that on all accounts the amateur doctor could not have chosen a more unfortunate case for the exercise of his fatuous diagnosis and fateful treatment. The Coroner pointed out it was the duty of the chemist to dispense and not to prescribe, and the case should serve as a warning against chemists treating disease, and to all people to call in a doctor rather than to risk life in that way. Surely some further action should be taken by the police or by some other bodies concerned in this gross violation of public interests. The medical man called in during the later stage of the disease said in so many words that the child probably would not have died had she been taken to a medical man instead of to a chemist. There is no need to emphasise the significance of that exceedingly strong and apposite statement.

Medical Men and the Civil List.

THE case of Dr. Hall Edwards, the well-known radiographer, who has recently lost his arm through prolonged exposure to the X-rays and consequent dermatitis, has recently been brought to the notice of His Majesty King Edward. It was suggested that he would be a fit recipient for a civil pension. A letter of sympathetic appreciation has been returned, pointing out that the more regular course for such an application would be through the Prime Minister. Although we cannot recall any instance in which the disablement of a medical man sustained in the exercise of his profession has been recognised by a pension, we can, nevertheless, imagine no more worthy recipient for the bounty and gratitude of the nation.

Delusions in Court.

THE proceedings of police courts now and then suggest obvious insanity on the part of prosecutors or defendants, a fact that does not appear to have suggested itself to anyone concerned. In the coroner's court the mental condition is kept more in view, and miscarriages of judgment are not so likely to happen. A curious case of delusions in father and son came before the Hackney Coroner last week. The inquest was held upon the body of a man who was said to have been killed by flames emitted from a telephone receiver. The chief witness was a son of deceased, who stated with detailed emphasis that the breath was drawn out of his father's body by a flashlight from the National Telephone Company. Death was caused, in his opinion, by a complicated system of wires. Another son stated that he had heard his father speak of the flashlights, but had never seen them himself. The whole evidence of the former witness reads like a page from an asylum record. A curious point about the incident is that possible danger from telephone receivers has been suggested. In more than one instance fires in the City of London have been traced to contact of telephone wires with "live" conductors of electric railways. The danger of electricity conducted by wires is a form of delusionary insanity familiar to all who have to deal with mental disease.

The Proposed Taxation of Motor Cars.

IT is strange that at the present moment, when the further taxation of motor-cars is being so generally suggested, it is apparently left to the lay journals to suggest that motor-cars belonging to medical men should be treated as the shepherd's dog and allowed to escape taxation. Moreover, as far as we know, not one of the various bodies who are supposed to guard medical interests have taken any steps to place their views on this important subject before the Chancellor of the Exchequer. The only person who appears to have taken any interest in this particular question is Dr. J. J. Lock, who attended with a deputation from the Motor Union and addressed the Chancellor on the part of medical men. His action in this respect was most commendable, but still it cannot have the weight which it would have if he had come as the representative of the profession generally. Apparently the medical profession are quite content to submit to the infliction of an extra tax from which an organised effort could deliver them. Their action in this respect is similar to their action, or, rather, to their want of action, regarding the new regulations of the Telephone Company, which by a stroke of the pen has imposed an extra expense for telephones on medical men amounting to many thousand pounds annually. What is the use of having a costly mechanism worked by a large and wealthy representative Association if it is not brought into action in cases such as these? At the present moment we find that the profession has already been mulcted to a very considerable extent in respect of its telephones, and that it will shortly be taxed in respect of what is becoming its most important means of locomotion, and yet no protest is made!

Medical Men and Night Calls.

Our notice has been drawn to a somewhat curious letter addressed by a lay correspondent to the editor of a leading East Anglian newspaper. The writer details two cases in which a medical man, summoned hastily in the night time, declined to attend a patient. He further extols, by method of the "puff oblique," the zealous promptitude and humanity of another practitioner, who at once attended in both instances, and we can imagine the embarrassed anger and annoyance of the latter gentleman upon finding his name thus freely advertised. The correspondent winds up with the usual query as to "whether doctors have any legal right to refuse to attend to such cases of urgency, without apparently any adequate cause?" An equally pertinent inquiry is whether patients have any right to summon a medical man at any time, night or day, unless they are prepared then and there to pay him an adequate fee. With advancing experience of the rough and tumble of general practice, the medical man becomes more and more chary of going out at night to chance calls, in which he has long since learnt there will be little or no chance of any remuneration. There are limits to human energy, and he finds it necessary in the interests of his wife and family, not to mention his own health and the requirements of his other patients, to secure some amount of sleep. The young practitioner for the first few years of practice is keen to attend everything, night or day, regardless of fees. We wonder if the public ever knock up the quacks and prescribing chemists in the night, and, if so, what sort of response is made as to fees and attendance.

A Judge and Public Health.

We have from time to time heard complaint of the practice existing in Ireland of judges delivering speeches at the opening of their courts on matters they deem of public importance. We could wish, however, that some of his learned brethren would follow the excellent example set by the Honorable the Recorder of Dublin last week. Speaking with a due sense of responsibility, the Recorder drew attention, not for the first time, to the deplorable condition of the housing for the working poor of Dublin. The crowded slums were the spawning-ground, not only of intemperance and crime, but also of diseases of all kinds, and specially of tuberculosis. "The subject," he said, "affected both the moral and physical health of the citizens, and for them was not second to any other. He regarded the condition of the housing of the workers and the poor as a gruesome monument to neglect of civic obligation." The charge made in solemn language from the judicial bench is one often made in these columns. The responsibility lies with the health authorities of Dublin, who hitherto have shown no due sense of the magnitude of the evil resulting from their neglect. It is possible that the Recorder's grave rebuke may have some effect in rousing public opinion. For himself the attitude he has adopted is worthy of the best traditions of his ancient and honourable office.

PERSONAL.

Professor J. A. MacWilliam has been elected Honorary President of the Aberdeen University Medical Society.

M. Ribemont-Dessaignes has been appointed Professor of Clinical Obstetrics in the Faculty of Medicine of Paris.

Dr. Comyns Berkeley and Dr. Herbert Williamson have been elected physicians to in-patients at the City of London Lying-in Hospital.

Dr. Duncan Forbes, Medical Officer of Health of Cambridge, has been selected for the post of Medical Officer of Health for Brighton, in succession to Dr. F. Newsholme.

Dr. H. Campbell Thomson, M.D., F.R.C.P., has been elected Dean of the Medical School of the Middlesex Hospital, vice Mr. John Murray, F.R.C.S., who has resigned after holding the office for six years.

Dr. F. M. Sandwith, Gresham Professor of Physic, is giving four lectures at Gresham College, Basinghall Street, E.C. The lectures are at 6 p.m. Two have been already given, and the remaining two take place on Thursday and Friday.

The directors of the Royal Edinburgh Asylum have appointed Dr. George M. Robertson, M.B., C.M., F.R.C.P. (Edin.), to the post of Physician-Superintendent in succession to Dr. Clouston, retired. Dr. Robertson is at present Medical Superintendent of the Stirling District Asylum at Larbert.

It is announced that Mr. Andrew Carnegie has given half a million marks (£25,000) to the Robert Koch fund for the campaign against tuberculosis, and that so far the amount collected for carrying out research work in connection with the disease amounts to 800,000 marks.

Dr. P. A. Smith, a well-known Glasgow medical practitioner, was, on February 27th, entertained at a complimentary dinner in the Grosvenor Restaurant on the occasion of his silver jubilee. Rev. Canon M'Carthy, St. Andrew's, presided, and about 120 gentlemen were present.

An interesting presentation took place last week at Fraserburgh, when a motor-car was given to Dr. Trail by the townspeople in recognition of his services in the town, and more especially the good work he has done in attending to the poorer classes.

The Duke of Westminster has subscribed £200, Dr. Ludwig Mond £500, and Lord Sherborne £50, towards founding, in commemoration of a heroic Cheshire doctor, a "Dutton Memorial Chair," in tropical entomology and arachnology, in the Liverpool School of Tropical Medicine and the University of Liverpool.

The Attorney-General for Ireland has stated in Parliament that the Chief Secretary for Ireland proposes to introduce a "Tuberculosis Prevention" (Ireland) Bill, and that this will contain a clause providing for the compulsory notification of tuberculosis. The official supervision of dairies and of the sale of food will also be dealt with in this Bill, and in a new "Dairies Order" which the Local Government Board are about to issue.

A Clinical Lecture

ON

INDIGESTION IN CHILDREN.(a)

By G. F. STILL, M.A., M.D., F.R.C.P.,

Professor of Diseases of Children, King's College, London; Physician for Diseases of Children, King's College Hospital; Physician to Out-Patients, Hospital for Sick Children, Great Ormond Street.

Gentlemen,—Amongst the common disorders of childhood, I suppose there is none commoner than indigestion. And it appears under so many guises that it is little wonder if it is often mistaken for other conditions, and the child is dosed with this drug and that, when the one thing necessary is that the diet should be revised.

I do not propose to-day to consider the chemistry or physiology of indigestion, but simply to make some clinical remarks on indigestion as it is seen in children past the age of infancy.

The child, unlike the adult, is still in the active stage of construction, and should be steadily building. So that it requires an income sufficient not merely for the upkeep of what is already built, but for its extension. Anything which reduces its income interferes with the upkeep of the existing structure, for it is a fact that building continues even in spite of serious disease. Hence in the child any disorder which interferes with assimilation quickly tells upon the nutrition, and the child wastes. Such a disorder is indigestion. I lay stress upon the wasting because, not only does it arouse the mother's anxiety, perhaps more than anything else, but the doctor, too, is apt to be led astray by it, and to regard the case as one of tubercle. There is much to suggest tubercle in many of these cases, particularly if much mucus is being passed in the stools (the condition to which Eustace Smith gave the name mucous disease). In such cases often the skin becomes dry and harsh, as in tuberculosis, and there is also a hard, dry cough, which, with the wasting, makes the clinical picture very suggestive of tubercle. But the child rapidly improves under a proper diet.

Next to the wasting, I suppose no symptom distresses a mother more than the child's loss of appetite. Anorexia is often a most baffling symptom in childhood. A child of 3 or 4 will sit down to the table at meal-times and either refuse food altogether or take so little that the mother becomes alarmed. If the child is coaxed to eat, and persuaded to swallow against its will, retching follows, and it may even be sick.

There may be pain in the abdomen, sometimes in the epigastrium, sometimes in the middle part of the abdomen, sometimes over the lower part. The pain is at times so severe as to make the child cry out, though that is not usual. The abdomen is often enlarged in this condition, too, and the picture is not unlike that of tabes mesenterica, for which it is sometimes mistaken. Enlarged mesenteric glands should never be diagnosed unless they can be actually felt. In these cases of indigestion with recurring colicky pain, there may be little else to point to indigestion, and the case may therefore be puzzling. I saw, in consultation, a child, æt. 3½, with constant pain in the abdomen, which had been present six months. The child turned white sometimes with the pain, was nervous, could not sleep well, and during the two months before I saw it, had lost a pound in weight. I saw the child in one of the attacks; she leaned forward and pressed her hand over her abdomen in evident pain, but only for a moment. Two doctors had seen the case, and the various treatments had not done any good; neither did anything I suggested do good. At last the parents took the child to a surgeon, who advised an exploratory laparotomy. It was not, however, acquiesced in at the time, the parents preferring to postpone such a drastic measure. Then, as another chance of giving some relief, their own practitioner tried pancreatin, and thereupon the pain disappeared and the child became well, and remained so. It was a case in which there was difficulty in dealing with carbohydrate food, and the pancreatin happened to succeed. The pain in these cases is often associated with the passage of mucus in the stools, and one can understand why that should be so, when one has seen, at autopsies, especially on children who have suffered from worms, the thick, viscid mucus coating the intestines. The nervousness and inability to sleep well which the mother mentioned in the case just related is another common manifestation of indigestion. The mother's tale often is that "the child cries almost if you look at him." He lies awake for hours, or, after falling asleep, wakes frequently, and sleep is often disturbed by night terrors. Another symptom which makes the parents anxious is a sudden change of colour, the child going quite white. This is not imagination on the part of the mother—I have seen it happen. Such attacks have been spoken of as "vasomotor epilepsy." I confess I do not like the term; it seems to imply a connection with ordinary epilepsy, but, so far as I can judge from my own observation, no such relation exists. I used to think that consciousness was never lost in this condition, but I have found that rarely this does occur. The child turns white, and then falls down; the attacks appear to be syncopal in character rather than epileptic.

"My child is always tired. He never used to be so, but now, if he walks ever so little, he complains that he is so tired." Such a complaint, with the pain in the abdomen and the poor appetite, always suggests to me indigestion. The presence of indigestion is often suggested by a child's appearance; in some cases there is a blue puffiness under the eyes, especially at the outer part of the lower lid; in others there is what the mother calls "a dark ring round the eyes." Both these symptoms are often associated with mucous catarrh in the intestines. The puffiness is, of course, not pathognomonic of indigestion; it is seen with cyclical albuminuria in children, a condition, by-the-by, which is often accompanied by an unexplained colicky pain in the abdomen, which may possibly signify some mucous catarrh in the intestine here also.

The abdomen may be considerably enlarged in indigestion, and there is an enlargement of it which always suggests to me bread-and-butter feeding. The subject of it is usually a rather pale child, with a big, prominent abdomen, which lacks the resistance and doughy feeling of tuberculous peritonitis. This chronic enlargement of the abdomen is often found far beyond the usual age for rickets; it is not the rickety "pot-belly"; it is found especially in the child who does not care for milk, and will not eat meat, but is fond of bread and butter, off which he would willingly make all his meals. These cases are frequently sent to the hospital with a diagnosis of tuberculous peritonitis, whereas the effect of careful dieting, and perhaps of the administration of malt, speedily shows that the child is suffering from chronic indigestion.

Next, nausea and vomiting. I put them late in the list because they are not prominent in indigestion; but when they occur, they are apt to cause some anxiety. The association of occasional vomiting with wasting, perhaps with some headache and constipation, makes one think of the possibility of cerebral mischief. Usually the vomiting in indigestion is not continuous: it may occur only once or twice at intervals of several weeks. Sometimes there is not only vomiting, but a rise of temperature as well, the breath is offensive, the tongue furred, and the child seems ill. It is what the mother terms "a bilious attack." This usually means that there is an exacerbation of the digestive disturbance due to some more than usually indigestible food having been taken. The stools are commonly pale in these attacks, and, indeed, both in infancy and in later childhood whiteness or paleness of stools, which may remain for considerable periods, is a frequent manifestation of indigestion. On this account I am the less inclined to adopt the term acholia, the expressive term used by Dr. Cheadle as signifying a special disorder. Dr. Cheadle, in a very valuable paper on this subject, described a group of cases which are not very rare. A child of 3 or 4 years of age passes white stools, which are also greasy, as if they contained an excess of fat and were very deficient in bile. The child wastes gradually, but usually, after months of feebleness and ill-nutrition, slowly improves, and ultimately recovers. Very rarely do such cases end fatally. But similar stools are seen, sometimes for a day or two, sometimes for much longer, in the case of infants who have had for some time previously chronic indigestion, and it seems clear that the primary disorder in such cases is not deficiency of secretion of bile; the acholia is merely a secondary phenomenon.

(a) Delivered at the Hospital for Sick Children, Great Ormond Street, W.C.

The child with indigestion has also frequently offensive breath. Children are brought to the medical man sometimes only on this account. Of course, there are other causes for foul breath, such as bad teeth, and decomposing secretion in the crypts of enlarged tonsils; or the cause may be further removed and be due to bronchiectasis or ozæna. But the breath of chronic indigestion is heavy smelling, and not like these others, especially not like the sickening metallic odour of bronchiectasis or ozæna.

I have sometimes had children brought to me because of shortness of breath; at times the difficulty has amounted to "air-hunger." There may also be palpitation, so marked that the mother sometimes says she can feel the heart beating as the child sits on her lap leaning against her.

Another symptom which is very common in early childhood is lichen urticatus, and in some it persists until the sixth or seventh year. This, when present, is almost proof positive of there being something wrong with the feeding or the digestion.

The last symptom I shall refer to is one which is seldom mentioned in books, and that is dryness of hair, with loss of gloss. I have seen this only in two cases; in both there was chronic indigestion. With the improvement in the digestive condition the hair becomes normal.

Treatment.

With regard to the important matter of treatment, remember that faulty digestion does not always mean faulty diet. The teeth may be very defective, carious teeth in children being very common. Or many of the teeth may have been removed, and so mastication is apt to be very defective. Another cause for digestive disorder, apart from the diet itself, is bolting the food, not only because of bad teeth, but because, in this twentieth century rush, the child suffers as well as the adult from the all-pervading hurry which despatches even meals in the minimum possible time. This bad habit of hurried meals is often due to bad domestic arrangements; the meal times might be much better arranged. A child should not have to start for school about ten minutes after the beginning of a meal. Moreover, both mothers and nurses are apt to be impatient with a child over its food, and sometimes, to hasten proceedings, actually spoon the food into the child at such a pace that the child has barely time to take breath between the mouthfuls. I have seen this done, and the child vomit the whole of it immediately afterwards; and no wonder. Another small but important point is the midday sleep in relation to food. One sees children awakened from sleep to have their meal before they have had time to rouse themselves thoroughly. This, I always think, is bad for digestion. There should be an interval of twenty minutes or half an hour during which the child can run about between the midday sleep and the meal.

With regard to the food itself, there are two principles which I would emphasise: First, what is one person's meat is another person's poison—dogmatism and dietetics go ill together; the second principle is the one enunciated by Trousseau: never advise what a person should have until you know what he does have. Children, like adults, have their idiosyncrasies, and very marked ones, and the more experience I have the less I am inclined to pooh-pooh the mother's statement that the child cannot take this or that. For instance, I know no more valuable food for a child than eggs; neither do I know any in regard to which there is such marked idiosyncrasy. There are children who will vomit if you conceal the smallest amount of egg in their food. It is not a matter of dislike; the child seems to have a physiological inability to tolerate egg. Take another glaring example of idiosyncrasy to food: Porridge is taken well enough by many children, but with some it disturbs digestion badly, and, as a rare occurrence, it may have a remarkable effect, as the following instance may show:—I was told that a boy about 14 years of age could not take porridge, as it made his face swell. I was rather sceptical, and the boy was given some porridge one day in my presence. He had not finished the meal before one-half of his face began to swell, and about twenty minutes later it was so completely swelled up that he could scarcely see out of his eye. I have a photograph of this case of angio-neurotic œdema produced by porridge. It is, of course, a mere curiosity, but it illustrates my point that we must allow for idiosyncrasies in diet. There is need for much care in making inquiries as to what food the child is having. The mother may tell you the truth, and nothing but the truth, but nevertheless she often does not tell you the whole truth. Asked what the child has been having, she will sketch out an ideal diet, but she does not mention, unless carefully cross-examined, that the child has a raw apple before breakfast, a banana after breakfast; the bread eaten is brown bread; the child is fond of potatoes, and eats much more of that than of the chicken and gravy which the mother specially mentions. "Daddy's" sweets are not mentioned, nor the bits of rich cake coaxed out of mother when the child is allowed to be present at "afternoon tea." Get out all these details before you say what the child ought to have.

Turning now to the consideration of particular foods, let me say at once that the dyspepsia of childhood is generally a carbohydrate dyspepsia; hence it is that one of the foods which give rise to trouble is, as I have already mentioned, bread and butter. Many children do not care about meat and vegetables, but are much too fond of bread and butter, and it is a food which it is difficult to eliminate from the diet. The wise plan is to substitute proteid food as far as you can. Let the child have an egg with its tea; that will satisfy its hunger to some extent, and less bread and butter will be required. Breakfast should not, as it sometimes does, consist of porridge and bread and butter, but should include fish or egg or bacon fat. At tea I think it is well to allow a slice of plain Madeira cake and some plain biscuits or nursery biscuits, so as to reduce as far as possible the bread taken. I say Madeira cake rather than sponge cake, because I believe many of the shop-sold sponge cakes are less digestible than Madeira cake. A fruitful source of trouble with children is brown bread. It contains a large amount of unaltered husk, and so is very irritating. Where there is mucus in the stools, improvement will sometimes follow at once if you stop the brown bread which the child has been having. Any food which leaves a coarse residue is one which is tolerated badly by a child with any tendency to indigestion, and brown bread and porridge leave a very coarse residue in the stools. In stools from children fed on these foods the woody, indigestible material of which oatmeal and brown bread largely consist can be seen almost unaltered. Both brown bread and oatmeal have a laxative action, which depends entirely upon the mechanical irritation which they cause in the bowel. I often hear that bread has been forbidden, but that toast has been recommended as more digestible. There is some truth in this, but also a fallacy. If toast is given, it should be toasted through, so that it becomes brittle. But the child practically never gets it done in that way; it gets "pluffy" toast, or tough, greasy, buttered toast, which is anything but digestible.

At dinner potato is a source of much trouble. Children are very fond of it, and will often make their meal off it almost entirely. In the mucous disease which Dr. Eustace Smith so admirably described, potato is almost poison to the child, and the smallest amount of potato will re-start the symptoms just as the child is nearly well. If given at all, it should be well mashed, not simply with a fork, but with a potato-squeezer, or with a special potato-masher. I have seen, in children's stools, lumps of unaltered potato as large as the end of my little finger, looking as if the potato had come straight off the child's plate. What is to be given in the place of potato? You may give the child bread sauce. I do not think that is ideal, but it is better than potato, and most children like it very much.

I have spoken only of eatables so far. Let me remind you that the "drinkables" may be at fault. I need not say that tea is quite unsuitable for any child with digestive difficulty, and should never be given, except in weakest dilution, to the healthiest child; but I want to lay some stress upon the possibility of excessive milk drinking. I feel sure, from my own observation, that it is not very uncommon for a child to suffer with indigestion, with furred tongue, and offensive breath, because the mother insists in forcing upon the child perhaps more than a quart of milk a day, in addition to what is given in porridge or milk puddings. By all means let a child have as much milk as it can *easily* digest, but be careful not to pass this limit.

Lastly, let me say a few words with regard to drugs. Let me paraphrase Sir William Jenner's famous dictum and say, "When you see a child who is wasting, do not always think of cod-liver oil." There are many children who are losing flesh solely from indigestion, and the administration of cod-liver oil is more likely to retard digestion than to assist it. These are the cases in which malt is vastly superior to cod-liver oil, for, as I said, the indigestion of childhood is usually a carbohydrate dyspepsia, and the diastasic action of malt is therefore just what is required. I am fond of preparations in which some digestive ferment is also combined with the malt. There are many excellent preparations in the market, containing either pepsin or a pancreatic extract in combination with malt. Sometimes, especially when there is much gastric flatulence, a better result is obtained by giving alkalies with nux vomica; and where the appetite has become very poor without much flatulence, I think a mixture of dilute phosphoric acid with nux vomica is often better than an alkali.

Lastly, I would remind you that constipation—especially habitual constipation—is an extremely common association with chronic indigestion in children, and your treatment, if it is to be effectual in overcoming the digestive difficulty, must include the cure of the constipation.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Dr. H. Rabé, Professor in the Paris Faculty of Medicine. Subject: "Fœtid Bronchitis."*

ORIGINAL PAPERS.

TWO CLINICAL STUDIES OF CASES OF ENLARGEMENT OF THE SPLEEN

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Synopsis.—I. Sailor, æt. 36. History of increasing asthenia, not exceeding two months. Admitted with profound anæmia and cachexia. Great enlargement of the spleen; slight enlargement of lymphatic glands. No leucocytosis; constant pyrexia; violent diarrhœa and delirium preceded death. *Diagnosis,* acute Hodgkin's disease

II. Great enlargement of the spleen in a pregnant woman, the subject of syphilis. Anæmia; two hemiplegic seizures. The post-mortem disclosed recent cerebral hæmorrhage, exuberant mitral vegetations, tuberculosis of one kidney, cystic degeneration of the other. The placenta showed evidence of syphilitic disease.

I. The ordinary form of Hodgkin's disease, which I may call, for purposes of contrast, chronic Hodgkin's disease, is well known. The clinical picture is as follows:—In more than half the instances the disease occurs in childhood. The constant feature is progressive enlargement of the lymphatic glands, and this almost always begins in the cervical region. Neighbouring glands become enlarged during this stage, which may last for months. The general condition is apparently normal. The second stage is marked by progressive asthenia, cachexia, and anæmia, and usually develops after one or more years. The anæmia is of the secondary type, and there is no increase in leucocytes. Irregular pyrexia is the rule. Enlargement of the spleen is nearly always present, and may be extreme. Pressure symptoms are frequent. The general duration of the disease is from one to four years. Its causation is unknown, and whether the disease is to be classified as a specific inflammation or a new growth has been much discussed. Similarly it has been denied and affirmed that any diagnostic histological structure existed in the glands.

The position held a few years ago is well shown by an anecdote related by Mr. Butlin during a discussion at the Royal Medico-Chirurgical Society, 1902.

A lady with enlarged glands in the neck was referred to him for an opinion—(1) as to whether an operation should be undertaken, (2) whether early marriage and residence in South Africa were permissible and desirable. Mr. Butlin at once recognised that the case was lymphadenoma, and both questions were, of course, answered in the negative. Shortly before the consultation a portion of a gland had been sent to the Clinical Research Society, and a report received to the effect "that the examiner could not make up his mind as to the structure, but that, although it was not typical of tubercle, he thought it was as much like tubercle as anything else."

A distinguished surgeon had also seen this section; his report was equally instructive: "I can't say that it is tubercle; but all I can say is, that if it is not tubercle, I don't know what it is."

A section was submitted to Dr. Kanthack, who, says Mr. Butlin, in about the time that one takes to recognise the structure of ordinary cancer, said:—"It has the characteristic structure of lymphadenoma." Mr. Butlin told the Royal Medico-Chirurgical Society that this was the first time he had heard that lymphadenoma had a characteristic structure. This statement of Kanthack's has since been fully confirmed by the writings of Andrews, Dorothy Reed (1902), Longcope (1903), and is accepted in the critical review of Max Borst (1905).

Longcope summarises as follows:—"The lesions in the lymph glands are especially characterised by the early increase in the lymphadenoid tissue, with later proliferation of endotheloid cells, formation of uninuclear and multinuclear giant cells, thickening of the reticulum, and final overgrowth of connective tissue. Eosinophile cells, though not specific, are frequently found in great abundance. The tubercle bacillus plays no part in the production of the lesions."

Thus, after a lapse of seventy-five years, Hodgkin's statement in his original description, 1832, that "any scrofulous condition is regarded as an accidental concomitant to the idiopathic interstitial enlargement of the absorbed gland tissue throughout the body" is confirmed.

Ordinary Hodgkin's disease itself is not a common disease, and still more infrequent is the group of cases characterised by enlargement of glands, a rapid course terminating fatally in a few weeks or months with fever, profound anæmia, hæmorrhages, coma and delirium. The glands enlarged may be the superficial glands or the intrathoracic or abdominal glands. If the superficial glands are enlarged, acute tuberculous or primary malignant sarcoma have to be considered; whilst, if abdominal symptoms predominate, the disease may simulate typhoid fever, acute tuberculous peritonitis, or forms of septicæmia with purpura. When the glands of the mediastinum are affected, the physical signs may resemble mediastinal tumour; but I think it is proper to adopt the position taken by Dr. Lindsay Steven, and to separate clinically, at least, primary sarcoma of the lymph glands of the mediastinum which may give true metastases or enlargement of superficial glands by pressure on the right or left lymphatic duct from a generalised morbid enlargement which incidentally may affect the glands in the mediastinum. The latter condition may best be called acute Hodgkin's disease, and clinically seems to be distinguished from primary sarcoma by the more rapid course, with marked constitutional symptoms, and a less degree of severity of pressure symptoms, which are usually the cause of death in the primary mediastinal tumours.

I may now relate the history of my patient who suffered from what I prefer to call acute Hodgkin's disease in preference to such names as malignant lymphoma, or lymphosarcoma. The clinical summary is:—Sailor, æt. 36. History of increasing asthenia, not exceeding two months. Admitted with profound anæmia and cachexia. There was an enlarged spleen and *slight* enlargement of the inguinal and axillary glands. Violent diarrhœa, delirium, and constant pyrexia were marked symptoms, and death occurred in a month after admission.

In forming the diagnosis, malignant malaria, typhoid fever, and pernicious anæmia have to be considered.

F. K., a sailor, æt. 36, employed in the South American trade, and has had many attacks of malaria. He was well up to Christmas of 1906, but was unable to return to sea on account of general weakness.

On admission the patient was obviously very ill. His temperature was 103°; pulse 140 and of low tension; the tongue was thickly furred and sordes were present on the lips.

The cardiac apex was diffuse and felt just outside the nipple line. The cardiac sounds feeble, with a soft systolic murmur over the pulmonary area. No lesion was found in the lungs. The urine contained a trace of albumin.

He was found to have marked anæmia, and the spleen and many lymphatic glands were enlarged, though only slightly, none being larger than a hazel nut.

The examination of the blood gave the following results:—

Erythrocytes = 1,750,000.
Hæmoglobin = 22 per cent.
Leucocytes = 6,400.

The lymphocytes were relatively markedly increased, being nearly as numerous as the neutrophile cells. The red cells were normal in appearance, with the exception of the presence of a few normoblasts. There were no malarial parasites, and no ova were detected. The serum reaction to *B. typhosus* was negative.

The glands of both axillæ and inguinal regions were moderately enlarged. They were discrete and elastic, and not larger than a hazel nut. In the cervical region there was also some enlargement of glands, but to a much smaller degree. There were no clinical indications of enlarged glands in the thorax or abdomen.

The spleen was markedly enlarged, reaching to within two inches of the level of the umbilicus. The liver was of normal size, and no lesion was found in the lungs.

Progress.—The anæmia increased. On March 15th, the erythrocytes numbered only 1,008,000, and the hæmoglobin index had fallen to 17 per cent. A large number of normoblasts and poikilocytes had appeared. No noticeable alteration in the white cells.

The constitutional symptoms increased in gravity. On the night of March 3rd wild and maniacal delirium set in, and though at times the patient was rational, the delirium was a constant feature until his death.

Irregular fever, violent diarrhœa, and the "typhoid" state continued until the end, which occurred one month after admission.

The autopsy showed the heart muscle to be pale and soft, the cavities dilated; the valves were normal. Beyond slight degeneration of the coronary arteries, there was no atheroma. The lungs, stomach, and bowels were normal. The liver weighed 3 lbs. 11 ozs., and showed fatty changes in the cells. The spleen weighed 2 lbs. 2 ozs.; the organ was lobulated and of a soft consistence. It contained numerous white, hardish nodules, the size of hazel nuts, which were visible both superficially and found in its substance.

Enlarged glands were found in the axillary and inguinal regions, and larger masses in the abdomen, especially situated on the posterior wall. The mediastinal glands were not enlarged.

The bone marrow removed from the femur shaft was redder than normal.

Microscopical examination showed in the glands the characteristic structure of Hodgkin's disease: 1. The disappearance of the normal contrast between medulla and cortex. 2. The increase of the fibrous network and diminution of the lymphoid cells. 3. Presence of numerous large, multinuclear endothelial cells, the so-called "lymphadenoma" cells. I was unable to find eosinophilous cells.

The enlargement of the spleen was found to be due to increase in the connective tissue stroma, great venous congestion, and the presence of nodules, which were seen to have the same structure as the glands, together with much necrobiosis in places.

I cannot now discuss the numerous observations on the relationship between the various kinds of glandular enlargement. Orth remarks, "There are few regions of pathological anatomy where there is such darkness, even error, or where the gaps in our knowledge are so wide."

Certain facts seem clear:—

1. In ordinary Hodgkin's disease the glandular enlargements have a specific or recognisable structure.
2. Tuberculosis, if present, is merely an added lesion.
3. I have shown in my acute case that the same characteristic structure was present.
4. Many observations show that in acute conditions the blood may rapidly alter, a great increase of lymphocytes occurring, so that the disease may clinically be indistinguishable from lymphatic leukæmia; but that
5. Further observation is required on the structure of the glands in such cases.

The section of a gland I show from a fatal case of lymphatic leukæmia has an entirely different structure from that of the present case.

It has been urged in an interesting paper by Dreschfeld on acute Hodgkin's disease that the changes in the glands are merely modifications of the same process and to be explained by the rate of growth.

J. H. Abram makes some precise statements as to the clinical differentiation between lymphadenoma, lymphosarcoma, and lymphatic leukæmia, which undoubtedly correspond to clinical findings.

Türk gives a classification depending on the condition of the blood and the benign or malignant nature of the growths, *i.e.* their proliferating and destructive characteristics, and states that all the clinical conditions in this classification pass over into each other.

A. Chronic benign growth.
    1. Alymphemic (chronic Hodgkin's).
    2. Sublymphemic (pseudoleukæmia, *i.e.*, a slight absolute lymphocytosis.
    3. Lymphemic (chronic lymphatic leukæmia).
B. Acute growth:
    Partly benign, partly malignant, including acute lymphatic leukæmia and chloroma.
C. Chronic malignant growth without blood changes, including general lymphosarcoma or local lymphosarcoma.

I think there is little doubt as to the accuracy of the clinical pictures of these varying conditions, but submit that, in view of the very demonstrative findings of Reid, Longcope, and others, and which, judging from the literature, are hardly yet recognised, the anatomy of the acute cases should once more be reinvestigated.

II. N. C., a married woman, æt. 28, was sent into hospital by Dr. White, of Northwich, on March 26th, 1907, on account of an abdominal swelling. She had been married six years, and of three pregnancies, one resulted in a miscarriage, the second a still-born child, and at the third, eighteen months ago, she gave birth to a child who lived only four days. Four years ago she had a sudden left hemiplegia, without loss of consciousness; the weakness soon disappeared. Since Christmas an abdominal swelling had been noticed, and there had been amenorrhœa for eight months. Five weeks ago the patient was awakened by severe pain in the left upper limb, which in the morning was noticed to be greatly swollen.

On admission the patient was very anæmic, with marked œdema of the left upper and lower limbs, and to a less extent of the right lower limb. There was œdema also of the trunk, almost entirely limited to the left side, and the superficial veins over the left half of the thorax were dilated.

In the abdomen there were two large, obviously independent tumours. One of these, a hard, smooth mass, coming from under the left costal margin, reached inwards as far as the umbilicus and downwards into the left iliac fossa, was diagnosed as the spleen. The other, a softer tumour springing from the pelvis and displaced by the spleen to the right, was considered by Dr. Willett, who kindly saw the case, as a pregnant uterus. The outlines of the fœtus could be palpated, but no evidence of life was detected. In both axillæ the glands were slightly enlarged, but the neck and inguinal regions were free. Examination of the blood showed the number of erythrocytes to be 2,154,000; white cells, 7,100; hæmoglobin = 40 per cent. The percentages of the varieties of white cells were practically normal. There were no myelocytes, but a few normoblasts were seen.

The heart was normal in size, but the first sound at the apex replaced by a long systolic bruit conducted to the axilla. Respiratory system normal. The urine contained a small amount of pus.

Progress of the Illness.—The dyspnœa on any exertion troubled the patient a good deal, and later examination of the blood showed that the anæmia was increasing; the erythrocytes fell to 1,480,000 per cb. mm., and the percentage of hæmoglobin to 17 per cent., whilst the number of white cells equalled only 2,187 per cb. mm. The blood cells preserved their normal appearance.

On April 22nd, a dead child, weighing 2½ lbs., of about seven months' intra-uterine age, was born. Labour lasted nine hours, and was attended with but little hæmorrhage and discomfort to the patient. Five days later the patient became unconscious; a series of left-sided convulsions occurred, followed by hemiplegia. The patient never regained consciousness; the temperature rapidly rose to 105°, and death occurred on May 1st.

Autopsy—Brain.—At the junction of right Rolandic and Sylvian fissure a small cyst was found, containing hæmorrhagic, amber-coloured fluid. The brain tissue immediately beneath the cyst was red and softened. The arteries were not degenerated, and no evidence of a thrombus or embolus was seen. This lesion was no doubt recent, and the cause of the convulsions and hemiplegia, which appeared shortly before death. An anatomical basis for the earlier hemiplegia could not be found; an obsolete, probably tuberculous lesion was present in the apex of the right lung.

The bronchial and axillary glands were distinctly enlarged. The heart showed some slight enlargement; the muscle was soft and friable. Tricuspid valve dilated but normal; aortic and pulmonary orifices normal. The mitral orifice was dilated, and on both cusps of the valve there were copious, large, mostly recent vegetations.

No ascitic fluid in the abdomen. The spleen was enormously enlarged, and weighed 58 ozs. There was marked perisplenitis, the capsule being in some places 1-16th inch in thickness. There were depressed cicatrices on the surface, and two large infarcts, one reddish brown, the other hard, white, and triangular, with its base at the surface. The liver was slightly enlarged, pale, and soft. The left kidney weighed 5 ozs.; its cortical part was replaced by numerous cysts, varying in size from a pin's head to a cherry; they contained dark brown gelatinous fluid. The medulla was nearly free. The right kidney weighed 6½ ozs., and contained a typical caseous, tuberculous mass. The rest of its substance was fairly healthy.

Putting together the clinical and pathological findings, I think we may summarise the case as follows:—

A young woman suffering from acquired syphilis developed hemiplegia, probably due to endarteritis—rapid improvement and fair health for three years. Pregnancy then occurred, and after some months, in addition to the uterine growth, a very large spleen with marked anæmia was discovered. Thrombosis of the veins of the upper limb probably accounts for a sudden painful seizure and rapid œdema of the upper limb. A systolic cardiac murmur was found to be due to large, probably recent vegetations, on the mitral valve; pyuria and albuminuria due to a tuberculous lesion of one kidney and a cystic degeneration of the other. Death occurred from a second cerebral seizure, probably hæmorrhagic.

During life the pathological interpretation of the clinical picture was difficult. An explanation had to be found for the very large spleen. Leucocythæmia, Hodgkin's disease, malaria, and primary splenomegaly are diseases generally credited as associated with the largest spleen. The first three could definitely be excluded. This left for consideration primary splenomegaly, the high probability of acquired syphilis, and the suspicion that the cardiac bruit might be of organic origin. In spite of the copious literature now existing on primary splenomegaly, it seems to me that the diagnosis must often be made more by exclusion than from the presence of any certain and precise symptoms.

Critical remarks would hardly be in place with my case as a test. A few observations may, however, be made.

The conception of primary splenomegaly seems to have evolved out of observations on Hodgkin's disease, so that a splenic form of this disease or of pseudoleukæmia, as it is often called, became recognised. In 1883, Banti described a series of three cases characterised by a splenic tumefaction independent of any preceding morbid condition, with grave disturbances in the organic functions, irregular fever, and hæmorrhages, and terminating fatally. Sippey, in 1899, recognised a syndrome group characterised by enlargement of the spleen, which preceded or developed with an anæmia which might be very severe; a second stage of gastro-intestinal disturbance; and general asthenia and fatal termination in cachexia. Osler, in 1902, analysed a large number of cases occurring in the practice of American physicians. Rolleston soon after discussed the question, and Taylor, in the Lumleian lectures for 1904, generally accepted these conclusions, and sums up as the criteria of splenic anæmia or primary splenomegaly:—

(1) Enlargement of spleen; (2) absence of glandular enlargements; (3) anæmia of chlorotic type; (4) leucohemia; (5) long course; (6) tendency to hæmorrhage, especially from the gastric mucous membrane; (7) pigmentation of the skin and a termination in secondary enlargement of the liver, with ascites and jaundice, these added symptoms constituting what is called Banti's disease.

This precise definition no doubt covers the natural history of many cases. It may be very difficult to classify individual cases.

In my cases the pathological findings show that no less than three sources of toxæmia were present—viz., syphilis, tubercle, and recent virulent endocarditis, and these may have been sufficient to account for both the anæmia and large spleen.

The spleen most readily reacts to systemic or portal infection. Its swelling is due to congestion, accumulation of non-granular phagocytes, and of elements in the process of destruction, bacteria, neutrophile leucocytes, red corpuuscles and degenerating cells.

In looking over the records of cases of large spleen, I was surprised to find how very large the spleen in ulcerative endocarditis may be. Taylor mentions several in which the weight was between 35 and 43 oz.

The largest weight mentioned I find was 128 oz., and this was probably due to cardiac stagnation with malaria. Lastly, as showing the complex nature of some instances of splenomegaly, I may recall Coupland's case published in 1896—a woman with an enormous spleen and severe anæmia. The spleen was removed, and the patient rapidly regained health. Some years later hæmatemesis and ascites appeared, from which the patient died. A typical syphilitic liver was found at the autopsy.

This case seemed to present the combination of primary splenomegaly with syphilis, perhaps as an independent lesion.

HÆMANGIECTATIC HYPERTROPHIES OF THE FOOT AND LOWER EXTREMITY, CONGENITAL OR ACQUIRED.

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Some time ago I drew attention to a group of rare cases (*a*) seen in children, in which hypertrophy of one limb is found to be associated with tumour-like overgrowth in the corresponding portion of the vascular system. It seems as if the hypertrophy, affecting the soft tissues, and usually the bones as well, depended in these cases to some extent at least on excessive vascularity of the affected parts caused by the overgrowth of blood-vessels. The abnormalities in question are congenital, or at all events are noticed soon after birth, though they may be "developmental," and become more obvious and remarkable later on as the general development of the child progresses. The vascular overgrowth differs in amount and kind in different cases, and is not rarely accompanied by quite obvious tumour-formation in the shape of some kind of superficial hæmangioma (occasionally lymphangioma). There may be, for instance, a diffuse cutaneous capillary (simple) nævus of the "port wine stain" kind (nævus flammeus), or there may be hæmangiomatous nodules (cavernous angiomata), or, more rarely, a lymphangiomatous growth of the skin (a lymphangioma may, however, be dark red in colour from hæmorrhage into some of the superficial lymph-vesicles). Sometimes the main arteries of the part can be felt greatly enlarged, and one or more veins may be dilated; in fact the affected limb may be the site of a so-called congenital or "early developmental" varicose vein. (*b*)

From what is known as congenital (or early developmental) "trophœdema" (*c*) or "trophic œdema" of extremities, which tends to run in families, the condition now under consideration may be distinguished: (1) by the associated vascular abnormalities, and (2) by there being usually an actual increase in the length of the bones of the affected limbs, which is generally not noticeable in trophœdema. (*a*)

From what may be termed the real or *typical* cases of local "gigantism," the condition under consideration may be distinguished (1) by the hypertrophy being not nearly so great as in characteristic examples of giant fingers, giant toes, giant feet, etc., and (2) by there being usually no disproportionately excessive vascular development in *typical* local gigantism. Confusion is hardly possible with cases of so-called "elephantiasis," due to chronic or recurrent lymphangitis and lymphatic obstruction.

Cases of congenital and early developmental hæmangiectatic hypertrophy are certainly rare, but a similar form of hypertrophy acquired in later life is rarer still. I have recently met with a case of hæmangiectatic hypertrophy of the left foot arising in a young adult. (*b*) The patient is a motor driver, æt. 19, whose left foot is decidedly larger than his right foot, and of a red, or bluish-red, colour as if turgid with blood. The skin over part of the foot, especially over the dorsum, is closely studded with small projecting bluish venous loops (varices), and so also, though to a lesser degree, is the skin over the knee-cap of the same extremity. The calf-muscles and other muscles of the leg are about equally developed on the two sides, but there is considerable wasting of the left thigh and buttock, and there is ankylosis of the left hip-joint. The two lower extremities are about equal in length. The knee-jerks and plantar reflexes are natural, and there is no ankle-clonus on either side. The pulsation in the dorsalis pedis artery is well felt in both feet. There is no anæsthesia to touch, pain, heat, or cold, and the reactions of the muscles to galvanism are normal. In the dorsal region of the spinal column there is considerable kyphosis. No evidence of any disease can be discovered in the thoracic or abdominal viscera or elsewhere in the body. Dr. Archibald D. Reid has kindly taken Röntgen photographs of the feet and hip-joints. They show that the hypertrophy of the left foot is practically confined to the soft parts, and likewise that there is bony ankylosis of the left hip-joint (of doubtful origin).

The history is that about two years ago the patient complained of pain in the back of the left thigh. He was at first treated for sciatica, and was afterwards supposed to have hip disease, and wore a Thomas's splint for 18 months. The hæmangiectatic hypertrophy of the left foot and the wasting of the thigh muscles, etc., have developed during the last two years, but apparently the dorsal kyphosis existed previously, though it seems to have increased during the last two years. There has been no pain in connection with the changes in the lower extremity excepting the pain (previously mentioned) at the back of the thigh about two years ago. In this case I think that the condition of the foot (increase in size, engorgement with blood, and superficial hæmangiectases is of vasomotor origin (due to vaso-constrictor paralysis?) are possibly connected with some organic change in the spinal cord.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Retro-Pharyngeal Abscess. — Mr. Willmott Evans operated on a child, æt. 16 months, who had been admitted for difficulty of swallowing. For three

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(*a*) "Angioma-Formation in Connection with Hypertrophy of Limbs," *British Journal of Dermatology*, July, 1907. I originally included certain cases of hemi-hypertrophy.

(*b*) The occasional occurrence of such congenital or "early developmental" varicose veins affords strong support to the view that varicose veins are venous overgrowths allied to venous angiomata. On this subject see A. Pearce Gould's "Lettsomian Lectures" in the *Med. Soc. Trans.*, 1902, vol. xxv., p. 132; also W. Thorburn's remarks on "Developmental Varix," *Brit. Med. Journ.*, November 17th, 1900, p. 1,421, and Sir W. H. Bennett's remarks on "Congenital Varix," *Lancet*, November 22nd, 1902, p. 1,374. In fact, although intravenous pressure and inflammatory conditions are probably the usual exciting causes of the ordinary varicose veins of the lower extremities, a peculiar, sometimes hereditary, tendency towards varicose veins must be admitted in many cases. In regard to the analogous relationship which the ordinary hair-like telangiectases of the skin bear to cutaneous angiomata, see "A Note on Cutaneous Telangiectases and their Etiology—Comparison with the Etiology of Hæmorrhoids and Ordinary Varicose Veins," by F. Parkes Weber, *Edinburgh Medical Journal*, April, 1904, p. 346.

(*c*) Vide H. Meige, *Presse Médicale*, Paris, December 14th, 1898; H. Meige, *Nouvelle Iconographie de la Salpêtrière*, 1899, No. 6, p. 453; H. Meige, Société de Neurologie, Paris, November 7th, 1901; Debove *Presse Médicale*, Paris, May 28th, 1902; H. D. Rolleston, *Lancet*, September 20th, 1902, p. 805; O. Grünbaum, *Reports of the Society for the Study of Disease in Children*, 1905, vol. v., p. 4; Zuber, *Société de Pédiatrie*, Paris, June 19th, 1906; Senlecq, *Société d'Obstetrique*, Paris, December 10th, 1906; and Guinon, *Ibid.*, March 11th, 1907.

(*a*) When hæmangiectatic hypertrophy affects older persons the bones probably do not take part in the hypertrophy, and the increase in size is probably confined to the soft parts (see later on), if it occurs at al..

(*b*) I showed the case at the Dermatological Section of the Royal Society of Medicine, London, on February 20th, 1908.

months before admission the little boy had had some difficulty of swallowing, and the mother had noticed a swelling on the left side of the neck, extending forwards as far as the submaxillary region. Occasionally there was dyspnœa, and once or twice the child had nearly choked. Fomentations had been ordered, and the swelling slowly decreased in size. On admission it was seen that the child was very thin, this being probably due to the fact that it had been able to take very little nourishment in the last three months during which time it had been hand-fed. On examination there was a little fulness on the left side of the neck, but nothing like the swelling described by the mother; at the back of the pharynx could be seen and felt a soft, fluctuating swelling extending upwards to about the level of the floor of the nose and downwards for nearly three inches, but the lower limit could not be well defined as the finger could not reach so far. A diagnosis of retro-pharyngeal abscess was made, and it was decided to drain it. A vertical incision was made along the posterior border of the left sterno-mastoid, beginning about half an inch below the mastoid process, and extending downwards for about an inch and a half. As soon as the deep cervical fascia had been cut through the deeper structures were carefully dissected, partly with a knife and partly with a steel director. The sterno-mastoid was retracted inwards, and the dissection was carried on towards the middle line of the body. The transverse processes of two or three of the cervical vertebræ were defined, and the director was passed inwards immediately in front of them. Thin, yellowish inoffensive pus was readily found, and about an ounce and a half was evacuated; the abscess cavity was washed with normal saline solution until the fluid returned clear. A small drainage tube was inserted. Four stitches were employed to close the upper and lower parts of the wound, and sal alembroth dressings were applied. Mr. Evans said that an abscess behind the pharynx may be due to one of three causes: the most severe was that associated with tuberculous caries of the cervical spine; it may also follow the passage of a sharp septic body such as a spicula of food or a bone through the posterior pharyngeal wall. The third cause was, however, the most common; the disease occurring in small children associated with suppuration arising in the retro-pharyngeal lymphatic glands, and caused by the absorption of organisms from some septic focus in the mouth or throat. Whatever may be the origin of a retro-pharyngeal abscess it was essential it should be opened early, for if not irremediable trouble may result in several ways. By pressing forward the posterior wall of the pharynx it interfered with swallowing and with breathing, and in this way may lead to a fatal result, or the abscess may burst through the pharynx, and the pus flowing into the pharynx may cause death; equally serious were the consequences of pus tracking downwards behind the pharynx and œsophagus, in this way it reaches the posterior mediastinum, and spreads widely in the loose connective tissue. There were, he pointed out, two methods of draining a retro-pharyngeal abscess: the older was to make an opening into the swelling as it presents at the back of the pharynx, a straight bistoury guarded by strapping except at the point being employed. The objections to this plan are twofold: in the first place, if much pus be present, the sudden outflow of it may conceivably prove fatal by its entering the larynx; there was, however, the additional danger that the opening through which the abscess has been drained might prove a point of entrance for other micro-organisms, and thus a very septic condition may be set up behind the pharynx, worse, even, than the abscess which has been incised. Far better was it, he thought, to employ the more modern method of draining the abscess through an opening made through the outside of the neck. It was true the operation required more skill and knowledge of anatomy, but the results were far better than those following the pharyngeal incision, and the risks were much less. It was important to remember the situation of the abscess; it lies in the cellular tissue, bounded behind by the layer of fascia covering the prevertebral muscles, and in front by the posterior wall of the pharynx. To reach this space most conveniently, it is necessary to pass behind the carotid sheath; the incision, therefore, is made at the posterior border of the sterno-mastoid, and when that muscle is retracted towards the middle line, the carotid vessels will be brought forward also. After this the surest guide to the retropharyngeal space is to be found in the anterior tubercles of the transverse processes of the cervical vertebræ, to which are attached tendinous slips of the Longus colli and Rectus capitis anticus major muscles. One structure should be carefully avoided in the preliminary incision behind the sterno-mastoid—viz., the spinal accessory nerve. It was important that the cavity should be drained for a week or two, so that it may close from the bottom. With regard to the dressings to be employed, he held that when an operation case was aseptic, it was desirable to use simply aseptic dressings, but when micro-organisms were already present, as in opening an abscess, it was better both for the patient himself and for the other cases in the ward that antiseptic dressings should be employed.

It was noticed soon after the operation that the breathing had improved, and the child was able to take his milk much better. On the third day after the operation, from no apparent cause, the temperature rose to 101°, but it fell on the same evening, and did not rise again above normal. The stitches were removed on the sixth day, and the tube was withdrawn fourteen days after the operation. On examination of the pus, no tubercle bacilli were found. The patient left the hospital on the sixteenth day with a minute sinus and perfectly well in himself.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, FEBRUARY 7TH, 1908.

The President, E. H. TWEEDY, F.R.C.P.I., in the Chair.

OVUM FROM HORN OF BICORNUTE UTERUS.

THE PRESIDENT exhibited an ovum from the horn of a bicornute uterus. It was, he said, a very perfect ovum, though now shrivelled in spirit. The woman, who had borne three or four children, had had persistent hæmorrhage since January. He made a tentative diagnosis of tubal pregnancy. He operated the following day, and, to his surprise, found a small uterus, with the tumour growing out from the side of it. When he split the tumour in the direction of the tube, the ovum came out, and it then appeared that he was dealing with a two-horned uterus. In thinking the case over, he was convinced that the woman would have carried her child to full term. She had had two miscarriages and three children, and they had all, he believed, developed in that horn. The whole question of operation in a two-horned uterus was in an unsettled state. They were led to suppose that even if they diagnosed a pregnancy in a two-horned uterus, they should treat it as though it were a tubal pregnancy; but there was no doubt that there were many women who bore children in the presence of this abnormality. The size of the tumour might have led him to a correct diagnosis; it had grown enormously in the ten days between his examination and the operation, yet it had not burst. He had never seen a tubal pregnancy so large without rupture taking place, a fact which might have put him on the way to a correct diagnosis.

Dr. **HOLMES** asked if anything had come away from the uterus since the operation, as it had recently been stated that false decidua would give rise to trouble in the other horn?

Dr. **NEILL** asked if there had been any trouble with the former deliveries?

The **PRESIDENT**, in reply, said that if they could diagnose that the pregnancy had taken place in the well-developed horn, everyone would agree that it should be left; but the difficulty of diagnosing between the horns was very great. In the case before them the undeveloped horn was as large as a normal uterus. Nothing had come from the uterus since; and, so far as he knew, all the other full term deliveries were normal and easy.

A MODIFICATION OF NEVILLE'S FORCEPS.

Sir A. **MACAN** said it was not without a good deal of thought that he had ventured to make a modification on Dr. Neville's forceps, on which he had a stop put, so that, by making a slight movement of the axis-traction handle, he could tell at once, without looking, that the pointer was in the right direction. He described in detail, with specimens, the development in the shape and mechanism of forceps, from the straight to the extra-curved German form.

Dr. **FITZGIBBON** said that being able to utilise one's ears was an advantage, though he did not see the necessity of watching the perineum at the time the axis-traction was in use.

Dr. **HOLMES** thought the addition of the small check was of great use in allowing the eyes to be taken off the forceps and the whole attention to be given to the perineum.

Dr. **SPENCER SHEILL** said that although the Scottish forceps had a device by which a click would tell when they were pulling in the axis of the pelvis, it had the disadvantage of possibly nipping the vaginal mucous membrane; but the one shown had the advantage of the Simpson forceps without its disadvantages.

A VESICULAR MOLE.

Dr. **SPENCER SHEILL** exhibited a vesicular mole. He was, he said, somewhat disappointed, as he had entered it in the hope of being able to exhibit it as a case of a twin mole, one embryo having been, so to speak, converted into the mole, and the other fairly normally developed. The patient had a marked history of twins in her own and her mother's family. She had aborted four times, one being a twin abortion. Afterwards, in a twin conception, she aborted one, and he subsequently delivered her of a full term child. The specimen shown was the next pregnancy. There was a marked amount of fibrous degeneration and a great deal of fibrous tissue and thickening, but there was no syphilitic history to account for it. The pathological report which had been kindly made by Dr. Rowlette, and which he read, not only disappointed his hope of being able to exhibit a specimen of a condition which had only been reported a couple or three times, but also drove him to the opinion that it was a case of what he might call mixed carneous and hydatidiform mole.

The **PRESIDENT** said he had never seen a vesicular mole together with any portion of a formed fœtus, as in Dr. Sheill's specimen. He did not, however, agree that it was a carneous mole. He would like to know if the specimen came away spontaneously or if it had been delivered manually.

Dr. **SHEILL**, in reply, said the specimen was delivered by the natural contraction of the uterus. His opinion as to the nature of the mole was based on the naked eye appearance, and on considering again the pathological report, he bowed to the Pathologist's opinion that it was not a carneous mole.

THE OPERATIVE TREATMENT OF PUERPERAL INFECTION.

Sir A. **MACAN** read a paper on the above subject, the discussion of which was, on the motion of Dr. Holmes, seconded by Dr. Ashe, postponed until the next meeting.

A paper entitled (*a*) "Twin Abortion with Double Placenta Prævia and a remarkable condition of the Cervix Uteri; (*b*) Labour Shock," by Professor R. J. Kinkead, of Galway, was read by Dr. G. FitzGibbon, the Acting Secretary.

Sir A. **MACAN** and the **PRESIDENT** expressed the thanks of the Section to Professor Kinkead, and the hope that other members in the country would contribute similar valuable papers.

The following card speciments were shown:—Dr. Tweedy—(*a*) Dermoid cyst of ovary containing teeth; (*b*) ovarian cyst specimens (2); (*c*) fibroids of uterus (3), one showing cystic degeneration; (*d*) abscess of ovary.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, FEBRUARY 21ST, 1908.

The President, Dr. **WALKER DOWNIE**, in the Chair.

Dr. **J. CRAWFORD RENTON** showed a lad who had his elbow-joint excised, and showed the bony parts removed from this and other three cases of the same kind. He made remarks on the results following excision of the elbow-joint when the ends of all the bones entering into the formation of the joint are removed. Attention was called to the large space left without bone, and special stress was laid upon the amount of usefulness regained by the limb some time after such extensive operations. In about two years there is not much deformity, and the muscles get so strong that the usual occupations can generally be engaged in. This was shown in the case brought forward, and in photographs from other cases. Dr. Renton then showed two ruptured spleens that had been removed by operation, and gave a short account of the cases. The rupture in both cases was due to injury, and in one of the cases resulted fatally. The other case was a lad, 19 years of age. An hour after injury he was found suffering from internal hæmorrhage. On opening the abdomen the spleen was found to be ruptured, and was extirpated. A week later the right pleura filled with fluid, and 60 oz. of blood-stained but sterile fluid was drawn off. A week later he had to be treated for empyema of the same side, and later still pneumonia supervened. The patient, however, made a good recovery. During the first three weeks after operation there was a gradual diminution in the proportion of hæmoglobin, lymphocytes and phagocytes in the blood. After that time the blood began to regain its usual proportions of these, and on the sixty-third day it was quite normal again. Dr. Renton then showed a number of calculi he had taken from the kidney, ureter and bladder, and exhibited Cole's apparatus for allowing the escape of urine after suprapubic cystotomy. In the case where several large calculi were removed from the kidney, the patient was suffering from pulmonary catarrh. Administration of a general anæsthetic was not considered safe, and stovaine was injected into the spine. There was absolutely no pain, and Dr. Renton expressed great satisfaction with the use of this anæsthetic.

Dr. **RENTON** also showed specimens of four ruptured vermiform appendices, and made a few remarks on the cases. These illustrated the importance of operating at the earliest possible moment when the appendix is diseased, an opinion expressed by him six years ago, and which he has had every reason to adhere to up till the present time. In conclusion, Dr. Renton gave notes of four cases of intussusception, and then made some remarks on Mayo's method of gastro-enterostomy based on his experience of 15 cases. In recommending this method, he referred to its being the application of the posterior portion of the stomach to the jejunum, this being the normal anatomical relation of these parts. He referred to a case pictured in an old pathology book in which Nature had accomplished the same result as the operation by adhesion of the stomach and jejunum at the seat of a gastric ulcer on the posterior wall, and perforation through this into the jejunum.

Dr. **WILLIAM MCLENNAN** related the clinical history of an unusual case of mediastinal tumour, and illustrated it by lantern slides. The patient was a woman, æt. 28. Twelve years ago she had a swelling of the neck, and for this an operation was performed. This was the removal of an encapsulated tumour from the thyroid gland. No microscopic examination was made of this, and nothing further noted till recently. The woman was admitted to the infirmary with a swelling at the root of the neck. Six weeks previously she was confined, and after this event the swelling appeared and grew rapidly. It formed a large mass behind the sternum and at the root of the neck, setting up pressure symptoms which, after ten weeks' illness, ended in death from asphyxia. For some time before death the temperature was observed to be above normal, fluctuating between 100° and 101°. Dr. William McLennan considers this a fairly common occurrence in malignant tumours, and was often a help in making the diagnosis. Sections of this tumour showed it to be a double tumour consisting of a carcinoma of thyroid gland tissue and a much larger amount of sarcomatous tissue, made up both of round and spindle cells. Only the lymphatic glands that receive lymph from the region of the tumour were affected with secondary deposits of carcinoma; but nearly all the organs of the body had secondary deposits of sarcoma. The interest of this case rested upon the presence and extirpation of an innocent thyroid tumour at the age of 15, the growth of a malignant thyroid tumour, and the development from this of a sarcomatous growth which extended rapidly and disseminated itself throughout the body, leading to death.

Dr. **JOHN SHAW DUNN** showed lantern slides made from a case of accessory thyroid tumour of the neck. Dr. Alex. McLennan gave a short report of this case, and showed photographs of the patient taken before operation. The sections of the tumour showed thyroid tissue with fibrous septa, and from these septa numerous papillomatous processes.

Dr. **ALEX. MACLENNAN** also gave a lantern demonstration of the changes that occur in the bones and other organs as the result of extirpation of the thymus gland. He described experiments conducted on rabbits six weeks old, and the results he observed. When the thymus gland was removed in these animals, they recover very rapidly from the operation and become more vigorous than others of the same brood. They are more active and energetic, eat more, and increase in weight at a quicker rate than normal. They are also healthier than normal rabbits, and are rarely attacked by favus and other parasitic diseases to which normal rabbits are very subject. After extirpation of the thymus gland the rate of growth of the bones was demonstrated by lantern slides made from sections. These showed the activity of the formative process as compared with that of normal bone, which was also shown for comparison. There is no change in the bone marrow nor in the spleen after removal of the thymus gland, but the thyroid gland is enlarged, its alveoli are smaller, its structure becomes infiltrated with leucocytes, and it looks paler in colour. To some extent it takes on the function of the thymus gland. In contrast to this, when the thyroid is extirpated the thymus gland atrophies and disappears, and in Grave's disease the enlargement of the thyroid is accompanied by an enlargement of the thymus gland. An animal can live without its thymus gland or without its spleen, but when both these organs are extirpated death always occurs immediately. The thymus gland plays a part in the processes of metabolism and in the causation of some diseases, although that part cannot yet be accurately defined. Sufficient is known, however, to suggest certain means of treatment in some diseases, and this demonstrates the practical importance of these experiments. Several conditions can be benefited by extirpation of the thymus gland, while others can be improved by feeding upon this gland or an extract of it. Thus rickets has been benefited by giving thymus gland or its extract, and improvement in exophthalmic goitre is often marked when treated by this means. When this does no good in exophthalmic goitre, the thymus which is usually enlarged should be extirpated before the thyroid gland is interfered with. Extirpation of the thymus gland has been found of benefit in some cases of laryngismus stridulus, and does not interfere with the normal development of the child.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD FRIDAY, FEBRUARY 21ST, 1908.

The President, Dr. A. J. WALLACE (Liverpool), in the Chair.

DR. **W. BLAIR BELL** exhibited a new portable operating table.

Dr. **MILES H. PHILLIPS** (Sheffield) showed a specimen of the uterus in which there was an unusual degree of cystic degeneration of the cervix. It was removed by vaginal hysterectomy from a patient, æt. 48, who had had one child 27 years ago. Menstruation, which had always been regular, of 4 days' duration every 28 days, had ceased abruptly six months ago. For the past five months there had been occasional pain in the right iliac and hypochondriac regions, but never severe. On two occasions vaginal examination had caused hæmorrhage. The cervix uteri was found to be enlarged from the presence of cystic cavities, measuring 8-12 mm. in diameter, situated chiefly in the posterior lip. They were filled with mucoid material. The cervical mucosa was normal, as was also the corpus. Microscopically the cysts were shown to be dilated cervical glands, lined by a single layer of columnar epithelium. There was a great preponderance of fibrous tissue surrounding the glands, and Dr. Phillips regarded the condition as due to a fibrosis of the supravaginal cervix leading to closure of some of the gland ducts, and retention of their secretion, comparable to involution cysts of the breast.

Dr. **LLOYD ROBERTS** (Manchester) recorded a case of Cæsarean section successfully performed on a patient, æt. 25, who was the subject of pelvic deformity due to achondroplasia. He also gave particulars of a ruptured ovarian cyst occurring in a nulliparous woman, æt. 52. At the operation evacuation in the usual way by trochar was impossible, owing to the gelatinous nature of the contents. The wall of the cyst had ruptured, and similar material filled the peritoneal cavity. The patient made a good recovery.

Miss **FRANCES IVENS** (Liverpool) related a case of pregnancy complicated by bilateral ovarian dermoid cysts, occurring in a nulliparous woman, æt. 35. Menstruation was always regular, and ceased in February, 1906, and the patient sought advice five months later, thinking herself to be pregnant. On examination a cystic swelling the size of a tangerine orange was found lying low in the pelvis beneath the pregnant uterus. On opening the abdomen, the opposite ovary was found to be the seat of a similar but slightly larger tumour, also dermoid in character. It was possible to enucleate both cysts, leaving all healthy ovarian tissue behind. Recovery was uneventful, and the pregnancy was uninterrupted.

Dr. **GRIMSDALE** (Liverpool) communicated a case of carcinoma of the cervix uteri complicating a three months' pregnancy in a patient, æt. 36. There had been loss of flesh and a sanious discharge for three months. Abdominal hysterectomy was performed, and the patient made a good recovery. Mr. George G. Hamilton showed a photograph of the specimen taken by Lumière's colour process.

Dr. **E. EMRYS-ROBERTS** (Liverpool) read a short note on cell dehiscence in pseudomucinous cysts of the ovary, illustrated by colour drawings. He described the epithelial lining of these cysts as being—(1) typical, and (2) atypical, the former being the more frequent, although both varieties were occasionally met with in the same cyst. He drew attention to the changes in the epithelial cell during the formation and extrusion of pseudomucin, and thought it highly probable that the so-called "ovarian cells," or Drysdale's corpuscles, were really aggregations of pseudo-mucin granules, and that their identification would have borne out the contention of their describer as being pathognomonic of this disease of the ovary. The process of cell dehiscence was also described, as occurring especially in cysts lined by more than one layer of epithelium. In the atypical variety cell dehiscence is especially marked, and represents the last stage in the life history of the epithelial cell. The living cell is capable, not only of the production, but also of the extrusion of pseudo-mucin; the dead cell is filled with the substance which it cannot extrude, hence it ceases to be any longer a uni-cellular gland, and, tightly distended, is shed into the lumen of the gland acinus.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 1st, 1908.

BEE STINGS.

THE effects of a bee sting are generally local and benign, but sometimes it produces very grave accidents, indicating profound intoxication of the organism.

A medical paper relates, in this connection, the following fact: A man, æt. 57, of strong constitution, was watering flowers near a beehive, when he felt himself stung on the back of his neck and on the top of his head. He rubbed the parts with some aromatic plant, and continued his work. But soon he was seized with vertigo, and went into the house when he fell into an armchair. A few minutes afterwards he became of waxy colour, and was threatened with coma. Summary measures were employed by the family, and consciousness returned. A doctor arrived a quarter of an hour afterwards, and found the pulse beating at 20 per minute and six inspirations. During the day the pulse went up, and the following morning the condition was normal. The stings were not painful nor was there any local inflammatory reaction observed. Syncope supervened ten minutes after the stings, and lasted about the same period of time.

It seemed that for some years this man was peculiarly sensitive to the venom of bees, and when he handled the hives urticaria appeared some hours afterwards.

Another case differed from the preceding by the absence of grave nervous disturbance, and was characterised more especially by vague malaise and general urticaria.

A woman of 55, of healthy constitution, was stung by a wasp. Ten minutes after the sting she complained of great itching over the region, and soon vesicles of the size of a five shilling piece appeared *loco dolenti*. The eruption spread over the body, but the bullæ were smaller. Four hours after the accident these disappeared, and the following day only a slight erythema over the knees and the palms of the hands was observed.

Dr. Lamarche made a communication on bee stings recently before the Société de Médecine de Lyon. He said that he had for many years been interested in the beehive industry, and from being frequently stung he was rendered immune to the poison. According to him seasons and temperature influenced the character of the bees. They stung seldom while gathering the honey, and when they have well eaten they are gentle. The dart always remains in the wound with the reservoir of venom. The males have no sting, while that of the female is inoffensive. He advised that no pressure should be exercised on the little wound until the reservoir holding the venom (formic acid) attached to the dart was resected.

LOCAL TREATMENT OF DIPHTHERIA.

Large irrigations by means of an irrigator should be practised in each case of diphtheria in order to remove the mucosities and portions of false membranes which encumber the pharynx. The nature of the liquid is more or less immaterial, as it is chiefly the mechanical action that should be desired. Boiled water, a solution of chloral (5—1000), or oxygen water (2—100) might be employed. These liquids should be used warm, as heat relieves the pain, and in large quantity, one quart at least. The injections should be repeated every two hours.

At the same time, spraying the parts with some antiseptic solution is advisable—

Thymol, 1 dr.
Phenol, 5 dr.
Proof spirit, 3 oz.
Water, one quart.

Beyond these irrigations and sprays the local treatment amounts to but little. At least the above is that employed in the Paris hospitals.

However, many practitioners apply directly divers solutions, as—

Perchloride of iron, }
Alum, } āā ½ dr.
Boric acid, }
Glycerin, 5 dr.

Or,

Menthol, 20 dr.
Camphor, 10 dr.

Or,

Menthol, 6 gr.
Camphor, 3 gr.
Olive oil, 3 oz.

A teaspoonful poured into each nostril three times a day to insure antisepsis of the superior respiratory tract.

Paralysis resulting from diphtheria is best treated by repeated injections of anti-diphtheritic serum. The injections should be made for several consecutive days by 10-gramme doses until 60 or 80 grammes are reached, irrespective of age or previous condition.

M. Dopter recommends the use of lozenges prepared with the serum. Their use would bring about, in a few days, the disappearance of the bacilli of Loeffler from the throat.

GERMANY.

Berlin, March 1st, 1908.

AT the Verein für Innere Medizin, the discussion on TUBERCULIN REACTION was continued.

Hr. Martin spoke from a gynæcological point of view. Twenty-five tuberculous pregnant women were tested with the ophthalmic reaction, and in every case the result corresponded to the actual condition. In 10 women the test was repeated 10 weeks later, with a similar result.

Hr. Muscat thought the procedure very valuable for the practising physician. Since November he had applied the test in about 80 cases. At first he used Calmette's preparation, but more recently the German one, since it had been supplied in ampullæ, each ampulla containing enough for one test. The patients he tested were out-patients, so that the test could not be controlled within the first 15 or 18 hours, as it ought to be, so as to avoid missing the height of the reaction. His experiences corresponded to those of others: 87.5 per cent. of tuberculous cases reacted to the test; in 31 non-tuberculous cases a positive reaction was met with only once. Of suspected cases 76 per cent. gave a positive reaction, a proof that not all apical catarrhs were tuberculous.

Hr. Möller claimed that the test by subcutaneous injection was not dangerous. In ten years he had employed it in 30,000 cases, and had never seen mobilisation of the tubercle bacillus, nor had ever met with a disagreeable accident, even in out-patients. It would be a misfortune to displace injection by the ophthalmic reaction, as with the latter we were able to bring about recoveries. In using the ophthalmic reaction he had always to ask himself—what is a positive reaction and what is a negative one? A slight reaction might be shown by dropping a different fluid into the eye, but with subcutaneous injection the thermometer always declared the certain result. He had tried the ophthalmic reaction in 12 cases; sometimes the result was positive and sometimes negative. Many patients objected to the test, as it had got spread abroad that it caused inflammation of the eyes.

Hr. Levy had tried the test in 120 cases in the surgical department of the Israelitish Hospital. The results agreed on the whole with those obtained in the medical department. The result was positive in 62 per cent. of the cases; in quite a number it was doubtful. As regarded misfortune attending it, severe purulent ophthalmia was observed in two cases, and in one it was bilateral. It was worth considering that the subcutaneous method by injection could not be made use of after it. Therapeutically it was, of course, of no value.

Hr. L. Casper reported on the following case: Four weeks ago a female was sent to him with pus in the urine. The family attendant stated that tubercle bacilli had been twice found in the urine. Otherwise the lady was quite well; she was not suffering, and, above all, there was no hæmaturia at any time. On palpation the left kidney was found to be considerably enlarged, but there were no tubercle bacilli in the urine. The patient was now cystoscoped, with the surprising result that the urine from the enlarged left kidney was quite clear, but that from the right was purulent. Here the ophthalmic reaction was tested, and the result was positive. The patient, who had already heard something, now urgently begged for an operation, to which Hr. Casper, although he was not completely satisfied about the tuberculous condition of the kidney, consented. After exposing the kidney, 12 calculi were found in the pelvis of the kidney; there was no trace of tubercle. Naturally, the kidney was not removed, and the patient was now quite well. To the favourers of the new diagnostic method he would recall the words of the poet, "Der Wahn ist kurz, die Reu' ist lang" ("The madness is short, the repentance long").

Hr. Levy recommended the Höchst preparation, the Alttuberculin, in preference to that of Calmette, and the degree of concentration should be from 1 per cent. to 4 per cent. Slight, ordinary conjunctivitis was not a contra-indication, but with follicular conjunctivitis and after trachoma it should not be used. As regarded a positive reaction in non-tuberculous cases, in five typhoid cases he had met with it once, but never in acute rheumatism, although he had examined a large number of cases, and not once either in pneumonia or influenza.

In his reply Hr. Stadelmann pointed out that it was important to discover why the reaction appeared in some cases and not in others.

Hr. Citron pleaded for weak solutions. It was the same with tuberculin as with Widal's reaction in typhoid. It was an undeniable fact that the greater the degree of dilution was, the more specific was the reaction.

The President (Hr. Kraus), in closing the discussion, said that a good deal of importance must be conceded to the ophthalmic reaction, but the results of further investigations must be waited for. For the present, at any rate, its introduction into general practice was not to be recommended.

AUSTRIA.

Vienna, March 1st, 1908.

"Beckenflecken."

At the "Gesellschaft" Robinsohn gave a long description of this latest novelty in Röntgenology, which was first brought to the notice of the profession by Albers-Schönberg in cases of ischialgia or sciatica. These spots or shadows seen by the rays are located to the spina inferior ossis ilii, and the Pass horizontalis ossis. They appear as spherical balls of chalk or other concretions, which have given rise to a number of theories, each with its appropriate name according to classification; Phlebolithia suggests the origin from the veins, lymphatic calcification, intra-muscular calcification, and pedicular exostosis.

Robinsohn believes these "beckenflecken" to be a morbid process affecting the pelvic nerves, which alter the function of the pelvic organs, particularly the urinary apparatus.

In order to demonstrate this opinion he brought forward a male patient, æt. 28, who had a severe attack of gonorrhœa eight years ago, and is now a martyr to bilateral ischialgia. Every form of treatment has been unavailing, and the agony is still being borne. In this case the "beckenflecken" or pelvic shadows are present on both sides, viz., in the spina ossis ischii posterior and the horizontal rami of the pubis. In these positions multiples of concretions are found forming typical pelvic spots with the Röntgen rays, which he considers act as gonorrhœic synovitis on the serous membranes of the pelvis, and probably in the sheaths of the nerves.

Bum thought we could hardly object to Robinsohn's argument, as the compression phenomena were very prominent in the disease, judging from the severity and constancy of the pain. We have always been inclined to favour such an origin as the deposit of chalk crystals as an old theory.

Winternitz said that as long as it is not proved what these concretions are, we cannot rashly conclude that we have yet arrived at the cause of ischialgia. Are these concretions composed of uric acid or its salts, and why do the joints go free while special nerves are afflicted in the pelvis? As yet we have only the testimony of radiologists to support the theory. Again, how comes it that ischialgia can be cured without the diminution or dissolution of these so-called pathological spots? The compression is likely to remain as long as those concrete masses are present, and the ischialgia to continue.

Altered Secretion and Extirpation.

Epping-Falta and Rudinger have been experimenting with animals by removing the thyroid gland to measure the metabolic changes after the operation. In a dog the albuminous metamorphosis is reduced by one-half the normal amount, but the carbohydrates and fat are not altered. In those animals where the thyroid is removed, it does not require any more adrenalin injected into the peritoneum to produce glycosuria, as in the normal animal. If glycosuria be produced by administering adrenalin before the extirpation of the gland, the glycosuria will reappear after the operation, though it may temporarily have disappeared. If adrenalin be administered and the pancreas removed, the glycosuria is not reduced, but decidedly increased. It is important to note that adrenalin is active in the dog after both thyroid and pancreas are removed. He considers the mobilising of the carbohydrates by the adrenalin stands between two antagonistic influences, the thyroid promoting and the pancreas inhibiting.

Empyema of Frontal Sinus.

Hajek presented two cases of severe chronic empyema which he successfully treated by Kilian's operation. One of them came to him with an enormous swelling in the orbital cavity apparently originating in the frontal sinus which was freely laid open and cleared out, taking care to remove the trochlear attachment carefully. After the operation the trochlear has a rapid, trembling movement, but is otherwise functionally intact. It has always been held that this operation is impracticable, owing to the double vision that follows from the displacement of the trochlear attachment. This danger is not so great as was represented when proper care is taken to disturb the superior oblique as little as possible. It may be noted here that this operation is a modification of Kilian's which Hajek maintains preserves the obliquus.

Microscopic Milk Analysis.

Kreidl showed a number of ultra-microscopic preparations of milk from different animals, such as the reindeer, the cat, the dog, the guinea-pig, the rabbit, etc., which he compared with human milk. The latter differed from all the other animals in not having a corpuscular element which was constantly present on the dark field with the other animals. In human milk a fine granular or molecular substance is present in the plasma, possessing the Brownian movement. These fine particles Kreidl names "Tröpfchen Laktozonien."

Escherich thinks this may be due to the animals having more inorganic salts than the human subject.

HUNGARY.

Budapest, March 1st, 1908.

The Association of Apothecaries and Druggists has decided to give up the preparation of anti-diphtheria serum. The work is, however, to be taken up by the Municipal Experimental Bacteriological Institute for one year as an experiment. It will be carried on in the same laboratories and with the help of the same scientific staff as heretofore. The Association has for some years past issued from 2,000 to 3,000 doses of antitoxin of 1,500 units each, most of which has been used in the hospitals of the University of Budapest.

In 1898 the pediatricians of these hospitals undertook the bacteriological examination of diphtheria cases. The object was that the treatment might be tested on a large scale. At that time the serum was yet regarded with considerable doubt, not only by the public, but also by not a few members of the medical profession, and it was believed that if the serum were prepared with the sanction of the Association of Apothecaries, controlled by the Medical Society, more confidence would be felt in the remedy. The present Municipal Institute has no profit out of the work.

A CASE OF RABIES DUE TO PREVENTIVE INOCULATIONS.

In a Hungarian medical journal a case was reported in which a doubt existed as to whether the symptoms were due to the bite of a rabid dog or to the preventive inoculations. A woman, æt. 45, was bitten by a young dog, which was almost immediately killed, without having given any evidences of having had rabies. The patient was given Pasteur treatment, 24 injections being made within 12 days, beginning five days after the injury. On the eighth day of treatment a series of symptoms came on, regarding which it was doubtful whether they were due to true rabies or the inoculated modified form—malaise, nausea, slight cerebral disturbance and stupor. These increased in severity, and were accompanied by obstinate constipation, paralysis of the bladder, dyspnœa, mental depression, with paresis of the face, tongue and pharynx. Gradual improvement came on after a month, but then she became melancholic, and finally a complete idiot, dying within ten months after the injury. It seems probable that in this case the symptoms were due to the inoculations, for the disease began to show itself within 13 days after the bite, which is unusually early, particularly as the injury was superficial. Another servant in the same house was more severely bitten by the same dog, but was not treated, and remained perfectly well. The dog, in all probability, was not mad. The case is of interest because the symptoms could be traced without much question to the inoculations, and the production of such a modified form of the disease has usually been ascribed by other authors who have observed it to the character of the bite itself. The author thinks that if the treatment had been continued so that a true immunity was developed the woman might have been saved.

At the recent meeting of the Medical Society, Dr. Ladànyi read a paper on the

TREATMENT OF BASEDOW'S DISEASE.

He advocates the milk treatment, which gave very excellent results in his cases. This treatment consists of feeding patients afflicted with exophthalmic goître with milk from thyroidectomised goats, and is based on the theory that in thyroid cachexia a poison is circulated in the organism, which, if used in Basedow's disease, might have an antagonising effect on the poison of this affection.

Dr. Ladànyi had a particularly severe case, the exophthalmos and the goître being very prominent; there were considerable emaciation and choreiform movements. The milk was given in various quantities from 1 to 1½ litres daily. Improvement was slow, but constant, and in three months she gained about 6 kilos. The author believes that, instead of the milk having a direct antagonistic action, the process is one of neutralisation (as already stated also by Dr. O. E. Lademann in America), or possibly combination, and the effect lasts only as long as the milk is given. Moreover, the severer the exophthalmic goître, the more milk is required to neutralise. He does not consider that this treatment is specific for Basedow's disease, but believes that further observations are necessary to establish its value. He would also suggest to use desiccated thyroidectomised milk in the form of tablets, if these were obtainable in Hungary.

THE VENTILATION OF RAILWAY CARS.

The State Railways have, after a period of experimentation, adopted a device for ventilating their passenger coaches which promises to do away, not only with bad air, but also with the overheating and underheating of the cars, three evils from which every passenger has at some time or other suffered. The description (in the engineering papers) of the device, indicates that there is about it nothing that is severely complex. Outside air is brought into the car through hoods covered with wire gauze to exclude cinders, passed through vertical down-takes to a space under the floor, whence it is driven into the heater boxes and warmed by the radiators. From the heater boxes the air passes into the car, performs its mission, and is allowed to escape through the ventilators. When all the ventilators are open, 40,000 to 50,000 cubic feet of fresh air can be provided per hour.

The tests on the Hungarian fast trains have been so satisfactory that several dozen cars have already been equipped with the device. If all that is claimed for the system is true, its general adoption, it would seem, cannot long be delayed.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

GLASGOW UNIVERSITY CHANCELLORSHIP.—Lord Rosebery has consented to be nominated as Chancellor of the University in succession to Lord Kelvin. The nomination, which is unanimous, will take place at the statutory meeting of the Court on April 1st.

CARNEGIE TRUST AND THE SCOTTISH UNIVERSITIES.—In order to bring the financial year of the Trust into line with the academic year, the present report covers a period of nine months only, concluding at September 30th, 1907, instead of covering the whole of the year. The quinquennial system of grants in aid of equipment, inaugurated in 1903, closed on December 31st, 1907, and will be reported on in next year's report. It is hoped that before long the Executive Committee will be able to announce their decisions as to a second quinquennial scheme. The expenditure on endowment of post-graduate study and research was £7,003 in 1906-7, and the estimate under the same head for the current year is £7,615. Owing to this being merely an interim report, not including the expenditure on class fees during the winter session, comparisons cannot be made with previous years. The average fee per student has, however, risen from £6 16s. 8d. to £7 2s. 7d. The Trust have been negotiating with the Universities concerning the possibility of coming to some arrangement as to fixity and equality of the fees chargeable to the beneficiaries, such as the institution of a scheme of inclusive fees. The University of Aberdeen has declared itself against such a project; St. Andrews is generally in favour of it; while Edinburgh and Glasgow have definitely proposed to institute an inclusive fee in the Faculty of Arts. The total income of the trust for the year was £71,749 5s. 7d., and the expenditure, management, £2,164 2s. 7d., leaving a net revenue available under Head A—payment of class fees, £34,792 11s. 6d.; under Head B—improvement of equipment, £34,792 11s. 6d.

CHAIR OF CLINICAL SURGERY, UNIVERSITY OF EDINBURGH.—Owing to legal difficulties which have arisen in connection with the fact that the holder of this Chair will be compelled to resign his charge of wards in the infirmary at the age of 65, which will prevent his being appointed to the Professoriate for life, as in the case of other professors whose teaching is not absolutely dependent on their having clinical material, it is probable that some little time may elapse before Professor Annandale's successor is appointed by the Crown.

BELFAST.

PUBLIC HEALTH.—The death-rate last week in Belfast reached the alarming figure of 30.7, the rate from zymotic diseases being 2.1, and from chest affections 6.6, above the corresponding period last year. There were eight cases of cerebro-spinal meningitis notified, as against six the previous week. There are now 22 cases of this disease in the Purdysburn Fever Hospital, and there were two deaths from it in hospital during the week. An interesting report was presented at the last meeting of the Public Health Committee, giving an account of a five days' tour in the country round Belfast made by one of the officials of the department for the purpose of inspecting the sources of the city's milk supply. The general drift of the report is that there is simply no attention paid to sanitation or cleanliness in the cow-sheds, and that the cattle generally are poorly bred and poorly fed.

LETTERS TO THE EDITOR.

TINKERING MEDICAL LAW.

To the Editor of The Medical Press and Circular.

Sir,—The wretched Bill to prevent fraudulent medical practice under the cloak of the Companies Act, which was examined into, with full exposure of its futility, before a Select Committee of the House of Lords a year or so ago, seems to have been revived by Sir J. Batty Tuke, M.P. A Bill with a similar title has, at any rate, been brought forward by him in the Commons. Sir J. Batty Tuke is much too serious a man to be charged with wishing to amuse himself in this procedure; but it is difficult to imagine what, excepting his own personal amusement, he expects to get out of it. There exists not the remotest chance of the Bill becoming law, and it is amazing that he has not realised this. If it became law, moreover, the only effect would be to put to temporary inconvenience less than 5 per cent. of the rascals practising as doctors under false pretences. They would need only to drop the term "Limited," and reconstitute themselves "unlimited," or cease to use any term of the kind. To advertise effectually a quack need only announce "Dr. Bogus's treatment," or "Dr. Bogus's electrical apparatus," or "Dr. Bogus's cure for cancer, consumption," etc. The advertisements offer advice; the patients who apply believe they are consulting the fictitious doctor; and the quack, with quite unnecessary caution, avoids using terms implying that he is qualified. There are half-a-dozen other ways, all equally easy, and sufficient, and all being employed on a large scale to effect the same purpose; and Sir J. B. Tuke's Bill, if it became law, would not inflict more than the most trivial of pin-pricks upon that huge monster, fraudulent quackery. I am among those of your readers who thoroughly agree with your contention that the only way to strike a deadly blow at fraudulent quackery lies first in authoritative exposure, and then in a demand for sweeping legislation. The suggestion first made in your admirable paper by Mr. Henry Sewill that a Royal Commission should be demanded, has been proved thoroughly practical by the result of the Australian Commission; and the fact pointed out by one of your correspondents this week that a Commission on whisky has just been appointed ought to encourage you, and those who are working with you, to promote Mr. Sewill's project. The quack medicine trade—a cloak for quack practice—and practice under other fraudulent pretences, are inflicting vastly greater injury upon the public than is caused by the sale of inferior whisky. The case for a Royal Commission on quackery is literally a thousand times stronger; and it is to be hoped that you, Sir, will persevere in the campaign you have so well begun until the profession, by a united effort, brings it to a successful termination.

I am, Sir, yours truly,
Another Reformer.

Manchester, February 28th, 1908.

CHRISTIAN SCIENCE.

To the Editor of The Medical Press and Circular.

Sir,—Those of your readers who were previously unacquainted with the professions and claims of Christian Scientists must have received full enlightenment from Mr. Dixon's letters, and especially from his last, published in your issue of to-day, and it seems quite unnecessary to prolong the discussion in your pages. I repeat we have little to do with Mr. Dixon's theology; but we can all recognise that, viewed in the dry light of science, his statements form a string of grotesque absurdities. The pith of it all is a claim to cure all diseases by miracle, although Mr. Dixon admits in passing that there is such a thing as "an incurable disease." Nevertheless, "cancer, epilepsy, and consumption are being destroyed by Christian Science every day," and no doubt organic degenerations are by the same means being done away with, and destroyed or obliterated tissues are being restored to their primitive intact physiological condition. To bring all these things about by the methods of Christian Science would not be as wonderful as to prevent by similar means the effects of a lethal dose of arsenic or strychnine, to set a fractured bone, or extract the missile from a gunshot wound. Those with the ignorance of true science, and the faith in Christian Science displayed by votaries of that cult, may accept Mr. Dixon's statements; but these ideas will be always rejected with scorn by the medical profession, and exposed and denounced on every possible occasion as pernicious nonsense.

I am, Sir, yours truly,
Henry Sewill.

February 26th, 1908.

THE MILK SUPPLY OF HOSPITALS.

To the Editor of The Medical Press and Circular.

Sir,—The reports of Surgeon-Colonel Flinn and of Dr. O'Donoghue before the North Dublin District Council, recently published in the daily Press, taken in conjunction with the report of the Central Hospital Council for London on the milk supply of the London Hospitals, provide food for reflection. In this last-mentioned report a number of recommendations are suggested, having the object in view of minimising the chances of adulteration of the milk and also of reducing the possibility of infection through the medium of this important article of diet. However advisable such precautions may be in London, their adoption is even more urgent in Dublin, in the light of the reports of Surgeon-Colonel Flinn and Dr. O'Donoghue.

It will be readily admitted that amongst the adult population the greatest sufferers from impure milk are the patients of our hospitals, for the effects of either a reduction in its nutritive qualities or an increase in its bacterial contents would obviously be felt most severely by organisations whose powers of resistance had been reduced by the ravages of disease. It is very evident that the time has arrived to do something towards the improvement of our milk supply, and no more fitting start could be made than by securing a supply of pure milk—pure in the bacteriological as well as in the chemical sense—for our hospitals.

Considerable facilities exist in this city for such an experiment that are absent in the case of London. In the first place, the source of the supply is in most cases within easy distance of the hospitals themselves, thus obviating the necessity of the long railway journey which, especially in summer, militates so strongly against the chances of receiving milk in a condition of even comparative freshness. Secondly, the hospitals of Dublin are relatively few in number when compared with those of London, and consequently their area of supply could be much more restricted than would be possible in the case of the hospitals of the larger city. The great advantage which would accrue from such a centralised supply would be, of course, in the facilities offered for frequent inspection of the sources of supply by the hospital authorities themselves.

What I would suggest is that the hospitals should agree to unite in giving their contracts to a few dairies, run upon the most approved hygenic principles; and open to inspection by inspectors appointed by the hospitals at frequent intervals; the purity of the milk being controlled by the aid of frequent chemical and bacteriological analysis. Needless to say such dairies would require to be conducted by persons who possessed a practical scientific training, combined with a knowledge of dairying.

I make these suggestions in no academical, but in a practical, spirit. In my own knowledge there exist facilities for the formation of at least one such dairy, and a practical lead having been given, there is little doubt that others would spring up to meet the demand which would inevitably arise.

The chief features of such a dairy would be :—(1) Special care as to the cleanliness of the cows, combined with frequent veterinary inspection. (2) Periodical medical inspection of all concerned in the handling of the milk. (3) The sterilisation, by the use of live steam, of all vessels used. (4) The distribution of the milk in sterilised sealed bottles of a pint or quart capacity. (5) The pasteurisation or buddeisation of the milk in certain cases when required. (6) The publication of periodical reports, including chemical and bacteriological analysis.

There are many more details which consideration for your valuable space forbids me mentioning at present, but I may discuss them in a future letter.

I am, Sir, yours truly,
C. Jocelyn O'Hehir.

Mount Alton, Knocklyon, Templeogue,
February 19th, 1908.

THE THERAPEUTICAL SOCIETY AND THE ROYAL SOCIETY OF MEDICINE.

To the Editor of The Medical Press and Circular.

Sir,—Will you kindly allow me short space to make a personal explanation? As soon as possible after the "Transactions" were published and the printers' account in my hands, I made up my balance account, and then wrote to Dr. Duncanson, saying that I should "have pleasure in handing over my accounts, etc., to the Royal Society of Medicine." The Council, of which he is secretary, met on November 24th. There was no cause, so far as I was concerned, why the treasurer's books, etc., were not at 20, Hanover Square, on the following day, November 25th. Dr. Hugh Woods will bear me out in this. As to any inconvenience caused by delay I know nothing, and have no responsibility therefor. When, in the end of January, the Secretary of the R.S.M. had an interview with Dr. Woods and myself the same statement was made, or rather it was so completely understood as not to require affirmation. Yet a little later I received a communication, by a circumlocutory route, that I should do something. I inquired what I could do more than I had already done? The answer was that I should change my attitude. Well, my attitude for these three months has been resignation. I am afraid I cannot change it yet.

I wonder at times where the Therapeutical Society is. It is like a river flowing through the desert, it disappears into the sand, and beyond the horizon springs issue. Are they the same river? When I meet Mr. Macalister he almost persuades me he has it under his keeping, with the others. But at other times other voices reach me, and I have my doubts.

I am, Sir, yours truly,
G. Crichton.

114, Lexham Gardens, Kensington, W.,
February 27th, 1908.

"THE ONLY WAY."

To the Editor of The Medical Press and Circular.

Sir,—In relation to your editorial in this week's issue of The Medical Press, you comment upon the successful action raised against the Hall Hygiene Company for damages. May I be allowed to mention that a similar action was raised against the same company some short time since by the Medical Defence Union on behalf of a "patient," but that the company, wiser then than later, paid the amount claimed into Court, and so avoided the extra penalty of publicity. The case just presented was brought practically as a result of our successful action, and after consideration of the solicitors of the Union, who were applied to by the legal advisers of the plaintiff. Where suitable evidence is brought before us, the Council would have no hesitation in thus acting, as the effect of such a verdict as that just given will cause unqualified practitioners to reflect if they have any wisdom. Other actions have been raised in previous years against quack vendors, and in one instance a very lucrative practice in "hernia specialism" was broken up by this means.

I am, Sir, yours truly,
A. G. Bateman,
Gen. Secretary.

Medical Defence Union,
4, Trafalgar Square, W.C.,
February 28th, 1908.

[We have much pleasure in drawing the attention of our readers to the above letter, and trust that medical men generally will help the crusade against quackery by reporting cases to the Medical Defence Union.—Ed. M. P. and C.]

NOTIFICATION OF BIRTHS ACT.

To the Editor of The Medical Press and Circular.

Sir,—The promoters of this Act were inspired by good intentions, but its provisions will not accomplish their objects. The storm of opposition in the medical profession that has been excited renders it very unlikely that it can be efficiently administered. There is, indeed, much in the Act that calls for amendment. The duplex nature of the duties imposed on the parent or guardian who is called on—(1) to notify to the Medical Officer of Health, and (2) to register the birth, is likely to seriously interfere with the important work of registration. Mr. Dudman, the Registrar of Births for St. Marylebone, has pointed this out, and, owing to the migratory character of large sections of our population, his apprehensions are well founded. The best solution of the problem would be to direct—(1) that registration by the parent or guardian within 36 hours of the birth of the child should be compulsory; (2) that on the day of registration the Registrar should notify the Medical Officer of Health for the district; (3) that medical men should not be compelled to divulge professional secrets.

Were these amendments embodied in an Act, the Medical Officer of Health would receive early information, whilst the sense of injustice now felt by the medical profession would disappear, and their loyal assistance in the preservation of life would be as zealous in the future as it has been in the past.

I am, Sir, yours truly,
John Fletcher Little, M.O.H.

Harley Street, Cavendish Square, W.,
February 22nd, 1908.

THE ST. GEORGE'S-NAUHEIM INSTITUTE.

To the Editor of The Medical Press and Circular.

Sir,—My attention has been called to a paragraph in the current issue of The Medical Press entitled "The Salt Water Cure." In this paragraph the following passage appears:—

"It will take its place by the side of such great institutions as the Sandow and the Nauheim, which, in their several ways, are doing so much for the relief of diseases, the origin of which has been hitherto entirely unknown to scientific medicine, and of which the treatment has been in consequence so completely at fault."

I should like to point out that the Nauheim Institute passed under the control of my colleague, Mr. W. de Marchott Hill, and myself three months ago, and that our first step on taking control was the cessation of all advertising in the lay press, and the avoidance of any methods not in the strictest accordance with medical ethics.

So far as the treatment at this Institute is concerned, the method of administration is in strict accordance with the latest scientific research, and that everything is done solely in conjunction with the medical profession, and all treatment administered here is on the recommendation of, and in collaboration with, medical men. The association of an Institute of which we, as medical men, are in charge, with such remarks as occur in the paragraph from which I quote, must, I feel sure you will see, be calculated to do us personally immeasurable harm. I should be glad, therefore, if you would give this letter the same prominence in your paper as you gave to the paragraph to which I refer.

I am, Sir, yours truly,
W. Bain.

"A SURREY DOCTOR" AND VACCINATION.

To the Editor of The Medical Press and Circular.

Sir,—In view of the confident manner that Dr. Gubb adopts in his criticism of Mr. West, in your issue of February 26th, I should be glad if you would allow me to ask him to explain how vaccination can afford any real protection against small-pox when it affords such little protection against itself?

As he is no doubt aware, there is ample evidence to show that the "protection" of primary vaccination wears out in twelve months, and the "protection" of any subsequent vaccination in three years.

This is a clear and straight issue, and I ask Dr. Gubb to give it an equally clear and straight reply.

I am, Sir, yours truly,
JOSEPH P. SWAN.

11, Scarisbrick Street, Southport, Feb. 29th, 1908.

OBITUARY.

CONOLLY NORMAN, M.D.DUB., F.R.C.P.I.,

Resident Medical Superintendent, Richmond District Asylum, Dublin

SELDOM has the hand of death fallen with more disastrous suddenness than when, on the afternoon of Sunday, February 23rd, it struck down Conolly Norman, just as he appeared to be recovering from his recent illness, and with years of usefulness, humanly speaking, before him. What so irreparable a loss will mean to his friends, to the profession, and, above all, to the institution of which for so many years he was the head, only time will show. Certainly, while the shock is still so fresh, it is impossible to estimate.

Conolly Norman was born on March 12th, 1853, at All Saints' Glebe, Newtown Cunningham, Co. Donegal, the fifth son of the Rev. Hugh Norman, who at that time held the living. He was one of a family of six brothers, only two of whom survive him. At Newtown Cunningham, and later at Barnhill, his youth was passed, as he was educated at home, either owing to delicacy of health or from some other cause, which means that to himself was due almost entirely the wide knowledge, amounting in certain directions to genuine scholarship, which he subsequently possessed. When only about 17 years of age he commenced the study of medicine, working at the Trinity College and old Carmichael medical schools, and at the Richmond Hospital, and he gained the licences of the Royal Colleges of Physicians and Surgeons of Ireland in 1874, as well as the licence in Midwifery of the Rotunda Hospital. Four years later he took the Fellowship of the Royal College of Surgeons, and in 1890 that of the Royal College of Physicians.

From the beginning of his medical career he devoted himself to the study of mental disease, in which he was to acquire so well-deserved a pre-eminence in this country. Shortly after qualifying, he was appointed Assistant Medical Officer at Monaghan Asylum, where he remained for over seven years, quitting it in 1881 to extend his knowledge by a period of study at the great Bethlem Royal Hospital. While there he established a lifelong friendship with Dr. G. H. Savage, now the acknowledged *doyen* of the speciality in the United Kingdom, but at that time Resident Physician at Bethlem. In the following year he obtained his first senior post, being appointed Medical Superintendent of Castlebar Asylum, and in the same year he married. He returned as Medical Superintendent to his old asylum at Monagham in 1885, and in 1888 he made his final change, being appointed by Lord Aberdeen to succeed the late Dr. Lalor in the charge of the Richmond District Asylum. Such rapid promotion indicates the reputation he was making, and it is common knowledge how well he justified it. Throughout his career the interests of the patients were his chief care, and on taking up work at the Richmond Asylum he at once began to re-organise the institution. How thoroughly this was done has been shown by the Chairman of the present Committee. Dr. Norman found the asylum a gloomy prison, the inmates regarded as offenders, and treated with restraint and suppression; he left it presenting "the twofold aspect of a hospital, where the sickly and infirm received the most beneficent care, and a hive of industry, where the bodily strong found occupation and relief. The "strait jacket" was abolished and the grounds thrown open, outdoor and indoor games instituted, the wards artistically decorated and brightened with pictures, and flowers, and music; workshops established in which nearly every article of clothing worn by the patients is manufactured by themselves, as well as many other things; an improved dietary and better clothing introduced, and the nursing staff properly trained, while their conditions of life were improved. Yet, successful as his work in this line was, he was not a mere administrator. but essentially a physician, and in both respects he recognised that a closed asylum could never afford the best means of treatment for every class of case, while for some it was unnecessarily costly—a point of great importance in view of the increasing numbers of the insane With a view to meeting these two difficulties, he visited the colonies at Gheel and Lierneux, and what he saw there led him to urge, as he did for some years past with voice and pen, the legalisation of some system of family care for the harmless insane.

Yet, notwithstanding the burden of his great responsibility, Dr. Norman found time to become distinguished as a specialist, and his opinion, well reasoned and level-headed, was much in request, not only as a consultant in private, but in the law courts. Perhaps, however, it was in connection with the Medico-Psychological Association that his more purely scientific bent found expression. From the time when his first paper appeared in 1878, a long succession of communciations are to be found in the pages of the Journal of the Association, of which for some years he has been co-editor, dealing with almost every subject connected with the speciality, and marked by a clearness of judgment, a wide knowledge and experience, and a precision of expression, which rendered them interesting and valuable. Wide as was his scope, it is as a clinician that he was at his best, and although he found time for a period to do pathological work, for some years past he laid increasing stress on the clinical study of psychiatry, which he believed to be unduly neglected in these countries. With his great experience and learning, and his original turn of thought, it was to be expected that he would work out the subject on his own lines, and thus he was no blind follower of any authority—his rejection of the current views of "dementia præcox" at the debate at the Oxford meeting of the British Medical Association is proof of this—and it is a matter of deep regret that a volume of clinical lectures which he was preparing for the press was incomplete at the time of his death. In the work of the Association he took keen interest, and held various offices in it—that of Secretary to the Irish Division from 1888 to 1904, when he vacated it on his election as President. The annual meeting held in Dublin under his auspices in the latter year was a signal success, and will be within the memory of many. Of recent years he was not so regular an attendant at the general meetings, but he was almost invariably present at those of the Irish Division, and readily contributed from his stores of knowledge to make them a success. Nowhere will he be more missed than amongst the friends and colleagues, to whom on those occasions he was so familiar and welcome a figure.

His professional eminence was also fittingly recognised last summer by the honorary degree of M.D. of the University of Dublin, a distinction which was, perhaps, the greatest source of gratification that has fallen to his lot in recent times, and by his election to the Vice-Presidency of the Royal College of Physicians of Ireland; but even the multitudinous interests of his profession were not enough for his many-sided mind. His knowledge of English literature amounted to scholarship, and he was a keen student of French, German, and Italian, a practical botanist, and a judicious collector of prints, portraits, old books, and antiques generally, which made his beautiful house a perfect museum. His personality was everywhere apparent, and, in the words of the President of the Medico-Psychological Association, "Conolly Norman was a clear, outstanding figure by himself, and, in his way, a perfect genius."

It is, however, as a friend that he will be chiefly missed, and his death has brought a terrible sense of loss, not only to his wife and relatives, but to many in no way bound to him by ties of blood. The Committee under which he worked, his assistants, both past and present, the attendants and servants, and even the patients, have been unanimous in expressing their affection and regard for him and their grief at his loss, while others, from the Lord Lieutenant down, have combined to pay the last sad respect to his memory. What the want of his kindly interest, level-headed advice, and cheery. humorous society means to his more intimate friends cannot yet be realised.

For the past twelve years Conolly Norman has suffered off and on from anginous attacks, which he himself was inclined to attribute to a form of beriberi, that disease having broken out in the institution at the time. The worry and responsibility of his duties, which he always took hardly, did not allow of much rest; but last autumn, after a holiday, he was better in health than he had been for a long time. At the end of last December, however, he developed influenza with bronchitis, and was obliged to give up work, and he only returned to his duties on the Monday before his death, looking well, and having regained weight. No inkling was there of the approaching end, and he appeared as well as usual when he strolled out on the afternoon of Sunday, February 23rd, only to fall and die after walking a couple of hundred yards, for, though help was immediately at hand, nothing could be done. So passed away, as he himself would have wished, a man whom there is none to replace, and whom the speciality, the profession, and the country could ill afford to lose.

HENRY ROBERT SILVESTER, M.D.Lond.

We regret to announce the death of Dr. Henry Robert Silvester, M.D., whose name is well-known as the author of the "Silvester Method" of recovering the apparently drowned, at Clapham Common, in his 80th year. Educated at King's College, London, he graduated B.A. in 1850, was admitted a member of the Royal College of Surgeons, England, in 1853, and proceeded to the M.B. degree, London, in 1854, and to the M.D. in 1855. Dr. Silvester, who formerly practised in Clapham, received the Fothergill Gold Medallion of the value of 50 guineas from the Royal Humane Society in 1883, on their adoption of the "Silvester Method." He was the author of several medical works.

SAMUEL ROOTH, M.D., R.U.I., M.R.C.S., J.P., C.C.

We regret to announce the death of Dr. Samuel Rooth, J.P., C.C., which occurred last week at Dronfield. Dr. Rooth was educated at Chesterfield Grammar School, under the late Rev. Frederick Calder, M.A., and afterwards at the medical schools of the University of Aberdeen, Queen's University, Ireland, Guy's Hospital, London, and at Paris and Vienna. His degrees were M.D., Queen's University, Ireland, 1863; M.R.C.S., London, 1864; and L.S.A., London, 1864. Dr. Rooth was for many years intimately associated with the public life of Dronfield. He served on the old local Board and the School Board, and later was appointed one of the managers of the Council School. He was for a long period the Poor-law Medical Officer and Certifying Factory Surgeon, positions which he only recently resigned, and he was also for many years Public Vaccinator for the Dronfield Registration Sub-District. He was appointed in May, 1895, a Justice of the Peace, and was a regular attendant at the Dronfield Petty Sessions. When the County Councils were first instituted he was Dronfield's first Concillor, being returned by a great majority, while afterwards he was re-elected triennially without opposition.

WILLIAM GANDY, M.R.C.S., L.S.A.

We regret to record the death of Dr. William Gandy, of Norwood. Dr. Gandy, who had been ailing for the past 18 months, died on the 13th of last month, at the age of 67. For 36 years he had practised at Norwood. Dr. Gandy was a member of the House Committee of Westminster Hospital, and also a Governor; Governor of Charing Cross Hospital; Governor of Middlesex Hospital; Governor of the Queen Charlotte Lying-in Hospital. At one time he was President of the Gipsy Hill Conservative Association, and for a period was medical officer to the Post Office for this district. Up to the time of his death he was Divisional Surgeon to the Metropolitan Police, and also was Surgeon to Court Alma of the Ancient Order of Foresters. He was Brigadier-Surgeon Col. of the Volunteer Batt. 2nd East Surrey Regiment, in which he had served for about 28 years. Dr. Gandy was born at Plymouth, the son of Mr. Thomas Gandy, the portrait painter, who was afterwards established in South Street, Park Lane. He was originator, with the Rev. A. Bell, of the Norwood Cottage Hospital, and had been Honorary Surgeon ever since its institution in 1882. He was also Honorary Surgeon of the Victoria Home, Central Hill.

REGINALD HARRISON, F.R.C.S.

We regret to announce that Mr. Reginald Harrison died on Friday, at 6, Lower Berkeley Street, Portman Square, at the age of 70. Educated at Rossall School and at St. Bartholomew's Hospital, he was admitted a member of the Royal College of Surgeons, England, in 1859, becoming a Fellow in 1866. He had been Surgeon to the Liverpool Royal Infirmary, Lecturer on Clinical Surgery in Victoria University, Examiner in Surgery at the University of Durham, and Lecturer in Surgery and Anatomy at the Liverpool Royal Infirmary School of Medicine, and was a life member of the Court of Liverpool University. In London Mr. Harrison was Consulting Surgeon to St. Peter's Hospital, and had been Hunterian Professor of Pathology and Surgery at the Royal College of Surgeons, England, of which he was a past Vice-President and member of Council. He had also been President of the Medical Society of London, was a Knight of Grace of the Order of St. John of Jerusalem in England, and President of the Metropolitan Street Ambulance Association. He was the author of various professional works, and otherwise a contributor to surgical literature.

GEORGE MONEY SWINHOE, M.R.C.S., L.R.C.P.

We are sorry to have to record the death of Dr. George Money Swinhoe, chief medical officer to the G.W.R. Works at Swindon, where 15,000 hands are employed Dr. Swinhoe, who had reached the age of 77 years, had suffered a great deal from gout, but he had been confined to his bed only about a week. Dr. Swinhoe went through his course of medical training at Guy's Hospital. When the Crimean War broke out he joined the medical staff of the 95th Foot Regiment, and went through the whole of the campaign, having some thrilling experiences, but coming out of the ordeal unscathed. On his return to England he had a practice near London for a short time, and then, exactly fifty years ago, he applied for and obtained the appointment of chief of the medical staff at the G.W.R. Works, Swindon. When he took up the duties the number of employees was 800; to-day it is 15,000.

SPECIAL ARTICLES.

ROYAL EDINBURGH ASYLUM REPORT FOR 1907. (a)

By Professor T. S. CLOUSTON, M.D., F.R.C.P.

Dr. Clouston, in his Report for the year 1907, stated that in the beginning of the year the number of patients was 837 (including 6 on probation), and that on December 31st the number was 743 (including 10 on probation). The admissions were 317, of whom 154 were men and 163 women. The total number of patients under treatment was therefore 1,154. The number discharged from the institution was 328, of whom 106 were men and 222 women. The number of patients who died was 83, of whom 40 were men and 43 women. The average number of patients resident during the year was 731.7, of whom 355.2 were men and 376.5 were women. The total number of admissions (317) was 100 fewer than the average of the past five years. The reason for this was the opening of Bangour Village, which had thus been able to receive most of the patients from the Edinburgh Parish Council. It was 22 years since there was so small a number of admissions. The number of private patients admitted was 134, which was considerably the largest number of this class that had been sent to the institution.

(a) Valedictory Report presented to the Corporation of the Asylum Feb. 24th, 1908.

Following the oldest and simplest classification of mental diseases, in which the elevated and excited were put in one category, and the depressed or melancholic in another, a very suggestive fact appeared when one compared the numbers of those two classes sent to the institution before 1890, the year of the great epidemic of influenza, and those sent since that time. From the year 1874, his first full year of office, up to 1890, the number of melancholics had never touched that of the maniacal. There were only 1,846 of the depressed in the 16 years, to 2,832 of the exalted, or 40 per cent. of the total, while in the 18 years since 1890 (inclusive) there had been 2,662 melancholics to 3,123 cases of mania, or 46 per cent. In 1900 for the first time the numbers of the depressed exceeded those of the excited, while in 1905 this was also the case. In 1896-97 and 1907 the numbers of both classes were equal. The depressing effect on the whole nervous energy of that scourge of humanity, influenza, was now fully recognised, and its direct effects, bad as they were, were scarcely equal to its indirect and distant consequences. Melancholia was not the only nervous disease predisposed to by influenza. Neurasthenic conditions, premature senility, various forms of paralysis, all kinds of neuralgic affections, and a general incapacity for work, both bodily and mental, had all been noticed as following influenza. It seemed as if no disease of whose effects there was any correct record had had such far-reaching evil effects.

He was glad to say that alcoholic excess did not appear in their list of the assigned causes of the disease in so many cases as usual. What did attract attention in their alcoholic statistics, however, was that women appeared about as frequently as men on the lists. Looking back over the past 10 years, the figures would decidedly tend to strengthen the idea that the women of the working classes had taken more to excess in drink of recent years than before. If this represented a general social fact, it was of bad import for the future of the population. The number and the proportion of the cases of general paralysis remained large, 40 cases having been sent to the institution during the year, and the number of women (14) was very much larger than used to be the case. The percentage of recoveries was 28.6, which was a low one as compared with their average of 38.5, but he believed this comparatively low percentage resulted from the fact that cases of a different class were now sent to mental hospitals from those who were sent 30 years ago among the poor. There were far more patients of the old, weakened and paralysed class sent than formerly. The number of deaths (83) was smaller in proportion to their population than usual, the percentage on the average number resident being 11.3, and on the total number under treatment, 7.2.

There were only 24 patients still in the institution who were there when he assumed office in 1873. One of these had been 60 years in the institution, and was now over 80 years of age. They suitably celebrated the occasion of her 60th year of residence, and she enjoyed herself very much. The only thing she bitterly resented was being thought old. For the first time in the history of the institution, the rate-paid class, Dr. Clouston went on to state, were fewer in numbers than the private class of patients. During the 35 years since he assumed office, knowledge of the nature and pathology of many of the forms of mental disease had greatly increased, and the terror and reproach of the disease were visibly lessening.

Dr. Clouston afterwards referred to his relationship with the staff of the institution, and with the Board of Management, and continued:—I find it harder to write this, my last report, than any of the 47 which I had written at Carlisle and here. To lay down one's official duty seems somehow to cut adrift from life's anchorage. The work of the institution has grown under my hand until some of it has quadrupled in amount. My old staff of assistant medical officers, over 35 in number, now scattered all over the world, have been to me not only helpers, but close friends. I cannot describe in words how loyal every one of them has ever been to me and to the institution, and it is a source of pride to me that they earnestly carry forward the work which they began here. It would be quite impossible for me even to indicate the feelings with which I shall finally leave the patients and my work. The institution has a great future before it for humanity, and my most fervent wishes and prayers will ever be for its continued prosperity.

REVIEWS OF BOOKS.

HYGIENE OF NERVES AND MIND. (a)

YET another of Professor Forel's interesting books has been translated into English, and so is accessible to an audience well familiarised with his writings. It is difficult to give an adequate review of this volume here, as it is impossible to discover the kind of audience for whom it is intended, and without knowing the standard it aims at, it is naturally impossible to discuss whether this standard is reached or not. On the one hand it seems unlikely that the volume is addressed to a medical audience, else it would not abound in such pieces of information as that "each half" or "hemisphere" of the cerebrum consists of three principal lobes, the frontal, occipital, and temporal," or that "lethargy is a sleep-like asphyxia, with limp muscles." Indeed, from the general tone and plan of the book, it seems more probable that it is intended for a lay audience. But if this is so, it is very difficult to understand why it should concern itself so much with discussions of such questions as apathy and Bethe's recent criticisms of the neurone theory, the origin of nerve fibrils, Müller's doctrine of the specific energy of the senses, the ecphoric action of engrams, etc. We protest against the current notion that these subjects have any relation whatever to mental hygiene, a notion that is productive of much harm in many directions.

It is hardly just, therefore, to criticise the book from a medical standpoint, though many views are presented as scientific which really rest on no basis of fact. Thus there is no critical evidence whatever for the view, expressed on p. 181, that "neurasthenia is an eminently hereditary disease," and, indeed, the opening sentence (p. 204) of the chapter on heredity frankly states that we know "precious little" about the subject; nor is there any reason to suppose that (p. 180) hypochondria rests on a strong inherited tendency to anxious, uneasy observation of oneself. Naturally, from this opinion, is the transition easy to p. 207—strong statements about the marriage of the mentally abnormal. The book abounds further with fallacious conclusions about the influence of parental alcoholism on the offspring, for which the author is notorious.

It follows that advice to the lay public, based on an antiquated psychology and on unproven data, is likely to be misleading, though we freely admit that it may be popular and well received by an audience holding similar assumptions. To state, for instance (p. 180) that it is a principal rule of hygiene to suppress the sexual impulse as much as possible, certainly accords with current educational teaching, though it ignores the fact that an enormous mass of evidence has been accumulated showing that a great part of the psychoneuroses can be directly traced to the misunderstanding of such teaching.

In our opinion no book on mental hygiene is likely to be of any practical value unless it is founded on modern psychology, which has in the past few years so revolutionised our conceptions of the human mind.

THE ACTION OF ALCOHOL. (b)

NUMEROUS books—good, bad and indifferent—have recently appeared dealing with the alcohol problem. It is a subject which requires thorough scientific exposition and absolutely unprejudiced treatment. The work recently issued by the Church of England Temperance Society is, we understand, a collection of articles which have appeared in one of the official periodicals of that body, and is said to have been written by a "hospital surgeon," but why the author should have masked his identity is not evident. His action has certainly impaired the value likely to be placed on his work, for we are of opinion that no book of this character should be issued by a scientific worker anonymously. The "side lights" deal with the nature of thirst, the influence of alcohol on the skin, the vascular system, and the regulation of heat in the body. The relation of alcoholism to arteriosclerosis and Bright's disease is also discussed. The most valuable chapters are those which deal with the inebriate and his management. The style is terse and attractive, and the writer is evidently a close observer of men and things, but the presentation is essentially "popular," and hence is scrappy and superficial. The work is evidently addressed to the unscientific layman, to whom it may be recommended. It is little less than a crime that there should be no index.

(a) "Hygiene of Nerves and Mind in Health and Disease." By August Forel, M.D. Translated from the German by Austin Hikins, Ph.D. (Progressive Science Series.) Pp. 343. London: John Murray. 1907. Price 6s. net.

(b) "Side-Lights on Alcohol and its action on the Human Organism." By "Medicus Abstinens." Pp. 189, with illustrations. London: Church of England Temperance Society. 1907. Price 2s. 6d. net.

SYPHILIS AND SMALL-POX. (*a*)

A GREAT boon is undoubtedly conveyed to the medical profession by the Council of the Sydenham Society in the publication of these translations and reprints. The essays on the "Occurrence of Spirochætes in Syphilis," by Drs. Fritz Schaudin and Erick Hoffmann (translated by Dr. T. G. Brodie); the abstract of a paper by Theodore Shennan entitled "Spirochæta Pallida (Spironema pallidum) in Syphilis"; the abstract of a paper by Dr. Aldo Castellani on the "Presence of Spirochætes in Yaws," and last, but not least, four communications giving the results of experimental investigations on syphilis by Elie Metchnikoff and Em. Roux (which embody the substance of the lectures given by the former savant in England)—all teem with interest and should be in the hands of every medical man. With reference to small-pox, an exhaustive treatise by Prof. Gary N. Calkins on the "Life History of Cytoryctes Variolæ Guarnieri"; a paper on "Epicrisis" by W. J. Councilman; and, lastly, "Clinical Observations on Variola," by Dr. T. R. Bancroft—form the second part of the volume, and furnish rich fields of observation and instruction.

PROSTATIC ENLARGEMENT. (*b*)

THIS book should prove of great interest to all surgeons, but more especially to those who make a speciality of prostatic diseases and operations. It embodies the results of investigations, the author explains, commenced in 1900 and undertaken to find a satisfactory solution of the operation known as "total prostatectomy." Whether a satisfactory solution has been found Mr. Wallace does not absolutely tell us, but he points out the various routes to be followed by the searcher after elucidation; for instance, when he writes concerning the operation on the encapsuled form and the non-encapsuled form, he says:—"Sufficient observation has not yet been made as to results of operation in the non-encapsuled form. . . . About the success of operative procedures on the encapsuled form there can be no doubt. . . . The position of the surgeon will be made much easier if the future is able to provide a certain means of diagnosis between the encapsuled and the non-encapsuled form." And again, in speaking of carcinoma of the prostate, he says:—"Time alone can show whether complete prostatectomy can give such results as to make it worth while submitting patients to such an ordeal." The chapter on Surgical Anatomy occupies 39 pages, and is of great value; it is embellished with 18 admirable illustrations; the next three chapters, which deal—(*a*) with the experimental pathology and function of the genital organs, (*b*) with the morbid anatomy, and (*c*) with the morbid histology, show painstaking research on the part of the author, and his close attention to the researches of others; and, again, here the illustrations leave nothing to be desired. Mr. L. S. Dudgeon next contributes a short but concise chapter on the bacteriology of the prostate, the tables on the bacteriological examination of the prostate and the urine in a series of cases being specially interesting. Mr. Wallace, in writing on the etiology, gives a list of nine theories of enlargement of the prostate, but pins his faith to three of them as being those best supported by facts—namely, (1) that it is due to a chronic inflammatory process; (2) that it is caused by a septic catarrhal process; and (3) that it is a neoplasm, giving his preference to the third. He brings forward nothing very new with regard to diagnosis and general treatment. In reference to operative treatment he puts aside (and we think with justice) vasectomy, castration, and operation on the pelvic floor, and considers that direct interference with the gland itself is, without doubt, the operation of the future. The remainder of the book gives the reader a description of the operation of enucleation as performed by a skilled surgeon, the illustrations being quite up to the mark of those before mentioned. The last chapter deals with carcinoma of the prostate, much stress being (with reason) laid on the difficulties of diagnosis. The book is very well got up, and the type is excellent, but we do not quite understand why the diphthongs are ignored, æ being given invariably as ae.

THE MUSCLES OF THE EYE. (*a*)

THIS treatise promises to be the most complete and comprehensive which has ever been attempted upon this special subject. In the volume before us the author first deals exhaustively with the general anatomy of the eye, and afterwards devotes ten chapters to the physiology of the ocular muscles. As showing the extent to which the author has pursued his researches it may be noted that in an appendix he adds a bibliography which includes no fewer than 41 pages of the work—a sufficient testimony to the thoroughness of his undertaking. The main objects of the author, as stated in his book, are to clear up the confusion of ideas which exist regarding the actions of the ocular muscles, and to insist upon the need of greater uniformity and completeness in methods of examination. He claims that at present most ophthalmic surgeons practice only a routine examination of patients suffering from asthenopia, heterophoria, and convergent strabismus, in consequence of which important details are overlooked, with the result that treatment proves to be unsatisfactory. The book is entirely one for the specialist, to whom, no doubt, the perusal will be found interesting and profitable. Scattered throughout its pages are many hints as to muscle action and testing of the ocular muscular apparatus, which cannot fail to be of use to the specialist in a practical sense. We can cordially recommend this work.

THE PHYSICAL TREATMENT OF CARDIAC DISEASE. (*b*)

OF recent years the so-called Nauheim treatment of heart disease has won considerable popularity, and in certain cases has proved of undoubted benefit. Mr. Dampier-Bennett's *brochure* should do something to advance its judicious application in this country under capable medical supervision. Much of his matter has already appeared in the *Practitioner*. The indications for and principles and methods of the treatment are dealt with on a basis of personal experience. The author is not desirous of restricting the cardiac subject to balneo-therapeutic measures, but would make use of regulated rest, massage, electrical applications and exercises. He also devotes a chapter to "Diet in Heart Disease," and gives considerable space to the consideration of "Drugs," so that the scope of the book oversteps the restrictions of its title. As an interesting expression of personal opinion the work is not without value, and practitioners will find many of the directions and suggestions of real service. There are no illustrations, which is a regrettable omission in a work dealing with physical methods.

(*a*) "Syphilis and Small-pox." Selected Essays on. Edited by Dr. A. E. Russell. New Sydenham Society, 1906. P. xii, 215.

(*b*) "Prostatic Enlargement." By Cuthbert S. Wallace, M.B., B.S Lond., F.R.C.S. Oxford Medical Publications. P. xii, 215.

(*a*) "The Muscles of the Eye." By Lucien Howe, M.A., M.D., Professor of Ophthalmology, University of Buffalo, &c., &c. In two volumes. Vol. I. Illustrated. New York and London: G. P. Putnam's Sons. 1007.

(*b*) "Physical Methods in the Treatment of Heart Disease." By Arthur G. Dampier-Bennett, M.R.C.S., L.R.C.P. Pp. 111. Bristol John Wright and Co. 1907. Price 3s. 6d. net.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The Surgical Aspects of Subphrenic Abscess.—Barnard (*Brit. Med. Journ.*, Feb. 15th and 22nd, 1908) discusses the anatomical varieties, causes, signs, symptoms and treatment of subphrenic abscess. The communication deals with 76 cases treated at the London Hospital. The under-surface of the diaphragm is marked out into four peritoneal spaces and two cellular ones. The peritoneal spaces are separated from each other by the cruciform arrangements of the coronary and lateral, and the falciform ligaments, forming—(1) right anterior; (2) right posterior; (3) left anterior; and (4) left posterior areas. The extraperitoneal spaces are divided into—(5) right, and (6) left, the right being between the layers of the coronary ligaments, and the left in the perinephritic tissue around the upper end of the left kidney. Right anterior subphrenic abscesses occurred 27 times in the 76 cases, in 11 of which it was limited to this fossa. The commonest causes were: appendicitis, 10; liver abscesses, 7; perforated gastric ulcer, 4 cases. Ten cases of subphrenic abscess occupied the left posterior intraperitoneal space; 6 of these were due to appendicitis. These all occupied other spaces as well. Left anterior intraperitoneal subphrenic abscess occurred in 30 cases, 26 of which were confined to this region. The commonest cause was gastric ulcer (16 cases). There were 3 cases of infection of the left posterior intraperitoneal space, one of which was confined to this region. Right extraperitoneal subphrenic abscesses occurred in 19 cases, in 15 of which it was due to pathological conditions of the liver. Left extraperitoneal subphrenic abscess occurred in 4 cases, each of which was confined to this region. Two were connected with disease of bone, 1 with the stomach, and 1 with the lung. As regards treatment, the author says that the transpleural method of drainage, in which a hole is made into the diaphragm from above, is most unsuitable for early and diffuse stages of subphrenic abscess. An abdominal incision (usually in the loin) should be employed in these cases, and a long tube passed under the diaphragm from below. At a later stage, when the abscess is well shut off under the diaphragm, this route is not suitable, as the liver may be torn in separating it from the diaphragm or pus may be admitted to the general peritoneal cavity. The author says that the promiscuous search for pus with an ineffective syringe is dangerous and deceptive, but the proper use of a good aspirating needle, 3 inches long, on the operating table under a full anæsthetic is the most certain means of diagnosis. With the patient in the semi-prone position, the needle is passed deeply into the tenth intercostal space in the scapular line, and, if no pus is found, into the ninth, eighth, seventh and sixth spaces in turn. If no pus is found, the spaces are searched in the mid-axillary line, working from below upwards. Posterior methods of drainage give much more favourable results than anterior. Recent investigations in connection with diffuse peritonitis have shown that the main cause of subphrenic accumulations is gravitation, as the posterior extremities of the subphrenic spaces are only separated from the skin by about half-an-inch of tissue. As to the results obtained in the 76 cases, 36 died, or 47.4 per cent.; of the 64 cases operated on, 24, or 37.5 per cent., died. S.

Two Cases of Splenectomy.—Lieut.-Col. Dimmock (*Indian Med. Gazette*, Jan., 1908) reports two cases. The first was in a lady, æt. 23, suffering from prolapse of the spleen, which caused acute intestinal obstruction. Three years previously the spleen had been sutured up to the abdominal wall in its original position. Owing to the symptoms of obstruction, immediate operation was necessary. An incision was made to the left of the umbilicus, and on opening the thickened peritoneum, dark-coloured blood began to well up into the wound, showing that the tumour was adherent to it. The peritoneum was then opened above the adherent part. The tumour, which was found to be the spleen, had contracted extensive adhesion to the parietal peritoneum and to the intestines in three places. The adhesions were broken down with great difficulty, causing severe hæmorrhage, which was controlled by compressing the root of the spleen. The pedicle of the spleen was defined and ligatured, and the spleen excised. The cause of obstruction was found in a mass of adhesions to the right of and posterior to the spleen pedicle. Through this band a great part of the intestines had slipped, and a volvulus had formed. The condition was successfully treated. The patient made a complete recovery, and is not suffering from any enlargement of lymphatic glands nor any digestive troubles. In the second case splenectomy was performed for malarial splenomegaly. On palpation the spleen was felt occupying the whole of the left side of the abdomen. As it stood in imminent danger of rupture from the slightest injury, it was decided to remove it. The original medial incision had to be prolonged to from an inch below the ensiform cartilage to the symphysis pubis on account of the size of the tumour. The spleen was adherent in several places to the parietal peritoneum and to the mesentery. The adhesions were broken down between clamps and ligatured. The pedicle of the spleen was transfixed by two silk ligatures, which were tied, and the spleen removed. All bleeding points were secured and ligatured. The patient made a good recovery. The author lays stress on securing all bleeding points, especially those connected with small adhesions. Those under the arch of the ribs are frequently overlooked, and cause fatal oozing after operation. S.

Operative Treatment of Umbilical and Ventral Hernia.—Barker (*Practitioner*, February, 1908) points out that it is a good practice so to place the incision of the operation for ventral or umbilical hernia that the omentum can be removed *en bloc* with the sac and overlying skin, to which it is attached. The incision through the skin is made so as to only leave enough of it to cover over the wound; all the rest is removed with the sac. The latter is opened at a point least likely to have formed adhesions. This is usually near the neck on its upper aspect. The opening in the first instance should be only large enough to examine for adhesions, and to draw an extra quantity of omentum out of the abdomen. The omentum is tied off in strands, divided beyond the ligatures, and the stump reduced into the abdomen. When the ring is free, any gut having been replaced, the sac and skin are divided all round nearly flush with the skin level of the abdominal wall, and taken away with all the omentum still adherent to it. The next step consists of closing the ring, which is still clothed with the reflected edges of the sac. Stitches which include the expanded linea alba and the cut edges of the sac are passed through the edges, half an inch from the margins, and tied. The next procedure differs in the case of small or large openings. In the former case a broad line of union is obtained by stitching the front of the rectus sheath of one side to the other. In case of large hernias or in patients with very weak abdominal walls, the anterior layer of the recti sheath on both sides is opened longitudinally by a curved incision, starting well above the upper end of the first line of sutures, and terminating well below it. Wire netting is then laid over the first line of suture, which it should overlap above, below, and laterally. The edges of this netting rest on the anterior surface of the recti, and lie behind the anterior layer of the sheath. The recti sheaths are then united in the middle line. The skin is brought together as usual. The author has used this method in 20 cases with excellent results. Septic infection, should it occur, does not necessitate the removal of the wire network. S.

A Second Report on Clinical Experiences with Spinal Analgesia.—Barker (*Brit. Med. Journ.*, Feb. 1st, 1908) discusses the results in his second series of 100 cases of spinal analgesia. He points out, in contradiction to Continental workers, that gravitation is an important factor in the administration of the injection. He has succeeded by placing the patient on the left side, with the head and shoulders raised, in inducing anæsthesia of the left lower extremity alone, the left leg being amputated painlessly, while the patient had complete power and sensation in the right limb. Anæsthesia is induced by injecting 5 cgm. of stovaine in the second lumbar interspace. The specific gravity of the solution is 1.023, cerebro-spinal fluid being 1.007. The operations done include gastro-enterostomy (3), strangulated hernia (7), appendicectomy (26). In only one case where the operation was begun under spinal analgesia was it necessary to give a few drops of chloroform in stitching the abdominal wall after the operation. In no case were there any untoward symptoms after the injection. Vomiting and headache were rare, and never marked. Three operations were done on pregnant women (one of these in the seventh month), with no ill effects. S.

The Removal of Foreign Bodies from the Air and Food Passages.—Paterson (*Brit. Med. Journ.*, Feb. 8th, 1908) reports two cases showing the advantage of using the direct method with good illumination, for extracting foreign bodies from even deeply-lying sites. A young sailor aspirated a piece of nutshell into his larynx, causing severe suffocative attacks. Under chloroform, with the air passages cocainised, a Killian tube was passed through the larynx into the trachea. The tube was passed down the right bronchus, which was explored as far as the second ramification and found empty. On searching the left bronchus a mass, reddish in colour, was found blocking it just below its commencement, but its relations were difficult to make out, owing to the insufficient illumination given by a worn-out lamp. The following day the patient was again anæsthetised, the tube, with a new lamp, was passed at once down to the left bronchus, and a piece of nutshell was found lying inside the bronchus, having a small, hook-like process over the bifurcation. A Killian long forceps was passed down, the hook end was seized, and the nutshell drawn out along with the tube. The whole operation did not last more than a quarter of an hour. The second case swallowed a plum-stone, and, as a result, was quite unable to swallow any food. Using an œsophagoscope, the plum-stone was discovered a short distance above the cardiac orifice 12 inches from the teeth, lying transversely across the gullet. The plum-stone, after a little manipulation, was turned lengthwise, and grasped with the forceps and brought out along with the tube. S.

Intraligamentary Bladder.—E. Fothergill (*Jour. of Gyn.*, p. 444) observes that malformations of the bladder are by no means common. In the rare congenital anomaly known as intraligamentary bladder, the organ lies more or less between the anterior and posterior layers of the broad ligament. The utero-vesical pouch is missing, so that the bladder is not separated from the uterus by the usual fold of peritoneum; on one or both sides of the uterus the bladder spreads literally into the broad ligament. The following points have been noted about this condition: The intraligamentary bladder may be either unilateral or bilateral; if unilateral, the uterus is pushed over to the opposite side, and the relations of the tube, ovary, and round ligament are altered; a fluctuating tumour in Douglas's pouch or in the parametrium may be an intraligamentary bladder. The relations of the ureters are altered; they are, as a rule, removed further from the bladder in a lateral direction, and so further away from the vagina. The peritoneum reaches very deeply into the pelvis in front of the bladder, so that in most cases a suprapubic operation cannot be carried out without opening through the peritoneum. In all the recorded cases this condition has been discovered either post-mortem or on the operating table. G.

Painless Effusion into the Knee-Joint.—Bennet (*Hospital*, Nov. 16th, 1907) recounts a number of cases in which effusion had taken place into the knee-joint without the occurrence of any pain. He draws the following conclusions from these cases:—(1) Painless effusion into the knee-joint is primarily the result of constitutional conditions, or defective structural arrangement; (2) in the absence of increased local heat, injury need not be considered as a cause, excepting in the case of great looseness of the joint, and of tall-growing youths, when excessive exercise may be followed by transient effusion; (3) whilst the treatment in all cases without increased local heat should be directed to the avoidance of muscle waste and rectification of the laxness of the joint by massage and exercise, a permanent cure can be obtained only by the treatment of the primary constitutional defect; (4) there is no reason for suspecting tuberculosis as a cause of painless effusion, no matter how long it may exist, or how resistant it may be to treatment, unless there is persistent increase of local heat in the joint. G.

Severe Hæmorrhage from the Kidney during Nephrotomy.—G. Millar (*Amer. Jour. Surgery*, December, 1907) while performing nephrotomy encountered very severe hæmorrhage from the kidney, which all ordinary methods failed to stop, as the kidney was hypertrophied, it seemed likely that this was a compensatory hypertrophy, and that the other kidney was not acting well, under these circumstances the author could not remove the bleeding kidney. The interior of the kidney was packed with gauze, the two halves of the kidney closed upon this packing, and the entire kidney surrounded by several layers of plain gauze, wound round sufficiently tightly to stop the bleeding. The sides of the skin incision and the ureter were covered with gauze to prevent adhesions forming, the entire kidney was then plentifully covered with sterilised dressings, and fixed on the outside of the body by several strips of plaster. The fifth day after the operation all this gauze was gently removed, the kidney showed no sign of bleeding, and was allowed to slip back into its normal place. The incision was closed, and the wound remained aseptic —the after history of the case was uneventful. G.

The Treatment of Chronic Urethritis.—H. Lohnstein (*Zeits. für Urologie*, Bd. I., Heft II.). The author believes that some cases of chronic urethritis will defy all attempts of cure by the ordinary methods, for such cases he has devised an ingenious curette which is used through a urethroscope, and by means of which the entire urethra can be curetted out. This method of treatment has been particularly successful in those cases where the posterior urethra and especially the caput gallinaginis are to a great extent covered by granulation tissue. The instrument resembles an ordinary metal catheter with two lateral openings near the point, through these openings the blades of the two curettes can be protruded to the desired extent by means of a screw at the other end of the instrument. G.

The Surgical Treatment of Brain Tumour.—A. von Gehuchten (*Kundig Congress*, 1907). The surgical treatment of a brain tumour presupposes, a genuine diagnosis that a tumour exists, its localisation, and lastly, that it is accessible. In a great many cases this last condition is unfortunately wanting. The superficial and lateral portion of the brain are fairly accessible, though all tumours of the surface of the brain do not permit of accurate localisation since they do not give rise to external manifestations which are sufficiently suggestive. The percentage of cures after such operation are very small, from the author's cases and many other similar cases, only about 2 per cent. could be called permanent cures. An early operation is especially indicated in the presence of a choked disc and diminution of the visual acuity. The incision and opening in the skull must be made very wide, so that an existing tumour may not be overlooked, in case the localisation may have erred by a few centimetres. G.

Clonic Facial Hemi-Spasm Cured by Injections of Alcohol.—Noceti (*Archives d'Ophthalmologie*, Nov., 1907) publishes the notes of three cases in which the injection of 80 per cent. alcohol made at the level of the stylo-mastoid foramen brought about a cure. In Case 1, that of a woman, æt. 36, the whole side of the face was affected. The attack commenced as clonic spasm and ended as tonic. The attacks were frequent, the intervals lasting from 1 to 15 minutes. The patient had no control over the spasms, and they occurred during sleep. An injection of 1 c.c. of 80 per cent. alcohol containing 1 c. gramme of cocain, produced in about four minutes a complete facial paralysis. In half-an-hour the spasm returned. After three days the injection was repeated, followed by pain and facial paralysis again. On this occasion the paralysis lasted an hour and a half. There was no return of the spasm for 119 days, when the patient passed from observation. Case 2 was that of a man, æt. 35. The whole side of the face was affected with the platysma myoides as well. There was seldom more than 10 minutes between the attacks, and they persisted during sleep. This case got three injections, 1.5 c.c. being used for the first, and followed by facial paralysis in four minutes, which lasted 10 minutes, to be followed by the spasm as bad as ever. The second injection was made a week later, after which there was freedom from spasm for a week. The third injection of 2 c.c. was followed by paralysis for 5 days, after which there was no recurrence of spasm. Case 3 was a man, æt. 23. He had longer intervals between the attacks; two injections were made, with results similar to those experienced in the other two cases. M.

MEDICAL NEWS IN BRIEF

Proposed Sanatorium for Children.

AT the Mansion House, on February 19th, a meeting was held in aid of the sanatorium for children threatened by consumption, which it is proposed to establish at Harpenden in connection with the Children's Home and Orphanage, Bonner Road. The Lord Mayor (Alderman Sir John Bell) presided, and was accompanied by the Lady Mayoress and Mr. Alderman and Sheriff Burnett and Mr. Sheriff Wakefield, who is joint treasurer, with Mr. J. R. Barlow, of the fund. Among others present were Sir Douglas Powell (President of the Royal College of Physicians), Sir Thomas Barlow, Sir Horace B. Marshall, Mr. Helme, M.P., Mr. Ferens, M.P., the Rev. A. W. Hutton, and the Rev. Dr. Gregory (Principal of the Institution).

The Lord Mayor expressed his sympathy with the movement, and dwelt on the importance of taking steps to stamp out consumption among the young.

Dr. Gregory, in an explanatory statement, said that it was not intended to build a general home for consumptive children. In the first place, they intended to deal only with those members of their own community who were in need of special treatment. They must raise 10,000 guineas as an establishment fund, towards which 4,400 guineas had been either promised or received. Mr. Sheriff Wakefield and Mr. Barlow had each given 500 guineas, and an anonymous friend of the former had contributed a like amount.

Sir Douglas Powell said that there was not much difficulty in supporting the appeal of such an institution as this, which had been established for well-nigh 40 years, on behalf of its work for little children. He understood that in its several branches it now had the charge of 2,000 children who, it should be borne in mind, came from the darkest places of the earth. For the past 50 years the mortality among those born in England and Wales had been between one-sixth and one-seventh, so that about 15 per cent. of them died in the first year of life. As on the battlefield one death meant many wounded, so in the campaign of life the sacrifice of 15 per cent. of those born meant the disablement of a very much larger percentage for the struggle of life. He gave his most cordial support to the scheme.

Sir Thomas Barlow spoke on the differences between tuberculosis as it occurred in children and as we were more familiar with it in adults. In the latter it took the form of consumption of the lungs, but with children that was not usually the case. If the young suffered from tuberculosis, it was very often locally—from affections of the glands and bones. Hitherto the special claims of children in respect to this disease had hardly been placed before the British people. In the children's home they had the means of dealing with the sufferers in the early stages, and he believed that the proposed sanatorium would permit of real, thorough work being done, and that the result would be to transform poor, delicate children into healthy men and women.

Mr. Sheriff Wakefield said that they were not starting out on an expensive enterprise, in which money was to be spent on elaborate buildings. They aimed at giving the little children a chance in life.

A collection was taken for the fund.

Royal Medical Benevolent Fund Society of Ireland.

A REGULAR quarterly meeting of the Central Committee was held on Wednesday last at the Royal College of Surgeons.

The Secretary reported the death of Dr. Conolly Norman, a member of the Central Committee. The following resolution was passed unanimously:—

"Resolved: That at this, the first meeting of the Central Committee held since the lamented death of Dr. Conolly Norman, the members of the Committee desire to record their sorrow at the sad event which has deprived the Royal Medical Benevolent Fund Society of Ireland of a staunch friend and annual subscriber, and the members of the Committee of a genial colleague. They would take this opportunity of conveying to Mrs. Norman an expression of their sympathy with her in the grievous and sudden bereavement which has befallen her."

The Secretary stated that a donation of £25 had been received from Dr. Atthill. Three urgent applications for aid were considered, and grants amounting to £16 were made.

The meeting then adjourned.

Glasgow Midwife in Trouble.

BEFORE Sheriff Mackenzie in Glasgow on February 21st, a middle-aged woman, Mary Hall or Russell, midwife, was charged with having omitted to give notice that she had received four children on consideration of sums of money. Accused while on bail attempted to leave the country, and was arrested on board an Atlantic liner at Southampton. The prosecution was under the Infant Life Protection Act. She pleaded not guilty, and four young women, the mothers of the children, gave evidence of having paid accused, in three cases £7 and in one £5, on the understanding that she was to obtain a home for the infants. The Sheriff found the charges proved, and ordered accused to forfeit the money she had received, the alternative being in each case imprisonment for 21 days. In a second charge, Mrs. Russell pleaded guilty to having failed to notify the Procurator-Fiscal of the death of two children. The Sheriff considered the observation of this section of the Act very important, but as a doctor was actually in attendance on the children, and in a position to give a certificate, that made the case much less serious. He imposed a penalty of £10, with the alternative of two months' imprisonment.

The Battle Against Tuberculosis.

AT a meeting of the Liverpool Health Committee, held on February 27th, Mr. Lyle Rathbone (deputy-chairman) presiding, Mr. Parkinson, in view of the alarming remarks recently made by Dr. Nathan Raw, asked was it not a fact that consumption had decreased by 50 per cent. in Liverpool during the past 30 years. Dr. Hope, the Medical Officer of Health, replied that consumption was declining very rapidly. Of course, the aim and object of the Health Committee was to enable people in their own homes to avoid the conditions which led to consumption. That, in fact, had been the policy of the committee for a great number of years, and it had received a very marked reward in this city. Other towns were, of course, doing the same thing, and, happily, with the same results, so that throughout Great Britain, in great towns and in small towns, there was a steady and continuous diminution in the number of deaths from phthisis and the various forms of tuberculosis. It was a great mistake to think that the disease was not showing the same marked decline as other forms of communicable diseases were showing.

Sickness in Mid Cheshire.

Another Northwich school, Danebridge Infants', was closed on February 18th owing to the widespread epidemic of measles in Mid-Cheshire. Two Northwich National and the three Northwich Council schools are still closed, and elementary education in the town is in a large measure at a standstill. Several other schools which have resumed work recently had to undergo periods of closure from the same cause.

At the meeting of the Saddleworth District Council recently, Dr. Ramsden, the Medical Officer of Health, reported that he had never in his experience known so much sickness as during the past month. Almost every family in the district had been affected, the chief ailment being influenza.

Death from Lock-jaw.

Mr. T. Foster Barham held an inquest at Taunton on February 19th on Wm. Hutchings, aged 56, an engine driver, of Combe St. Nicholas, Chard. On February 5th deceased was working at Donyatt, near Ilminster, when the needle of a threshing machine he was attending went through his right hand. As tetanus began to show itself, the doctor injected an antitetanic serum, but as the wound did not improve, the man was sent to the Taunton and Somerset Hospital. Here the injection treatment was continued, but without success, and the man died on the 16th. A verdict of "Accidental death" was returned.

Claim for Medical Attendance.

At St. Helens County Court, on February 19th, Dr. J. S. Fox sued Mrs. Kiernan, a widow, of Robins Lane, for £31 16s. for medical assistance. Mr. Greaves Lord (instructed by Messrs. Brewis), for plaintiff, said Mrs. Kiernan's husband was an insurance agent, and when he died there were considerable assets, the chief being an equity for £560. Efforts had been made to try and get defendant to administer, but there had been great delay, and they had brought this action against her as administratrix *de son tort*. Mr. Rigby Swift, on behalf of the respondent, read correspondence which had passed between Messrs. Brewis and Messrs. Oppenheim, who represented her, and said the action was brought in the wrong form. There was a will, and defendant had partially administered, and they ought to have waited until the administration was complete. Mr. Greaves Lord said they had not been precipitate because during the whole time a suggestion had been made that Mrs. Kiernan was too unwell, but they believed, as a matter of fact, that the thing had been delayed on purpose His Honour Judge Shand said Mr. Swift was entitled to have the action dismissed, but it could be amended. Mr. Swift said the assets were £564 9s., of which £4 9s. was in cash and £560 was the value of an equity, but the mortgagee was in possession and was receiving the rents. After some discussion, his Honour dismissed the action, and gave costs in favour of Mrs. Kiernan, but amended the application and gave judgment against her, as executrix, for £31 16s.

The Journal of the Royal Medical Society.

The appearance of the monthly Journal of the Proceedings of the Royal Society of Medicine marks a noteworthy addition to medical periodical literature. Issued in a green paper cover, small quarto size, it has a solid if somewhat sombre exterior that carries with it an indefinable air of authority. The contributions in the first few numbers are excellent, and if the future standard be maintained at an equal level, the new journal will speedily attain the position of a classic. That is quite as it should be, for hitherto the success of the Royal Society of Medicine has been phenomenal. Although its birth was accomplished under a cloud of doubts and difficulties, it has speedily justified its claims to existence by attaining both popularity and scientific distinction within an incredibly short space of time. It is to be hoped that some of the exclusive features that have hitherto hampered the work of scientific societies in this country will never be allowed to darken the counsels of the new Society. Meanwhile, we extend to our contemporary a hearty welcome, and at the same time venture to express a hope that the promise of its youth may be borne out by many years of prosperity and usefulness in the service of the great and humane profession of which it is the youngest handmaid.

New Tuberculin Preparations.

Messrs. Allen and Hanburys, Limited, have brought to our notice their numerous preparations of tuberculin, human and bovine.

They send specimens of the curative New Tuberculin T.R. in sterile azoules ready for injection; doses of New Tuberculin-Bacillus emulsion, and of Old Tuberculin for diagnostic use are similarly prepared. The Old Tuberculin, it is hardly necessary to remind readers, is chiefly used as a diagnostic agent by hypodermic injection. If tuberculosis be present, local and general reaction results.

They also submit a specimen of Tuberculin for ophthalmic use as a diagnostic according to the method of Calmette. This contains 0.5 per cent. of the solid matter of Old Tuberculin; a similar solution containing 0.1 per cent. can also be supplied. We have tried the preparation in several cases, and have found it satisfactory.

These preparations are for the most part put up in an extremely convenient form in azoules, containing any ordinary dose. Some of them are more conveniently sold in powdered or liquid form.

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society, was held at 6, Catherine Street, Strand, London, W.C., on February 21st.

There were present Dr. de Havilland-Hall (in the chair), Dr. F. J. Allan, Dr. Fredk. S. Palmer, Dr. J. Brindley James, Dr. H. A. Sansom, Mr. F. S. Edwards, and Dr. J. B. Ball.

The accounts presented showed a large increase in the amount of sickness pay, caused by the present epidemic of influenza. As on previous occasions a large number of medical men seem to be suffering from this troublesome malady, but the claims are generally of short duration, and make but a small inroad on the large reserves of the Society.

The number of members permanently incapacitated and drawing sick pay, usually one hundred guineas a year, is still growing; but special and full reserves have been made for them at each valuation of the Society's business.

Prospectuses and all further particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

The movement to commemorate in Glasgow the late Dr. James Finlayson by the establishment of a lectureship took practical shape on February 26th, when a lecture was given in the Hall of the Faculty of Physicians and Surgeons by Dr. Norman Moore, of St. Bartholomew's Hospital, London, on "Schola Salernitana." The lecture is to form one of a series on medical history.

No further cases of small-pox have been discovered on the steamer *Dalbeattie*, from Bilbao, now at Rothesay Dock, Clydebank. The members of the crew were all vaccinated, as well as some dock labourers, and even a policeman, with whom the victim, a Norwegian, is supposed to have come in contact.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

A NEW VERSION.

Examiner: "If a man fell into an empty well, forty feet deep, and struck his head against the bucket at the bottom, what would be your course if summoned as a surgeon?"

Student: "My advice would be to let the man lie where he was, and suggest that the well should be filled up."

Dr. McWalter and Mr. J. A. Walker.—Letters crowded out at press.

H. H.—We are glad to say that the military authorities have removed the prohibition against soldiers' wives having recourse to civil medical practitioners for themselves or for their children. There was a great want of common-sense about this last rule, seeing that many military medical officers have little experience of family practice, while it frequently happens that many of the young married women in a unit belong to families in the locality, who have for years been attended by their own family doctor. The incongruity of the order has presented itself to the Army Council, who have taken steps to remove the restriction, and to permit families to seek medical treatment where their preference lies.

Dr. **Blair Bell**'s letter came to hand as we were "at press"; we hope to have space for it in our next.

Dr. J. K. M. is thanked for his communication, of which a note has been made.

Mr. **J. S. Watson.**—Yes, but only in India and Ceylon, so far as we are aware.

Meetings of the Societies, Lectures, &c.

Wednesday, March 4th.

Royal College of Surgeons of England.—5 p.m.: Prof. F. C. Shrubsall: The Physical Anthropology of the Pigmy and Negro Races of Africa. (Hunterian Lectures.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Prof. W. E. Dixon: The Action of Tobacco Smoke.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m. Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

Thursday, March 5th.

Throat Hospital (Golden Square, W.).—5.30 p.m.: Lecture:—Mr. Faulder: Diseases of the Perceptive Mechanism—Chronic.

North-East London Clinical Society (Prince of Wales's General Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

Harveian Society of London (Stafford Rooms, Titchborne Street, Edgware Road, W.).—Discussion on the Treatment of Pneumonia (opened by Dr. S. West).

Child Study Society, London (Parkes Museum, Margaret Street, W.).—8 p.m.: Mr. W. T. Elliott: The Education (Administrative Provisions) Act in Relation to the Inspection and Treatment of the Teeth.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture:—Dr. D. Grant: Acute Inflammation of the Middle Ear.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson).

Great Northern Central Hospital (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

St. John's Hospital for Diseases of the Skin (Leicester Square, W.C.).— 6 p.m.: Lecture:—Dr. M. Dockrell: Fungous Diseases of the Skin: I., Tinea Circinata; II., Tinea Imbricata; III., Tinea Versicolor; IV., Erythrasma; V., Actinomycosis; VI., Madura Foot.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Hutchison: Intestinal Worms and their Treatment.

Friday, March 6th.

Royal Society of Medicine (Laryngological Section) (20, Hanover Square, W.).—5 p.m.: Dr. G. K. Grimmer, Dr. E. B. Waggett, M. A. R. Tweedy, Dr. H. B. Robinson, and Mr. F. J. Steward: Cases and Specimens.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8.30 p.m.: Dr. Wylie: Foul Breath, its Causes and Treatment; Mr. Bowen: Pneumococcal Otitis Media.

Society of Anæsthetists (20, Hanover Square, W.).—8.30 p.m.: Mr. H P Dean: Spinal Anæsthesia. Followed by the Annual Meeting.

Royal College of Surgeons of England.—5 p.m.: Prof. F. C. Shrubsall: The Physical Anthropology of the Pigmy and Negro Races of Africa. (Hunterian Lectures.)

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique (Ear).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Great Northern Central Hospital (Holloway Road, N.).—3.30 p.m.: Lecture:—Mr. V. W. Low: The Diagnosis and Treatment of certain Fractures.

Saturday, March 7th.

Royal Society of Medicine (Otological Section) (20, Hanover Square, W.).—10 a.m.: Mr. S. Scott, Mr. C. E. West, Mr. H. H. B. Cunningham, Dr. A. Bronner, Mr. M. Yearsley, and Dr. D. R. Paterson: Cases and Specimens. Mr. S. Scott and Mr. C. E. West: The Operative Surgery of the Labyrinth.

Appointments.

Breakell, Frederic James, L.R.C.P., and S.Edin., L.F.P.S. Glasgow, Second Assistant Medical Officer to the Suffolk District Asylum.

Elder, G. T. D., M.R.C.S., L.R.C.P.Lond., Surgeon to the Mansfield District Hospital.

Elliott, William Harold Arthur, M.B., B.S.Lond., L.S.A., Demonstrator of Anatomy at University College, Bristol.

Fortescue-Brickdale, John Matthew, M.D., B.Ch.Oxon., Director of the Public Health Laboratory, University College, Bristol.

Goulden, Charles Bernard, M.B., B.C. Cantab., F.R.C.S., Demonstrator of Anatomy at University College, Bristol.

McVittie, John, M.B., Ch.B. Glasg., Medical Officer and Public Vaccinator for the Parish of Dailly, Ayrshire.

Rhys, Owen L., M.B., B.Ch.Edin., Medical Officer in Charge of the Electrical Department, Cardiff Infirmary.

Thomson, H. Campbell, M.D.Lond., F.R.C.P.Lond., Dean of the Medical School of the Middlesex Hospital.

Vacancies.

Norfolk County Asylum, Thorpe, Norwich.—Junior Assistant Medical Officer. Salary, £150 per annum, and all found except liquors. Applications to the Medical Superintendent.

The Royal Albert Asylum, Lancaster.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, apartments, and washing. Applications, Archibald R. Douglas, Medical Superintendent.

London Fever Hospital, Liverpool Road, N.—Assistant to the Resident Medical Officer. Salary, £120 per annum, with residence and board. Applications to the Secretary.

St. Mary's Hospital Medical School, Paddington, W.—Demonstrator of Physiology. Salary, £150 per annum. Applications to the Secretary.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary, £150 per annum, together with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Hampshire County Council.—County Medical Officer of Health. Salary, £700 net. Applications to H. Barber, Clerk of the Council, The Castle, Winchester.

Lanark County Council.—Bacteriologist for Public Health Laboratory Salary, £250 per annum. Applications to the County Medical Officer, Hamilton.

Pontypridd Education Committee.—Medical Officer to the Education Committee. Salary, £200 per annum. Applications to D. Milton Jones, Secretary, Education Offices, Pontypridd.

Births.

Coldstream.—On Feb. 28th, at Belford, Northumberland, the wife of George Probyn Coldstream, M.B., C.M., of a son.

Shaw.—On Feb. 28th, at 41 King Street, Gt. Yarmouth, the wife of Raymond Henry Shaw, MS., M.B., of a son.

Young.—On Feb. 27th, at Stoney Stanton, Leicestershire, Helen, the wife of Graham Pallister Young, M.B., B.S.Lond., M.R.C.S., L.R.C.P., of a daughter (Elizabeth).

Marriages.

Little—Leslie.—On Feb. 29th, at St. George's, Hanover Square, London, Charles James Colebrooke Little, Lieut. R.N., son of Louis S. Little, F.R.C.S., B.A., of 31, Grosvenor Street, London, and Whitehill, Bletchingley, to Rothes Beatrix, youngest daughter of the late Colonel Sir C. H. Leslie, Bart., C.B., and Lady Leslie, of Rosemoor, Ipplepen, S. Devon.

Deaths.

Biss.—On Feb. 27th, at Hampstead, Janet, wife of Cecil Yates Biss, M.D., F.R.C.P., aged 57.

Cotterill.—On Feb. 27th, at Edinburgh, Mary, the beloved wife of J. M. Cotterill, F.R.C.S.

Ellett.—On Feb. 28th, at the Metropolitan Hospital, London, George Grigson Ellett, M.D., aged 31.

Hallam.—On Feb. 22nd, at Monte, Grand Canary, William Henry Hallam, L.R.C.P.Edin., M.R.C.S.Eng., D.P.H. R.C.P.I., of Fairview, Newquay, Cornwall, formerly Medical Officer of Health of Newcastle, Staffordshire

Smith.—On Feb. 24th, at Arnside, Carnforth, Fanny Eliza Smith, eldest daughter of the late John Whitaker Smith, M.R.C.S., formerly of Finsbury Square, aged 79.

THE LANCET,

Feb. 8th, 1908,

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Camphor	1/10 gr.
Caffeine Citrate ...	1/4 gr.
Aloin	1/20 gr.

ANTIPYRINE (Phenazone)
C.T. No. 111=3 grains.
C.T. No. 112=5 grains.

ASPIRIN
C.T. No. 278=5 grains.

FEBRICULA
C.C.T. No. 197

Quinine Hydrobromide ...	2 gr.
Ipecac. and Opium Powder	2 1/2 gr.
Aloin	1/8 gr.
Calomel	1/8 gr.
Powd. Capsicum	1/2 gr.
Aconite Tincture	3 1/2 min.

RHINITIS
T.T. No. 713 and C.C.T. No. 132

Powd. Camphor ...	1/2 gr.
Quinine Sulphate ...	1/2 gr.
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T.T. No. 644 and C.C.T. No. 133
Half strength of preceding.

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C.T. No. 273.

Phenacetin	2 1/2 gr.
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These are conveniently administered by the "Glaseptic" Nebuliser.

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Camphor	1/2 gr.
Quinine Sulphate ...	1/2 gr.
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Each fluid ounce contains:

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Fl. Cannabis Indica ...	46 min.
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Each fluid ounce contains:

Chloral	120 grs.
Potassium Bromide ...	120 grs.
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GRAN. EFF. SALINE LAXATIVE
Each drachm contains:

Sodium Phosphate ...	20 grs.
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Powd. Ipecac.... ...	1/16 gr.

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Each fluid ounce contains:

Potassium Hypophosphite,	1 1/2 grs.
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C.T. No. 27.

Quinine Hypophosphite,	1 gr.
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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MARCH 11, 1908. No. 11.

NOTES AND COMMENTS.

Medical Examination and Workmen's Compensation.

MANY important and difficult legal points affecting medical men are constantly arising under the Workmen's Compensation Act, and it is unfortunate that, so far, there have been but few authoritative decisions with regard to them. Last week, at Longton County Court, in Staffordshire, there was an interesting argument, in which two questions were at issue before the Judge. One of these was whether a workman, having submitted to medical examination, and having had his payments stopped in consequence, can be compelled to undergo a further examination with a view to obviating proceedings. The other was whether a workman can claim that his medical man shall be present at the examination; while incidentally it was suggested by counsel that a workman cannot be compelled to attend for examination anywhere but at his own house, and that therefore the employer's doctor is bound to visit him there. The Judge supported the contention that a workman cannot be compelled to submit to medical examination when his payments have been stopped, because the rules under the Act only provide for examination while the payments continue. He also, on the ground of custom, upheld the argument that it is proper that the workman's own doctor should be present at a statutory examination, and in this decision he will certainly be supported by medical opinion.

Representation at Examination.

WITH regard to the question whether an employer can claim an examination after payments have ceased, we have only to say that it is one of the legal flaws which the best-drawn Acts fail to obviate, but the point of the representation of workmen at an examination is a much more difficult one. So long as he is represented by a qualified medical man, no question should arise except one of practical convenience, but in many cases, whether by reason of expense or other factor, no medical man is employed, and the solicitor for the plaintiff insists on being present or having the examination conducted at his office. As a matter of professional dignity, we cannot agree that a solicitor should be present during the physical examination, but we think he has a right to hear all questions put relative to the injury in order that he may advise his client not to answer any question which is not medical in its bearing. We think that medical men, when acting for employers, should recognise that it is not their business to ascertain how an accident happened, but should confine their attention to deciding whether the alleged accident could have produced the condition found on examination, and how long the disability is likely to last. By restricting themselves entirely to the medical aspects of the case, they have not only the right, but the obligation to ask every necessary question as to the actual nature of the accident, for it is their duty to advise the employer on these points.

History and Place.

Now, as the history is the essential part of a medical examination, the further point arises whether a workman who refuses to answer questions relative to his history can be said to "obstruct" an examination within the meaning of the Act. For, if he refuses to submit to examination or wilfully obstruct it, no compensation is payable till a proper examination has been submitted to. The point has not, we believe, been decided, but it frequently arises through solicitors advising their clients not to answer any question put by the doctor, but merely to submit themselves to physical examination. Sooner or later it must be settled, for it is obvious to medical men that no "examination" which excludes the previous history is a proper examination, if indeed it can be called an examination at all. Further, we feel that the place of examination must be sooner or later settled. If a man is confined to bed or the house, naturally he cannot be expected to come to the doctor's house, but in any other case it is patently in the interest of justice that he should be examined in a proper consulting-room where all necessary light and apparatus are provided. Any employer insisting on examination taking place at the doctor's residence would have a very strong case if the matter were insisted on in court, especially if he offered the workman his expenses.

Cocaine and Dentistry.

ISIDOR ZEIFERT, the Soho "dentist," was acquitted at the Old Bailey last week of the crime of manslaughter, which the coroner's jury found against him when the death of Jane Farvish was lately inquired into. We are not concerned to say whether the offence of administering half or a third of a grain of cocaine to a person suffering from heart disease, of which fact the administrator was ignorant, is in itself manslaughter, because the jury found otherwise. But we do say that it is perfectly monstrous that an unregistered practitioner should have free play to administer these dangerous doses to his Majesty's subjects under the full protection of the law. Indeed, the community which complacently suffers such doings can only be regarded as one in a state of semi-barbarism. As the victims of the system are all poor people, their deaths excite but the most languid interest among our legislators, and we really think that the Labour Party who hold themselves out to represent the most helpless section of Society, might, nay, should, probe the shocking state of unqualified dental practice to the bottom, and set themselves to work to obtain for the less wealthy classes the same protection that the better-to-do ones enjoy. In working-class districts it is often impossible to find a qualified dental surgeon, and the labouring classes for their dental troubles are forced to go to the ignorant, untrained, and unscrupulous mechanicians who, having served an apprenticeship in the handicraft of making artificial teeth, set up as dentists, administer anæsthetics, and trifle with human life and health.

A Daniel on the Bench.

IF anyone wishes to realise the hopelessness of conveying to the laity the iniquity of this practice, he has only to read the summing-up and incidental remarks of Mr. Justice Bucknill in the Zeifert case. The defendant alleged that he had taken the "primary" degree of Bachelor of Medicine in Russia, but left that country before finally qualifying, owing to political matters. The statement was unsupported, but even admitting it to the full, we maintain it is patent evidence that Zeifert is not qualified to examine the hearts of patients who come to him, and not qualified to administer anæsthetics. Yet the learned occupant of the Bench described him as a "Russian gentleman of good education who had come here because he preferred to live in this country where he could practice his profession in safety without regard to his political views"! We wonder what his lordship would have said if a well-educated Russian gentleman who was not even called to the bar in his own country, had appeared before him to defend a prisoner charged with stealing a twopenny loaf? In one case the prisoner's liberty for a month might be involved; in the other the matter is one of life and death. Mr. Justice Bucknill, in fact, treated the prisoner throughout as if he had been a qualified man, and in assessing the culpability, took no account of the fact that the prisoner held himself out to perform certain duties which he is not capable of performing. Naturally he was found "not guilty" by the jury, and on his being discharged, the Judge addressed him, saying that he agreed with the verdict. "Let me remind you," he added, "so that you may be wiser in the future—take my advice, that with the knowledge that we now have of cocaine, and that you have, it will be extremely unwise of you if you ever administer it without first ascertaining the condition of the patient's heart." Whilst such wisdom is to be found on the Bench, how can we expect any restriction of improper practice?

A Pure Milk Bill.

MR. BURNS has made the definite and most satisfactory announcement we have seen for a long time, namely, that he intends to bring in this session a Bill dealing with the milk supply of the whole country. We cannot use sufficiently warm terms in which to congratulate the right honourable gentleman, subject to two provisos, namely, that the Bill shall be bold and comprehensive, and that it shall be meant to pass. There is, in our opinion, no factor of more vital importance to the public health, and especially to children's health, than a pure milk supply. We do not under-estimate the difficulties in the way of securing it. The agricultural "interest" is very strong in the House of Commons, at least as strong as the liquor interest, and Mr. Burns does not need us to tell him the enormous amount of opposition he will meet with from the Members for rural constituencies. Then, too, there are the railway companies, who will fight any additional burdens and restrictions, and commercial men generally who will oppose anything that interferes with trade. We think the time has long gone by for dallying with the question. The "smoking hetacombs of babes" which annually disfigure the vital statistics of every large town may not all be slaughtered by foul milk, but it is certain that a very large proportion of them are, and it is equally sure that nothing but a vigorous effort will bring the responsible parties to a sense of their duty in the matter. Let Mr. Burns grasp the nettle, and he will have every hygienist in the tountry at his back.

LEADING ARTICLES.

QUACKERY IN AUSTRALIA.—No. II.

THE storehouse of data on the subject of secret drugs, cures, and food contained in the first Report of the Australian Royal Commission is bewildering in its vastness. Here we find for the first time in history the protean aspect of a corroding social evil displayed to the public gaze. It is impossible to glance through these pages without being convinced that the essence of the enormous traffic under investigation lies in secrecy, deception, fraud, and crime. A general notion of the impression made upon the Commonwealth Commissioners may be formed from the following passage at the head of their "conclusions": "Quackery, it has been shown, affects the domain of therapeutics, hygiene, and nutrition. It demands secrecy and deception as indispensable conditions, where the racial interests demand truth and candour. And, again, by inversion, it invades, publishes, and profanes that which the consensus of sane mankind from time immemorial has made secret and sacred—the sexual privacies of women and the functions upon which depend the perpetuation of the race. It has also been shown herein, with such reserve as decency requires—when none at all is exhibited by the quacks themselves or exacted of them by our laws—that the natural phenomena of healthy puberty are utilised with Satanic ingenuity by these quacks and their collaborators in the Press to frighten young men and young women into seeking their help. That it is not casual or unusual for many young persons to correspond with the gilded miscreants has been shown by the fact that one concern—the J. W. Kidd Company (pars. 946-950)—offers for sale 300,000 letters from their unhappy "patients"; and another—a broker—offers 2,000,000 assorted letters from various quack syndicates. One of these concerns has over 7,000,000 letters (*vide* par. 965). How large is the traffic can be gauged from the cost of their advertisements in daily papers, which halve the spoils with the brigands—only that with highwaymen we do not read of quite such ruthless and ruinous betrayal. These letters thus offered in the market—again by the help of the Press—were written, as Dr. Stanley Hall ('Adolescence') informs us, from actual purchase and inspection, with the "youths' heart-blood." This extremely outspoken and emphatic opinion, be it noted, covers only a small portion of the ground. If similar practices are being carried on in the United Kingdom—and we know that such is the case—then the appointment of a Royal Commission is urgently required within our own gates. As a matter of fact, cases of wholesale blackmailing of luckless women have within recent years been divulged in the police courts. But the range of quackery is well-nigh illimitable, and wherever we turn to analyse its pretensions or its methods we are constantly faced with the same underlying trickery, cruelty, and fraud. The probability of a scandalous revelation is no argument against the need of authoritative British inquiry. Nay, rather, it is a strong reason why that course should be adopted forthwith without a moment's delay, viewed in the light of the damning evidence set forth in the Australian Blue Book. Turning to recommendations, we find the first contains the crucial advice that every preparation for the prevention, alleviation, or cure of human ailments should have attached to it its formula, legibly printed. Further, it is advised that no declaration of merits or advertisement of any kind be permitted on labels or wrappers; that no advertisement of any proprietary or secret cure be permitted in newspapers or elsewhere; that such advertisements shall not be sent by post; that there be compulsory registration of all proprietary names, and that the registrar shall be empowered to judge whether the formula represents a drug or compound preparation that may safely be entrusted to inexperienced and uninformed persons for the purpose of self-treatment. Another most practical and radical recommendation is that every imported article should be subject to the same control as would be exercised in the country of origin. Possibly our great Colony of Australia will be beforehand in adopting these principles. It is certain that no civilised people will indefinitely permit themselves to be exploited by the haphazard administration of drugs that can be used with safety in the treatment of human maladies only under skilled scientific supervision. The General Medical Council recently agreed to a wretchedly inadequate inquiry into the abuses of quackery. It is to be hoped that some of the members of that body, on both the Conservative and the Progressive sides, will peruse the Australian Blue Book we have here shortly reviewed. It is a human document of the very highest importance, and registers the first step of a crusade that is demanded in the interest of all sane ideals regarding the moral and material progress of mankind.

QUALIFICATION AND TENURE OF PUBLIC HEALTH OFFICERS.

A good deal of attention in public health circles will naturally be attracted by the printing of Sir Walter Foster's "Bill to Amend the Law Relating to the Qualification and Tenure of Office of Medical Officers of Health, and for other purposes." It is backed by Sir John Tuke, Sir Francis Powell, and Mr. Cooper, and is prefixed by the following memorandum:—

> "The main objects of this Bill are to ensure that none but those properly qualified shall be appointed as medical officers of health or sanitary inspectors, and to give all such officers and inspectors similar security in their tenure of office to that enjoyed by Poor-law medical officers and metropolitan medical officers of health. As the law stands, no qualification is required for a sanitary inspector except in London, and as a general rule a medical officer of health or sanitary inspector is appointed from year to year only, and thus has no true security of tenure. Poor-law medical officers and metropolitan officers of health are not appointed for limited periods only, and are removable only by, or with the consent of, the Local Government Board. Except in London, urban sanitary authorities have no legal power to appoint more than one sanitary inspector. It is desired to extend the metropolitan powers to all urban sanitary districts. In London the sanitary inspector is so called by law; but outside London the law names him 'inspector of nuisances.' It is proposed that the London name shall be universally used."

With regard to the security of tenure of office of the medical officer of health, the approval of the medical profession will be unanimous. There can be little doubt that the holders of such posts are prevented from discharging their duties in an efficient and independent manner because of the annual re-election they have to face by an authority which is largely composed of property-owners and tradesmen. If this piece of legislation be brought about it must necessarily effect a silent, though none the less a sweeping, reform in the public health administration of the nation generally. Something of the same line of argument applies to the sanitary officer, although to a much less extent. In our opinion, his tenure of office might well be settled, given certain safeguards by way of appeal, to the discretion of the medical officer of health to whom he is subordinate. As regards proper qualification, there will be, in all probability, a general consensus of opinion as to the desirability of such a condition in the case of the medical officer. When we turn to the sanitary inspectors, we find ourselves faced with a similar set of circumstances. In the first place, what is to be accepted as the qualifying board, and who is to fix the standards of examination for proficiency of knowledge? It would surely be only reasonable to demand that the certificate or diploma should be under official recognition. At the same time it may perhaps be not altogether impertinent to remark that there threaten to be too many examination boards for sanitary inspectors, and that an authoritative supervising body is needed. So far as the projected Bill proposes to improve sanitary administration in the rural districts of the United Kingdom, it may be heartily welcomed. The backward conditions of many such authorities as regards water supply, infectious disease accommodation, disinfection, and other primary essentials of health, are simply deplorable. In the vigorous hands of Sir Walter Foster the country may look forward to a substantial advance in a branch of social economy which has from the first been pre-eminently British, but which now threatens to lag behind other nations in the equality of its general standards. A village in the Black Country should be no less sanitary, *mutatis mutandis*, than a fashionable London suburb. Yet in London itself there is ample need for reform, as evidenced by the disproportion in the infantile mortality of its wealthy and its poverty-stricken districts. Meanwhile, Sir Walter Foster's Bill may be welcomed as a step in the right direction.

CURRENT TOPICS.

The New Poisons and Pharmacy Bill.

The new Poisons and Pharmacy Bill, introduced by Lord Crewe, has been read a second time and referred to a Joint Committee of both Houses of Parliament. It contains some salutary provisions, notably, that when a chemist carries on business in more than one shop, there shall always be a qualified chemist in charge. A sensible proposal is that certain poisonous substances used for agricultural and horticultural purposes, such as sheep-dips, may, in case of need, be sold by dealers who are not chemists. This step, while expedient, of course does not do away with the necessity for proper safeguards. One of the most important and controversial questions affecting the chemists and druggists, namely, that of the right of limited companies to carry on their particular trade, is not touched by the present Bill. Under parliamentary regulation, however, the Joint Committee to whom the matter has been referred have the power, if they so wish, to take further evidence on the point, and then to make recommendations to Parliament. Another vital issue in the hands of the Joint Committee is to consider and recommend upon the advisability or otherwise of the provisions of the Bill including Ireland within its scope. The two controversial points mentioned are of considerable public importance, and in view of the large vested interests concerned, a good deal of political activity is likely to be expended upon them during the next few weeks or months.

The Pharmacists and Quack Medicines.

AN interesting letter in our correspondence column, by a well-known London pharmacist, emphasises the state of angry revolt which has been arrived at by him and his brother pharmacists against the quackery medicine trade. It is indeed humiliating to our sense of modern social ethics to think that any self-respecting body of men should be asked to become the active participating agents in a traffic they know to be harmful, cruel, and fraudulent. If the underlying proposition of the last sentence be accepted, it follows that the newspapers, who participate in the profits of this villainous trade, are not self-respecting. It seems impossible for any man of sound sense, assuming him to be acquainted with the facts of the case, to arrive at any other conclusion. From an economic point of view, the loss to the nation in wasted money and in wasted lives must be enormous. On purely economic grounds the chemists have at length recognised that the money that should be spent on their legitimate wares is diverted to the pockets of the quack, with disastrous effects upon the misguided consumer. We are glad to believe, however, that there are high moral and ethical motives concerned in the revolt of the pharmacists against quack medicines, and we welcome them cordially as fellow-workers in the campaign which has been conducted in these columns well-nigh single-handed for so many years.

A Lunacy Prosecution.

AT the Middlesex Sessions, on March 7th, Dr. Dr. L. S. Forbes Winslow was prosecuted for "aiding and procuring a woman to receive for payment a lunatic in a house not licensed for the purpose." At the same time a Mrs. Lascelles was indicted for "receiving for payment to board and lodge a certain lunatic in a house not duly licensed for the purpose." A guinea a week was paid by the friends, and evidence was shown of neglect and want of proper supervision. The verdict of £50 against Dr. Winslow and of £10 against Mrs. Lascelles will serve as a sharp reminder that the Commissioners have no intention of permitting the lunacy law to become a dead letter. In many quarters it has become a sort of fashion to deprecate interference with the practice of harbouring insane persons, in private houses, and even to assume an attitude of defiance to the powers that be on that particular point. The action of the Public Prosecutor in the present instance will warn all such refractory persons to be "wise in time." As a victim of the unexpected exercise of the executive arm, Dr. Winslow is entitled to some sympathy. His offence was technical, but none the less it was clearly committed with a full acquaintance with the nature of his act and the possible legal consequences.

The Regulation of the Milk Supply in Ireland.

AT last the Local Government Board for Ireland have issued a much-needed and very stringent series of regulations dealing with dairies, cowsheds, and milk-shops in Ireland. Everyone carrying on the trade of cowkeeper, dairyman and purveyor of milk must be registered. The houses must be kept clean and properly ventilated and lighted. In shops, milk must not be exposed to impure air or kept in a kitchen or living room, or in any place directly communicating with a room used as a sleeping room or in which may be any person suffering from infectious or contagious disease. Vessels must be cleaned with steam or boiling water, and milk must not be distributed by persons whose hands and clothing are not thoroughly clean and free from infection and contamination. Arrangements are also made for protection against tuberculosis in cows. Swine must not be kept in any building used for keeping cows. A register shall be kept by every purveyor, setting out the names and addresses of those from whom he obtains milk. The regulations come into force on May 1st next, and, if only they are enforced, they will have a most beneficial effect on the milk supply, and through it on the public health.

The Necessity for Post-Mortem Examinations.

WE are glad to note that Dr. Symmers, Professor of Pathology at the Queen's College, Belfast, speaking at the annual meeting of the Ulster Hospital for Women and Children, drew public attention to a grave drawback to medical progress in Belfast. This drawback, which has existed for some time, consists in the manner in which every obstacle is placed in the way of the making of post-mortem examinations. Every medical man will agree with the view stated by Professor Symmers that it was not only impossible to progress very far in new medical ideas without post-mortem examinations, but it was impossible to progress at all. In Belfast, such examinations are of extreme rarity; in fact they are never made unless ordered by the coroner. In such cases the cause of death is usually an accident, and consequently the examination affords no teaching on the subject of ordinary diseases. Individuals who object to such examinations are incapable of understanding what hopeless feelings they cause in the minds of those who desire the advance of the human race. How can such advance take place unless the health of the race is first improved, and how can we learn to improve health if we are shut out from all opportunities of acquiring a knowledge of the causal factors of disease? It is one of the curses of the present age that a single faddist can stand in the way of the physical improvement of thousands of his fellow-creatures, and we fear there is at present no sign of improvement taking place. Whatever the result of Professor Symmers' remarks, he deserves high praise for making them in so pointed and public a manner.

An American Surgeon on British Surgery.

THE elder Mayo, the famous American surgeon who recently paid a visit to this country, has put on record in *The Journal of the Minnesota State Medical Association*, some of the impressions gathered by him on the state of surgery on this side of the Atlantic. He has, on the whole, formed a favourable opinion of the present condition of surgery in this country, but he notices the curious fact that the best British surgery is to be seen in the provinces rather than in London. It seems to be true, indeed, that the London surgeon is less in touch with the development of the art of other countries than is his fellow in the provinces. This is probably due to the habit of young provincial surgeons going abroad to study the methods practised in Berne, Paris, Vienna, or elsewhere, whereas the young London surgeon rarely goes beyond his own hospital. Mayo touches, too, on a gross abuse to which we have frequently adverted—the exclusiveness of the London hospitals towards accessions from without. No provincial surgeon, no Irish or Scottish surgeon, no matter how brilliant, has the smallest chance of being elected to the staff of the larger London hospitals without taking the qualifications of the London Colleges, and, in most cases, he is definitely excluded by the terms of appointment until he does so. The gross abuse of the hospital system has not escaped Mayo's notice, and he also draws attention to the lack of hospital provision for the great middle class of people of small means.

PERSONAL.

THE PRINCESS OF WALES is expected to present the Railway Challenge Shield of the St. John's Ambulance Association at the meeting at the Portman Rooms on May 15th next.

DR. FREDERICK T. ROBERTS has been elected an Honorary Fellow of the Medical Society of London.

DR. CLAYE SHAW gave a lecture at the Incorporated Institute of Hygiene yesterday on "The Psychology of Women."

SIR FREDERICK TREVES, Bart., G.C.V.O., C.B., has been appointed a member of the Advisory Board of the Territorial Army.

DR. J. H. DANBIE presided, on February 27th, at the eleventh annual dinner of the Chelsea Clinical Society at the Gaiety Restaurant

DR. P. A. SMITH, of Glasgow, was entertained at dinner by the leading Catholics of Glasgow on attaining his silver jubilee as a medical practitioner.

DR. J. LAWRENCE, of Crewe, has been presented with a handsome cabinet by the members of the Crewe Co-operative Society Branch of the St. John's Ambulance Association.

THE DUKE OF ABERCORN will hold a reception at the West London Post-Graduate College on March 18th. The Dean of the College will send invitations to such medical men as wish to be present.

DR. E. W. HOPE will read a paper on the Liverpool experience of dealing with insanitary property at a meeting of the Incorporated Society of Medical Officers of Health on March 13th.

COLONEL W. COATES, commanding Manchester companies Royal Army Medical Corps (Volunteers), has been appointed principal Medical Officer of the East Lancashire division of the Territorial Force.

LIEUTENANT-COLONEL R. H. FIRTH, R.A.M.C., will lecture on "The Sanitary Service of the Territorial Army" at the inauguration of the Public Health Laboratory at University College, Bristol, on March 20th.

THE Senate of Aberdeen University have decided to confer the honorary LL.D. on Professor Halliburton, of King's College, London, and Colonel W. Johnston, C.B., late Assistant-Director of the Army Medical Service.

A FUND was inaugurated at a meeting at Birmingham University on March 5th for the benefit of Dr. Hall Edwards, who recently lost his left forearm in consequence of X-ray dermatitis through exposure to Röntgen-rays.

MR. A. LESLIE WRIGHT, of Butterley Hall, Derbyshire, has addressed a letter to the weekly board of the Derbyshire Royal Infirmary offering to build and equip wards for children, in memory of his late wife, at a cost of between £7,000 and £8,000.

THE first of the three Milroy Lectures on Mediterranean or Malta fever, under the title of "Melitensis Septicæmia," was delivered on the 6th inst. before the Royal College of Physicians of London, by Dr. John Eyre, Bacteriologist to Guy's Hospital.

DR. WALLACE BOYCE, President of the Leinster Branch of the British Medical Association, delivered an inaugural address at the annual meeting, in which he called attention to the necessity for establishing a National Medical Service, which should be entered by competitive examination.

THE KAISER has conferred the Second Class of the Order of the Red Eagle, with Star, on Surgeon-General R. H. Quill, A.M.S., Principal Medical Officer of Netley Hospital, and the Second Class of the same Order on Lieutenant-Colonel R. S. F. Henderson, R.A.M.C., Secretary and Registrar of the Hospital.

THE Volunteer Officers' Decoration has been conferred by the King on the following medical officers:—Surgeon-Captain H. T. Challis, Lieutenant-Colonel de Burgh Birch, Surgeon-Lieutenant-Colonel J. W. Moir (retired), Surgeon-Major C. N. Lee, Surgeon-Lieutenant-Colonel J. M. Harper, Lieutenant-Colonel G. W. Sidebotham, and Major C. Downing.

WE are officially informed by the President of the Local Government Board that he has authorised for the current year the following researches, in addition to those already announced, under the grant voted by Parliament in aid of scientific investigations concerning the causes and processes of disease:—(1) Further studies by Drs. Andrewes and Horder as to the methods of inhibiting in the animal body the activities of infection by certain cocci. (2) A study of the various forms of pneumonia, especially in children, by Mr. Foulerton, F.R.C.S. (3) A study of acid-fast bacilli in butter by Dr. Nabarro. (4) An investigation of the injurious gases evolved during artificial illumination by Dr. J. Wade, D.Sc.

A CLINICAL LECTURE
ON
FŒTID BRONCHITIS.

By H. RABE, M.D.,

Ex-Interne in the Paris Hospitals.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

CASES of fœtid bronchitis fall into two categories which differ widely in respect of prognosis, anatomical lesions, and clinical appearances. In the first group must be classed cases in which the fœtor, both of the breath and the expectoration, is intermittent and ephemeral, and does not affect the general health. This form of fœtid bronchitis is very apt to recur at variable intervals, and in some instances may become serious; indeed, may even determine a fatal issue. Yet, at the autopsy no anatomical lesion is discoverable to explain the fœtor of the expectoration, no gangrene of the lung or of the bronchial mucosa. Such cases were noted by Laennec, who remarked: "On two or three ocasions I found nothing on opening the body which would explain the gangrenous odour beyond proneness to putrefaction, especially of the bronchial mucus." It is to this form of fœtid bronchitis that Andral and Trousseau gave the name "curable gangrene of the lungs."

In the second group will come cases of fœtid bronchitis associated with gross anatomical lesions discoverable on post-mortem examination, bronchial and pulmonary gangrene of mucosal origin. These are, strictly speaking, cases of putrid bronchitis met with in association with dilatation of the bronchioles in which both the breath and the expectoration have a pronounced putrid odour. The constitutional symptoms indicate infection and intoxication of the organism. Recovery is possible, but rare, the patients usually succumbing to gradually-induced cachexia. Post-mortem we find gangrene of the bronchi and even of the lung The lesions have been thoroughly investigated by Cornil and Ranvier under the name "superficial gangrene supervening in dilated bronchioles."

As a rule these two classes of cases are included under the same head. It is, however, preferable to differentiate between the two anatomical types, describing each under an appropriate name. The clinical type described by Lasègue as curable gangrene of the bronchi, characterised by intermittency of the fœtor and almost invariable recovery, might be styled "simple fœtid bronchitis." The clinical variety dependent upon gangrene of the bronchial mucosa, which is necessarily of grave import, might be described as "putrid bronchitis, gangrenous bronchitis, bronchitis with superficial gangrene of the walls, or gangrene of the bronchi." The diagnosis no doubt will always be a matter of considerable nicety, but the bad constitutional state and the extreme fœtor of the expectoration will usually suffice to establish it.

Etiology.—The fœtor of the expectoration may, under exceptional circumstances, make its appearance in the course of an attack of ordinary or post-influenzal bronchitis. It is more frequently met with in cases of old-standing chronic bronchitis supervening after mental or physical strain or as the result of a chill. It is especially apt to present itself in alcoholic, malarial, and arterio-sclerotic patients. Broncho-pneumonia, especially the form that complicates typhoid fever, favours its appearance along with dilatation of the bronchi. The same remark applies to chronic pneumonia and pleurisy with pleural sympexis. According to Trousseau, multiple pregnancies and prolonged lactation predispose thereto, and Rindfleisch attaches considerable etiological importance to acute pneumonia occurring in the subjects of bronchial dilatation.

The fœtor of the breath and expectoration is often observed in the course of pulmonary tuberculosis. This fœtor, due to putrid fermentation, is promoted by pre-existing bronchial dilatation, by ulceration of the bronchi or lung, by aërobic and anaërobic infection of the cavities, and by gangrene of the walls of the cavities. It is also met with in cases of pulmonary carcinoma.

Pathological Anatomy.—The lesions discovered at the post-mortem examination of persons who have succumbed to the disease just described differ, of course, according as the case was one of simple fœtid bronchitis or of fœtid bronchitis complicated by gangrene of the bronchi. In cases of simple fœtid bronchitis we find the lesions of bronchiectasis. The mucosa is thickened, congested, often ulcerated, and may be covered with a blood-stained or muco-purulent fluid with a filthy odour, but there is no gangrenous ulceration, and, as Graver noted, if the bronchi be washed the fœtor disappears, showing that it was merely due to decomposition of the bronchial secretions. In the lungs we almost invariably find recent foci of broncho-pneumonia, either suppurating or gangrenous. In some instances putrid infarcts consequent upon gangrenous emboli are found in the viscera.

Numerous bacteriological investigations have been made, but they give such discordant and inconstant results that they cannot be relied upon. The staphylococcus pyogenes, mentioned by some observers, is probably present as the result of secondary infection, and has no direct connection with the original fœtor.

Pathological Physiology.—We may unhesitatingly reject the ancient theory of the fœtor of the expectoration being due to a special diathesis, to individual predisposition, and to abnormal secretion of bronchial mucus. Whether the case be simple or complicated by gangrene, the cause is really the invasion and multiplication of certain micro-organisms on the bronchial surfaces. In all probability, in cases of intermittent fœtor, we must incriminate aërobic germs. These exist normally on the bronchial surfaces, where they lead a saprophytic existence, but under the influence of chronic inflammation of these canals they become virulent and set up putrid fermentation of the bronchial mucous secretion, with the formation of butyric, valerianic, caprylic, and other acids. At the same time toxins are formed which cause fever, general depression, and emaciation. This decomposition, however, does not appear to aggravate the bronchial lesions, and under appropriate treatment the alarming symptoms subside, and recovery ensues until the condition recurs.

Symptoms and Course.—Lasègue describes the symptoms of simple fœtid bronchitis in the following terms:—"A person of variable age, of more or less robust constitution, usually much run down in consequence of fatigue or numerous antecedent maladies, is attacked by bronchitis which at first presents no special features. The oppression is moderate in amount, the cough severe, the expectoration fairly copious, of the nature usually met with in advanced cases of this affection. Then the sputum becomes more abundant and purulent, and is sometimes extremely fœtid. This first attack may pass without attracting attention, the fœtor of the expectoration becomes less or disappears, but the bronchitis persists, with little or no fever. After a variable interval the bronchitis seems to get worse, the expectoration becomes greenish-yellow, brown, or even grey, and the fœtor is more pronounced than before.

The fœtor varies in intensity. Sometimes it is not very marked, is only noted after paroxysms of coughing, and it is usually the patient himself who is the first to complain thereof. In other cases it is so pronounced as to invade the whole ward, but even so it is never as horrible as in true pulmonary gangrene. As Grisolle observes, it is a sickly, sweet, repulsive odour recalling that of sulphuretted hydrogen.

In these cases the fœtor of the expectoration is on a par with its copiousness, which in its turn is dependent on the degree of dilatation of the bronchi. Such patients may spit up a couple of pints or more of mucus, and as this is often thrown off suddenly, and is accompanied by nausea and even vomiting, one is apt to suspect a pulmonary or pleural vomica. Collected in a glass, the expectoration separates into three layers, an upper layer which is frothy and holds flakes of pus in suspension, a middle layer which is sero-mucus and contains a few yellow threads, and a lower layer which is frankly purulent and shows small granular masses known as Dittrich's buttons, made up of agglomerations of epithelial elements, fatty acids, crystals, and various microbes. It is important to note that no elastic fibres are ever present. Of course, in cases in which the bronchial dilatation is limited the quantity of expectoration is proportionally diminished.

The physical signs found in the lungs are, as may be imagined, most variable. We get the symptoms of chronic bronchitis, of bronchial dilatation, with or without pleuro-pulmonary sclerosis, moist subcrepitant râles, tubular or cavernous *souffle*, with cavernous râles when the bronchial cavity is large enough.

As already mentioned, fœtid bronchitis, even when simple, always affects the general health. The patient loses appetite, wastes, and the temperature rises to 37° or 38° C., the strength failing day by day.

The duration of the attack varies. The symptoms may improve in ten or twelve days, but are usually prolonged for two or three months, possibly even for five or six months, with alternating periods of improvement and recrudescence. A diminution in the amount of expectoration is the first favourable sign, soon followed by lessened fœtor. The general state improves, the temperature falls, and, usually after a few weeks' convalescence, recovery ensues. But the lesions of bronchial dilatation persist, the patient continues to cough, and he empties his bronchi every morning. It must be clearly borne in mind that even when the recovery, or, rather, the improvement, has lasted for months, or even years, these subjects remain very liable to recurrence. Mere fatigue, or chill, or excess of any kind may forthwith determine the return of the fœtid bronchitis. Moreover, if the remissions be of only brief duration, the patient's strength gradually fails, and he becomes cachectic. The cough and dyspnœa become more pronounced, and very often the pleuro-pulmonary sclerosis rapidly spreads. Fever and emaciation ultimately determine the fatal issue. In the same way, during one of the relapses, sphacelus of the bronchi may occur, or even pulmonary gangrene of the lung.

Under these circumstances the character of the expectoration changes, it loses its muco-purulent aspect, and becomes rusty or blackish, and at the last stage we find fragments of necrosed pulmonary tissue containing elastic fibres. The fœtor is very pronounced and invades the whole ward.

The symptomatology also affords evidence of profound constitutional disturbance. From the onset the patient complains of pains in the sides with increased dyspnœa. There is complete loss of appetite and extreme prostration. The pulse becomes frequent and compressible. The temperature chart does not present the irregularity and marked evening exacerbations of pulmonary gangrene, and oscillates between 37° and 38.7° C. The complexion becomes leaden, and the patient little by little assumes the aspect of the phthisical. During the last few days of life there may be œdema, purpura, and colliquative diarrhœa. Gangrene of the bronchi does not kill as rapidly as primary parenchymatous gangrene; it may run on for six or eight weeks, but invasion of the pulmonary tissue always precipitates the fatal termination. Whichever form of fœtid bronchitis we may be dealing with, its course may be chequered by more or less copious pyretic or apyretic hæmoptysis. This complication is not of much gravity, although Lancereaux records two cases in which death promptly followed profuse hæmoptysis.

Prognosis.—Whatever variety of fœtid bronchitis presents itself, the prognosis must always be guarded. Certain authors, it is true, claim that sphacelus of the bronchi may be recovered from, but this can only be in cases of simple fœtid bronchitis, for the prognosis in gangrenous dilated bronchioles comports a grave prognosis, the patient invariably succumbing to toxi-infection. Then, too, the prognosis is aggravated by the complications that may supervene: putrid pleurisy, fœtid pyo-pneumothorax, gangrenous abscess of the brain, &c. On the other hand, the cure of simple fœtid bronchitis may be hoped for, especially when the bronchiectasis is of limited extent, and the peribronchial pulmonary sclerosis does not tend to spread. But, unfortunately, the attacks of fœtor tend to become more and more frequent, each succeeding attack being more severe, until at last the patient dies in the course of a still more violent attack. Death is due to progressive cachexia, or follows some pleuro-pulmonary complication.

Diagnosis.—Fœtor of the breath and expectoration are not met with exclusively in Lasègue's curable gangrene and in Briquet's disease, but also in certain affections of the lungs and pleura, as well as of the digestive tract and upper air passages. The first question we have to ask ourselves, therefore, in presence of a patient with fœtid breath, is, What is the seat of the causal lesion?

The odour may emanate from the nasal fossæ or bucco-pharyngeal cavity (ozæna, tertiary syphilitic rhinitis, ulcerated pharyngeal cancer, &c.). Similarly, laryngeal epithelioma often renders the breath horribly offensive. The exploration of these different cavities will enable us to incriminate or eliminate them as the source of the fœtor.

The opening into the bronchi of encysted purulent pleurisy, whether interlobar or of the main cavity, is associated with marked fœtor of the expectoration, and the physical signs show the existence of an intra-pulmonary cavity. Suddenness of onset constitutes an important differential sign, and the appearance of vomicas has been preceded by an attack of some acute thoracic affection. Nevertheless, the pleural abscess, even after opening up communication with the bronchi, may take on a sub-acute or chronic course. The patient expectorates a certain quantity of ozænic pus, intermittently, most frequently in the morning, and the breath retains its character in the intervals. It is then impossible to decide whether the patient is suffering from encysted pleural abscess with periodical evacuations, or from putrid bronchitis with or without gangrene of the mucosa. Béclerc reports a case of this kind in which the diagnosis could not be settled without the aid of skiagraphy which rendered it possible to eliminate the hypothesis of pleural abscess and to recognise the presence at the base of the lung of a patch of pleuro-pulmonary sclerosis. It turned out to be a case of dilatation of the bronchi with fœtid secretions. In all such cases, therefore, we must have recourse to this method of exploration.

Certain extra-thoracic purulent collections (abscess of liver, subphrenic abscess, perirenal abscess, &c.) sometimes open into the bronchi. The gangrenous odour of the expectorated matter may lead us to suspect primary putrid bronchitis, but close examination of the patient and the course of the affection will usually enable us to identify the starting-point of the symptoms.

As a rule, the special character of the breath and sputum will suggest the idea of parenchymatous gangrene of the lung. Briquet's syndrome can usually be distinguished easily enough from primary sphacelus of the lung, even in cases in which the odour is peculiarly offensive and the signs of toxi-infection rather alarming. Lobar gangrene commences suddenly, solemnly, so to speak, and, at the same time, the patient complains of intense, persistent pain in the side with severe dyspnœa. The gravity of the constitutional disturbance points to profound infection. These signs are wanting in superficial sphacelus of the bronchi, an affection which is characterised by a gradual onset and a less striking symptomatology. The gangrenous focus is revealed by exact, circumscribed physical signs (dullness *en bloc*, souffle, crepitant and sub-crepitant râles, &c.). The physical symptomatology of putrid bronchitis is always somewhat vague and very polymorphous.

Directly we have made out the exact origin of the respiratory fœtor a second problem arises. It is due to simple putrid fermentation of stagnant secretions in the bronchial cavity, or is the bronchiectasis complicated with true gangrene of the mucosa. We have just contrasted the clinical characters of the two syndromes. The intensity of the odour, the gangrenous fœtor of the sputum, the progressive decline of the general health, and the protracted duration of the attacks, are all points that militate in favour of Briquet's disease. Nevertheless, these presumptive signs may be wanting, and microscopical examination of the sputum will then decide the diagnosis; in cases of bronchial sphacelus by showing the presence of elastic fibres, and their absence in cases of simple fœtid bronchitis.

Gangrene of the mucosa follows sometimes fixation in the bronchi of septic foreign bodies. The diagnosis of this etiological variety of putrid bronchitis does not present any difficulty. It is met with in the aged, in paralytics, and in the insane, in whom the passage into the air passages of a foreign body gives rise to attacks of dyspnœa with extreme distress, cyanosis and threatening asphyxia. In healthy adults bronchoscopy may furnish valuable information in respect of the diagnosis of the seat of obstruction.

Treatment.—This is based on the following therapeutical indications: To modify the bronchial secretions, and to facilitate their expectoration.

Inhalations and fumigations of eucalpytus, turpentine, thymol, and creasote fulfil the first indication. Leyden recommends inhalation of oxygen; Béclerc, intra-tracheal injections of oxygenised water and mentholated oil. We may also give internally terpine, turpentine, guaiacol, and creasote, which, however, must not be continued indefinitely for fear of upsetting the stomach. Gimbert and Bucquoy advise tincture of eucalyptus; Chauffard, tincture of benzoin; and Lancereaux, hyposulphite of soda in drachm doses daily. Sublimed sulphur (3 to 5 grains in the 24 hours) may also be recommended, and the waters of Eaux-Bonnes, Cauterets, Barèges, &c. If the stomach becomes intolerant, we must have recourse to hypodermic administration.

Kermes and ipecacuanha promote the elimination of the bronchial mucus, thus fulfilling indication number two. The protracted duration of fœtid bronchitis and its frequent recurrence, as has been pointed out, bring about gradual exhaustion and steadily increasing cachexia. This must be combated by the administration of ferruginous tonics, hypophosphites, and the like.

Note.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Robt. Saundby, M.D., MSc., LL.D., F.R.C.P.Lond., Senior Physician to the General Hospital, Birmingham. Subject: "Sudden Death."***

LETTSOMIAN LECTURES, 1908.

MALIGNANT DISEASE OF THE CÆCUM.

By CHARTERS J. SYMONDS, M.S., F.R.C.S.,
Surgeon to Guy's Hospital.

Lecture III.

The Lecturer first referred to the accepted view that extirpation was the only remedy for malignant disease, and that the success attending early removal demands on our part its early recognition. The difficulty that sometimes occurred in accurately estimating the nature and extent of abdominal swellings gave rise to two evils; firstly, to the postponement of operation till the appearance of certain well-known signs of disease occurred, and so to the loss of valuable time; and secondly, it led us to lose confidence in the value of those signs pointing to inoperable disease, and so to lead to exploration when unnecessary. Cancer of the intestine, being a painless infection, did not become manifest until the appearance of a tumour, or the signs of obstruction. It was, therefore, important to remember that when these signs arose the disease had been in existence some time, often for many months. Referring especially to cancer of the large intestine, excluding the rectum, he pointed out that the operative success was very satisfactory, even with removal of large portions. The lymphatic infection was slow to occur, and the extension to the peritoneum and other organs was long delayed. While advocating early, and even extensive removal in suitable cases, he did not wish anyone to think lightly of such operations, where a disaster might cut short a life with a year or more of satisfactory existence. Such operations demanded a knowledge when to proceed with, and when to abandon, an operation, what limits to set to the undertaking, and a patience that will not fail when further but removable infiltration is found after all had apparently been removed, and that will examine, and see that no weak point in the defence had been left unprotected. The first part of the large intestine, he pointed out, was particularly suitable for resection, on account of the length of the mesentery, the ease with which it can be handled, and the satisfactory condition in which the parts can be left, for in joining the ileum to the transverse colon, the functions are practically undisturbed. The two chief signs of malignant disease of the cæcum were the presence of a tumour and early intestinal colic. The typical appearance of such a tumour was next described. It appears as a movable, hard, well-defined mass, so close to the abdominal wall that it may be grasped by the hand, and even lifted forwards. From a position of rest it can be moved downwards, swinging inwards as it descends towards the median line, and the margin of the rectus. Upwards towards the ribs it takes a more vertical course, and does not pass into the loin. It again can be moved directly inwards towards the umbilicus. During this movement a gurgle will often be heard. While the range of movement varies with the natural mobility of the cæcum in any individual, and while it may be limited by fixation of the growth, it was held that the appearances described did not occur in any other tumour about the cæcum. The characteristic of the colic was that at first the pain was central, and later in the cæcal region. It was of brief duration, attended with gurgling, and often by vomiting, unaccompanied by nausea, so that an interrupted meal may be returned to. Where the disease begins in the ileo-cæcal valve, colic will precede the appearance of a tumour. On the other hand, when the disease begins above the valve, colic may be entirely absent.

The first case illustrating the lecture was that of a lady, æt. 48, operated upon in December, 1897. The first symptom was "pain in the stomach," in July and August. In November the pain became more severe, and right-sided, there was gurgling, and, at the height of the spasm, sickness. A tumour, easily handled, and movable downwards and towards the median line upwards, occupied the position of the cæcum. There was characteristic coiling of the intestine, and the typical colicky pain of obstruction.

The cæcum, with a considerable piece of the mesentery, was removed, the colon closed, and the ileum attached to the side of the large bowel by a Murphy's button. The specimen showed the disease to have begun at the ileo-cæcal valve, thus explaining the early obstruction. The appendix shared in the growth, and the ileum showed marked thickening. The recovery was rapid, and she was alive and well in February, 1908, more than ten years from the operation.

As showing how the mobility of the tumour, and the presence of good health may lead to error in diagnosis, a case of a lady of 34 was cited, who was seen in June, 1900, after an attack of abdominal pain. The next morning the temperature was 100, and a lump was found in the situation of the appendix. As it did not subside, Mr. Oram, under whose care the patient was, brought her for an opinion. The mass was painless, easily handled, and had a range of movement exactly like the first case. The colicky pain was equally characteristic. Immediate operation was advised, but, unfortunately, delay was recommended by a leading physician. on account of the mobility of the tumour, and, therefore, its apparently simple character, and also on account of her age. When seen six months later, the tumour had greatly increased, there was frequent pain, and the night before there had been an attack due, apparently, to perforation. Short circuiting seemed now the only remedy, and with this view the abdomen was opened. The manipulation required to obtain the end of the ileum, raised the whole mass from the iliac fossa, and it seemed quite possible to extirpate it. This was carried out, the ileum being united as before to the colon, and in the same manner. Though severe, the operation was well borne, but she died in three days from hæmatemesis, the vomiting beginning immediately after operation. The strength was not quite sufficient to bear so extensive a proceeding. The difficulty of defining the limits of operation was pointed out when the only consideration must be the welfare of the patient, and not percentage of success, though removal was surgically possible.

The next was a case where the growth was more diffused, and the tumour flatter and less defined. This was a gentleman of 75, seen with Mr. Donald Smallpeice, in January, 1904, for abdominal pain, indigestion, loss of weight, and a doubtful swelling in the right ilio-lumbar region. On deep inspiration the lump came forwards, and could be pushed in any direction, the mobility being unusually extensive. Unlike the usual tumour, this returned into the loin, and was almost lost to touch. He had typical colic, brief, sharp, accompanied occasionally with sickness unattended with nausea. Being a vigorous man, and likely to bear a fairly big operation, exploration was advised with a view to removing the cæcum. This was successfully carried out, and the ileum being united as before to the colon, an uninterrupted recovery followed. At the date of the lecture he was alive and well, and able to walk and cycle as usual. The growth in this case involved the cæcum and ileo-cæcal junction and was of a diffused variety. The peritoneal coat was thickened from old inflammation, probably starting in the appendix, as this body was enlarged and thickened.

A case without colic was that of a lady of 59, under the care of Dr. Steele Perkins. This patient had accidentally observed the tumour when handling the abdomen. There had been no pain or tenderness. The tumour was a little higher than usual, but had much the same characters, and seemed a favourable one for removal. The patient had some cardiac trouble, and was of a most nervous disposition. In March, 1904, resection was completed on the same lines as in the others, and was followed by a rapid recovery. The specimen and drawing showed the disease to be situated just above the ileo-cæcal orifice, thus explaining the absence of colic. On account of the glandular infection nearly the whole of the ascending colon was removed. Some glands on the spinal column were left. This patient died some 18 months after operation from some cardio-pulmonary malady, there being no evidence of recurrence.

The next case referred to was that of a man of 52, under the care of Dr. Carrell, of Ilford. The clinical signs of this case showed the disease to be more extensive, and the chance of extirpation doubtful. The signs of obstruction were marked, and the tumour less movable and less defined. Being a man of good physique and remarkable energy, it was decided to remove the affected parts, if possible. On exposing the tumour, a coil of small intestine was found adherent to the anterior aspect of the growth. This was first resected, and united by two continuous sutures. Then the cæcum, half the ascending colon, and a large piece of mesentery with numerous glands were removed. Recovery was interrupted by the most incessant hiccough, lasting four days. Then the skin was noticed to be bulging, and serum to exude from the wound. On opening the scar, a coil of small intestine was found, covered with lymph. The catgut sutures had given way owing to the hiccough. Without anæsthesia the intestine was returned, and the wound closed with two rows of silk. The man recovered, and took his food well. Later the whole scar and rectus muscle became infiltrated with growth, sinuses formed, and he died some months later with a fæcal fistula. It was suggested that infected peritoneal serum must have existed, and entering the wound with a coil of intestine, determined the deposit of cancer. In the operation the growth had not been torn or broken, though infected lymphatics must have been divided. In this connection, it was pointed out that this must often occur, and yet no similar result had been seen. It, therefore, seemed due to the cancer material being implanted on connective tissue.

Diagnosis.—Under this heading the various tumours occurring in the ileo-cæcal region were referred to. Those due to disease of the appendix were smaller and fixed. When permanent, the cause was a calcareous covered concretion. The resemblance of suppurating growth to appendicitis was illustrated by two cases, in one of which the sinus had healed. The occurrence of sudden pain in the iliac fossa, with a rise of temperature, and the finding of a lump was referred to as the earliest evidence of a malignant growth in two cases.

Tuberculosis of of the cæcum was discussed, and reference made to Professor Hartmann's paper read before the Society last year. One case, occurring in the lecturer's practice in 1895, was referred to. Here there was a fistula with a large irregular fixed mass. Excision of the cæcum was followed by recovery. It was thought that the age of these patients, usually under 30, and the earlier fixation of the tumour would decide, though cancer of the large intestine at 28, 19, and 16 had come under the notice of the lecturer.

Tuberculous glands in the ileo-colic angle had been operated upon in four instances, all in young people. The tumour in these cases was smaller, was fixed, and there was no obstruction.

One case of actinomycosis was referred to ("Med. Chi. Trans." vol. 75) as showing the resemblance to the suppurating stage of malignant growth. In the early stage actinomycosis resembled from its fixation, hardness, and persistence that form of appendix tumour due to a calcareous concretion, and not a new growth.

Limits of Operation.—While resection was out of the question in the presence of secondary deposits, and with infiltration of the posterior wall, he thought moderate infiltration of the anterior wall did not always negative operation. One such case was related in which he had successfully removed an infiltration scar—the result of a former operation in another's hands, together with the cæcum. Recurrence took place after a short interval. Adhesion and infiltration of a coil of small intestine was not considered to negative extirpation. The presence of pallor, as a rule, indicated a condition that would not endure a long operation. He referred to pallor as due to disseminated growth—true cachexia—to small hæmorrhages, as in gastric carcinoma, and to necrotic changes in the growth. When this last is the cause removal may be carried out when the patient is vigorous. One such instance was referred to where the hepatic flexure, ascending colon, and cæcum were successfully removed, the man being still active and well nearly four years later.

Murphy's button for making a junction between the end of the ileum and the side of the colon was referred to as preferable to direct suture. It was important to use a button not more than 13/16 of an inch in diameter, to place a row of Lembert's sutures round the junction, and, whenever possible, to surround the parts with the great omentum.

Reference was made to the importance of postponing anastomosis when the contents of the bowel were septic, and to two cases fatal from this cause. When palliative treatment by anastomosis was carried out, he saw no necessity for dividing or otherwise excluding the ileum below the junction. He thought such a plan determined the accumulation of fæces in the colon between the growth and the junction.

ORIGINAL PAPERS.

PERSONAL HEALTH PROBLEMS—EARLY AND LATE GROWTH.

By J. LIONEL TAYLER, M.R.C.S., L.R.C.P., Lond.

Now that the study of the individual health factor has, with the inspection of school children, become a public question, it is to be hoped that this problem of personal health will receive the attention that it deserves.

At the same time it is desirable that it should be clearly recognised that it is an altogether different study from that of public health.

It may or may not be a fair assumption to make to assume that, in one thousand school children of a certain age, a given number should be a certain average height, and that a lower standard implies an unhealthy or degenerate condition; but there can be no question that a like principle applied to particular individuals would be wholly fallacious. There are so many types of individual children and adults of both sexes that, until we know the healthy type standard to which any given person should conform, it is impossible for medical men to generalise on the relative healthiness or unhealthiness of small size, small weight, and shortness of stature. If we do not realise this danger there will be a real possibility of social disaster following medical efforts in this direction, as quite healthy differences will be confused with unhealthy.

As a small contribution to this difficult subject, I should like to draw attention to the phenomena of early and late growth.

It has long been known that some families mature quickly and others slowly; that children of the former group are big and tall for their age, while the latter are often small at first, but gain in height markedly from adolescence onward.

A chance observation on one man led me to note the co-incidence of three conditions of late growth: little hair on the face, pubes, etc., and exceptionally small testicles. On making inquiries into other cases, I also found this same association of poorly-developed sexual features and growth continuing four to seven or eight years after puberty.

To realise this it is necessary to distinguish between sex development and sex specialisation. There are many men who have fully developed beards, broad shoulders, and other masculine characters associated with large breasts, wide hips, and smoother feminine limbs. Such people are not deficiently sexualised, but they are unspecialised, and they probably revert to the old savage state of man, when man was more feminine and woman much more masculine. For such undifferentiated, mixed sex development the commonly accepted terms, femininism for the male and masculinism for the female are accurate and suitable. The kind of man or woman that I am referring to is, however, one who, in the strictest scientific sense, is unsexualised, and the term *asexualism* is, therefore, more suitable to apply to such a person's condition.

Such individuals are, especially in early adult life, thin and rather pinched-looking, having straight, inartistic figures, narrow shoulders, and hips and limbs that appear long by their lack of form, and the smallness of contrast between leg and thigh and forearm and arm. In men, particularly, I have noticed a prominent, sharp Adam's apple, its projection being, I think, due to deficiency in the size of the thyroid gland and to nearness of the wings of the thyroid cartilage to each other. Both men and women have thin voices, almost completely lacking in that richness and mellowness of tone that makes the human speech and song seem so pleasant to the ear; and it is curious that, though often not ill-natured, they are nearly always more or less disliked by individuals of the opposite sex, and, in my experience, seldom marry.

Some races are, it is well known, lacking in secondary sexual development, but the rate of growth does not appear to be known in them, nor has any comparison been made with other more evolved peoples. It would probably be a much easier task to determine whether castrated animals grow for a longer period than uncastrated. (*a*)

The question is one of peculiar interest at the present time, as recent studies of the comparative heights of underfed poorer and well-fed wealthier children, have assumed that the advantage that the latter possess is due solely to diet and general surroundings, when it may result from other causes.

The following brief summary of six cases of asexualism may therefore possibly be not without interest in this connection :—

(1) Man, over thirty years of age, with sloping, narrow shoulders, feebly developed lower jaw, little hair on face, very prominent Adam's apple, thin, hard voice, narrow hips and straight limbs. Of a mentally eccentric character, inclined to practice silly jokes on his friends; was very small till nearly fifteen years of age, and then grew rapidly and steadily till twenty. He comes of a family, all of whom reach adult height late, and all less strongly sexed than average people. One sister is not masculine, but almost devoid of sex characteristics. Food and surroundings have always been exceptionally good. Nothing remarkable in parents, except that one is much more capable of culture than the other. Disliked by women and "made fun of" by men.

(2) Man, over thirty, head very small, lower jaw feebly developed, hair on face average, prominent Adam's apple, rough voice, shapeless, thin figure, narrow shoulders and hips. Large, thin Roman nose, downy hair on body. Mentally much above average. Testicles rather small. Only sister and mother of same asexual type, and the man is disliked by women, and his sister by men. Growth rapid between fifteen and twenty years; very small before fifteen. Food and surroundings slightly deficient. House badly ventilated.

(3) Man, over thirty, one of large family, all healthy, all living, and all late in completing growth, has a feebly-developed lower jaw, facial hair average, rather prominent Adam's apple, narrow shoulders and hips, and thin, straight legs. "All the family thin." Food and surroundings very good. Not unpopular with men or women, deficient in ideas.

(4) A whole family—father, mother, two adult daughters, and one brother—all belong definitely to this type; all have thin, pinched Roman noses, very unpleasant thin, metallic voices, and straight figures. All are feeble mentally, and are actively disliked and ridiculed by both sexes. The brother and mother have marked Adam's apples, and the daughters ones that are easily observable. Food and surroundings average.

(5) Man, under thirty, little development of facial hair, feeble jaw, pointed Adam's apple, voice lacking richness, brother (at one time typical "hooligan type") and himself growing noticeably after fifteen years. Testicles extremely small. Father like son in asexual characters. Food and surroundings poor.

(6) Man, under thirty, of degenerate, but rather talented family, sexual organs infantile, voice incompletely broken, with little signs of hair on face and does not require to shave, treated as a child by most men and women, grew very rapidly after fifteen. Food and surroundings good.

All of the six men are unmarried, and only the third case has the least prospect of marriage. *All* of their sisters are, with the exception of the last case, unmarried, and in all six cases there is evidence that the unsexed condition is present in the other members of the family. Curiously, only one case is under 5ft. 10in., and no woman under 5ft. 6in., and two of them are nearly 6 feet in height; though another instance, which I am not sufficiently certain of in reference to age when growth was most marked to include among the others, is short.

I think the growth of young recruits, of "defective development," after joining the Army, could often be traced to this cause of late evolution, and the fact that the young under-sized hooligan type of lad is so seldom traceable in the adult form, is also, I believe, largely attributable to this reproductive retardation.

As confirmatory facts on this point, I may say that I have so far always found on inquiry that this narrow shouldered and hipped type is fast growing, though it has not been necessary for the other reasons which the patient consulted me about to make the requisite physical examination to prove or disprove my first impression. Thus, while only six cases have been studied, a much larger number have been observed.

That wide shoulders are associated with masculine tendencies, and narrow with non-masculine, the difference between the bull and the bullock; the stallion and the horse demonstrate, and that wide hips are feminine characteristics which increase in width and capacity at puberty, is, of course, a well-known fact.

If thickness and squareness of shoulders are evidence of masculine development, and width of hips and fulness of thighs are evidence of feminine strength, then it must be conceded that these slim types are to some extent asexual, but whether healthy or unhealthy is at present uncertain.

Laycock ("Nervous Diseases of Women," p. 28) alludes to a case of nymphomania reported by Alibert, in which the lower part of the body was extraordinarily plump and well-developed, as contrasted with the upper; and I have seen one similar instance myself in a young girl about eighteen years of age whom I treated for an hysterical malingering condition, and this patient was strongly attracted to the life of a prostitute. It is, of course, very difficult to prove that men whose figures are fully developed in the chest regions and taper downwards are more passionate than others, but my impression is that such is the fact.

Professors Geddes and Thompson, in their work on the "Evolution of Sex," refer to experiments of Selheim, which seem to show "that in mammals of both sexes the removal of the reproductive organs markedly prolongs the period of bone development, and has thus an effect on the shape of various parts."

The cases considered in Gould and Pyle's "Anomalies and Curiosities of Medicine," on "Precocious Development," seem, on the other hand, to largely support this position from an opposite point of view, namely, that early and very rapid growth is frequently, if not always, associated with early reproductive development.

Some definite information on the subject is much needed, not only because we do not know if the late-growing type is, or is not an unhealthy one, but also on acount of the fact that it appears small and stunted at school, when afterwards it often passes the average, and thus it vitiates school statistics in which height considerations have been included.

(*a*) See Selheim's experiments, alluded to further on. The Veddas of Ceylon seem to have many asexual characteristics, and their diet appears to be an insufficient one; many other races are deficient in sexual hair. (beard, etc.). Novelists have described this type—see Mr. Collins in "Pride and Prejudice,"—but I cannot state when it was first noticed in literature.

Further, if the asexual form is unhealthy, it may be that our education system is fostering it, or some other element in our social life may be favourable, and its presence should throw light on many obscure phenomena of sterility, and also on the increasing difficulty experienced by many women in regard to lactation.

I should be much interested to know if other medical men have noticed similar facts.

I have not referred to the influence of the thyroid, possibly the pancreas and pituitary glands in affecing the amount of bodily growth, though these are interesting questions, but have simply contented myself with pointing out that height—and the same is probably true of weight—is not simply a question of food and good hygienic surroundings. Thus, in the very interesting report of Dr. Leslie Mackenzie and Captain Foster (Glasgow School Board), it is shown that the "one-roomed child, whether boy or girl, is on the average distinctly smaller and lighter than the two-roomed; and the two-roomed than the three-roomed; and the three-roomed than the four-roomed." Without disputing the fact, which is borne out by the inquiries of the Inter-Departmental Committee on Physical Deterioration, I yet wish to draw attention to other factors which an individual study of different persons reveals. What may be true of a class is not necessarily true of single members of that class, and yet it is the unconscious forgetfulness of this that is the special danger in health problems for medical men, at the present time, to avoid.

SOME PRACTICAL POINTS IN THE TREATMENT OF GONORRHŒA.

By H. DE MERIC, M.R.C.S.,
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THE treatment of gonorrhœa, it must be confessed, has not advanced very materially during the past century. The gonococcus, it is true, has been discovered during this period, but no very definite means have been found to destroy it, and, by destroying it, to stop the inflammation and its consequences. There are, indeed, those who assert that it is still questionable as to whether the discharge is caused by the presence of the gonococci, or whether the discharge comes first and the gonococci afterwards. With regard to the first hypothesis, we must remember that in an old urethritis which has lasted for months and months we can still find gonococci; for the second hypothesis we must bear in mind the mild urethritis which is the outcome of connection with a woman suffering from leucorrhœa, or even with a woman either immediately before or immediately after her menses, to this being added an excessive consumption of alcohol. In this urethritis there are no gonococci; yet, if the discharge be neglected and at the same time the patient continues to absorb large doses of alcohol, it will take on all the characteristics of true gonorrhœa, and gonococci will make their appearance. It might be suspected in such a case that the woman was infected and gave the malady to the man; but I have often known cases (and they must constantly occur in the practice of other surgeons who see much of venereal disease) in which, of two men who have had connection with the same woman, one is not infected by her (and this is the individual who is accustomed to her), while the other, who has only been with her for the first time, and under circumstances of leucorrhœa, alcohol, etc., mentioned above, gets a non-specific urethritis which, if neglected, becomes a true gonorrhœa.

Since the discovery of the gonococcus by Neisser, very little real improvement has taken place in the treatment of the condition. We have still the same routine, which may be conveniently divided into—(1) the internal, and (2) the external treatment. With reference to the former, we still have the same procession of balsams, at the head of which copaiba still proudly marches, although oil of sandalwood disputes its right to command, a claim which, in recent years, seems to have been largely admitted, probably owing to the particularly obnoxious taste of copaiba. The best way to administer copaiba is in the form of the French opiat, which is a combination of oil of copaiba and cubebs rubbed up in a mortar so as to form a paste, which has such a disgusting taste and smell that it can only be administered in "Hosties." Sandalwood oil has also a disagreeable taste, though less nauseous than that of copaiba. It is best given in capsules. For the last thirty years in cases of gonorrhœa, when it has been necessary to order internal remedies such as those where the advent of epididymitis has precluded the prescribing of local external treatment, I have administered the above drugs with varying success, but I have always had a feeling that I was groping in the dark, and that I could never give a definite opinion as to the curative action of these remedies, which appeared to me to exert their modifying power over the disease more with reference to the idiosyncrasy of the individual patient than to the general characteristics of the disease. I have endeavoured in many series of cases to discover what was the peculiar idiosyncrasy of the individual which caused success on some occasions and failure in others, but I must confess that up to the present time I have been baffled. This much, however, I have observed—viz., that the inability of the drug to produce curative effects has not been more marked in those patients in whom the stomach and kidney troubles have been produced by the remedy—quite the contrary; for I have very often seen excellent results with regard to the gonorrhœa both by copaiba and sandalwood oil in cases in which I have had most reluctantly to stop the administration of either drug on account of intense nausea with eructations, combined with increasing kidney trouble; sometimes, too, the latter without the former. On the other hand, I have frequently seen patients take either copaiba or sandalwood oil for long periods with perfect impunity as regards the stomach and kidneys, but without producing any appreciable effect on the discharge. My mind has, therefore, always been open to the trial of any remedy which would offer a really curative effect without having to be stopped on account of extraneous complications.

My attention has lately been drawn to a preparation called gonosan, which I have tried at the French Hospital on a certain number of cases. Gonosan is the name given to a combination of one part of the resin of Kava-Kava with four parts of the best West Indian essence of santalum album. Now, Kava-Kava, the resin of Piper methysticum, is described by the best authorities as a diuretic and a motor depressant, resembling coca in its action when taken in small and moderate doses, and producing intoxication when taken in large doses. With regard to santalum album, it has been proved that its essence, and more especially the essence of West Indian santalum, loses to a large extent its noxious properties for the stomach and kidneys in proportion to its degree of chemical purity. The combination of these two substances seemed to me a very happy one, as I judged that the properties of the Kava-Kava would hold in check any noxious qualities of the santalum—if any remained in the carefully prepared West Indian product—and at the same time would aid the latter in its curative effects. I see that Boss, of Strasbourg, who first brought this remedy into prominence, has great confidence in the calming, almost anæsthetic action of the Kava-Kava, which he considers causes a paralysis of sensibility in the nerve terminals of the urethral mucosa. In addition, it possesses vaso-constrictor properties local to the urethra which must cause a certain amount of anæmia of the mucous membrane, diminishing thereby the irritation and preventing an extension of the inflammation. The German physicians go so far as to explain the diminution of the gonococci caused by gonosan by the hypothesis that the drug alters the culture medium; they also ascribe anaphrodisiac properties to the drug, and these undoubtedly must be of paramount importance in cases of chordee.

In view of the great advantages claimed for gonosan by many eminent medical men in Germany, a few of which advantages I have briefly alluded to above, I resolved to give the preparation a trial, although for many years I have as much as possible ceased giving the so-called curative internal agents for gonorrhœa, relying entirely on injections, lavages, etc. But those of my in-patients at the hospital suffering from gonorrhœa have, of course, some complication such as epididymitis, and this complication precludes the ordering of an injection for the time being. I had, therefore, every incentive to try a new remedy, more especially one coming to us with such excellent credentials. My opportunities for forming a very definite opinion in the short time I have ordered gonosan have necessarily been somewhat limited, but I must say that in the few cases I have had under my observation two of the advantages claimed for the drug have been amply realised, and these are undoubtedly the most important—namely, the curing of the discharge and the absence of any stomach or kidney symptoms.

CASES.

A. G., æt. 18. Admitted to the French Hospital with very painful epididymitis. This proved to be very rebellious to treatment. The epididymitis got slightly better, but the whole testicle became inflamed and enlarged, so much so that on the presumption that the testicular affection might be tuberculous, Calmette's ophthalmo-reaction was tried, but with a negative result. When the orchitis got better, a discharge appeared in the urethra. There was a history of gonorrhœa three months previous to admission. Gonosan was administered, and the remedy entirely stopped the discharge in a week. In this case, however, the gonosan produced slight gastric symptoms, but it was found that this was owing to the remedy having been administered at first on an empty stomach.

G. T., æt. 23. Admitted with epididymitis, and also a discharge from the urethra. Gonosan was ordered, which absolutely cured the urethral running in a fortnight, when the patient left the hospital, the epididymitis being also quite well.

E. D., æt. 36. Admitted with gonorrhœal rheumatism and a discharge from the urethra, for which last gonosan was ordered. The patient left the hospital twelve days after admission at his own request. The gonosan had cured the discharge, and the rheumatism had been much relieved by appropriate treatment.

H. M., æt. 26. Admitted for gonorrhœal rheumatism. Gonosan was administered for the discharge, and the man left the hospital cured in a fortnight.

E. P., æt. 25. Gonorrhœal rheumatism and gonorrhœa. This was a most successful case as far as gonosan was concerned, as in ten days the drug cured the discharge, which had been the thick and purulent discharge of gonorrhœa.

L. C., æt. 24. Balanitis, gonorrhœa, and epididymitis. Discharged cured in four weeks, gonosan having cured the gonorrhœa.

With reference to the external or local treatment of gonorrhœa and urethritis, I need not repeat the high esteem in which I hold urethral injections as administered by the patient himself, upon which I have dwelt in previous articles. Injections, when the patient has been taught the proper way to employ them (a highly important matter), must form the basis of all treatment for gonorrhœa when the case is one that offers no such complication as might for a time contraindicate their employment. But I would like to say a word on the success I have had in the revival of what is really an old treatment for the urethritis which persists for months in some patients, and which is a source of much mental worry to them. This urethritis, which is often, but not always, characterised by what is termed the "morning drop"—the French call it the "goutte militaire"—is generally the result of the patient leaving off treatment too soon, and resuming his ordinary absorption of alcohol, especially of beer. The discharge is liable to be very rebellious to treatment, especially as the patient only comes for our advice after it has lasted for weeks, frequently for months. The difficulty in curing this condition by ordinary means, such as urethral injections, arises from the fact that the inflammation which causes it is situated in the so-called posterior urethra, that is to say, the part of the tube posterior to the anterior layer of the triangular ligament and to the compressor urethræ muscle. Therefore the action of this muscle, which is brought into play when the anterior urethra is filled with injection, prevents the fluid from penetrating into the posterior urethra. This has been overcome by some surgeons, especially in America, by the irrigation treatment whereby the liquid is forced past the constriction caused by the muscle, and so brought into contact with the posterior urethra; this is effected by raising the vessel containing the fluid which flows through a tube connected with a nozzle, this last being inserted into the anterior urethra. I must say this method never appealed to me; in the first place I do not think such force should be applied to so delicate a tube as the urethra; in the second place, even putting aside my first objection, I consider that the fluid is forced in the wrong direction, thus carrying all the impurities of the urethra backwards towards the bladder. For some time, especially in my private practice, I have utilised a method which I have characterised as old, because I have heard of it from my earliest days, though I have only employed it extensively during the last few years: it consists in filling the *bladder* through a silver catheter with warm boracic solution, and letting the patient pass it through his urethra as forcibly as he can after the catheter has been withdrawn. There are one or two little points of technique about this simple operation. The catheter should have a double canal, as it is often useful to draw off the first liquid with which the bladder has been filled and replace it by some fresh lotion. The patient should empty his bladder of any contained urine before the catheter is introduced. I need hardly insist on the importance of aseptic measures. The part of the flexible tube just above its junction to the catheter should be nipped with catch forceps before the lotion is poured into the glass vessel at the other end of the tube; when the lotion has been poured in, it can only penetrate as far as the catch forceps; the india-rubber tube should then be gently massaged between the thumb and fingers from below (where the forceps nip it) upwards (to the glass vessel) so as to expel all the bubbles of air which otherwise would be forced onwards into the bladder with the lotion. The fluid is then allowed to flow into the bladder through the catheter by the removal of the catch forceps. Sometimes it is well to arrest the flow at short intervals; the lotion may feel too warm to the patient; he may be nervous, etc., besides it is always best to hold the forceps in readiness towards the end of the lavage, when the patient's own sensations as to the fulness of his bladder will be a guide to the surgeon. The bladder should be filled as far as possible to its greatest capacity, in order that the expulsive stream may be as powerful as possible. This lavage has in most cases to be repeated two or three times at intervals of three or four days. The cure, I find, is generally effected after two or three *séances*, but in some patients it may be necessary to perform the slight operation five or six times. It causes no pain whatever if the surgeon be careful and gentle in the passage of the catheter, taking the patient's attention off by talking to him if there is the least spasm. It is well to reassure the patient on this point, as many men are very much alarmed at the idea of having an instrument passed. Needless to say that during the whole period of treatment the patient must carry out a strict hygiene and refrain from all alcoholic beverages. He should wear a suspensory bandage, take an occasional saline purge if necessary, and keep as quiet as possible. I may say that out of the last 12 cases of long continued and obstinate urethritis which I have treated by lavage, in only one instance have I had to complete the cure by two instillations of nitrate of silver, and in this patient the morning drop had already been present for two years when he came under my care.

My experiences with gonosan have been so favourable that in a case where I should formerly have proceeded to instillation, I would now always try gonosan first, and I should be surprised if its exhibition, together with strict hygienic, dietetic, and other precautions, did not render the instillation unnecessary.

CLINICAL RECORDS

LABOUR SHOCK.

BY R. J. KINKEAD, M.D.DUB.,

Professor of Obstetrics, Queen's College, Galway; Physician and Gynæcologist to the Galway Hospital; Fellow of the Royal Academy of Medicine in Ireland, &c., &c.

IN the report of the Rotunda Hospital for the year ending 31st October, 1906, three cases of "Labour Shock" are given.

The case I now report is similar; the hæmorrhage following delivery was not profuse, nor greater than that generally observed in normal cases.

On August 1st, 1907, a little before 12 o'clock noon, I was called to see Mrs. X., —a 2nd para. She was in charge of an experienced nurse.

Her first child had been born dead after a protracted parturition, and as she had been many hours in labour the nurse feared that the same thing might again occur, and sent for medical assistance. I had not attended her in her former confinement, nor indeed ever seen her before. She seemed in good condition, no signs of exhaustion: the head was engaged in the brim, vertex, L A O presentation, the os was dilated, but the anterior lip not quite retracted.

The pelvis was roomy, and although there was a little trouble in getting on the forceps owing to a somewhat prominent sacral promontory, there was no difficulty in extracting a large male child.

Immediately after the birth of the child I administered a drachm of Long's liquor ergotæ.

I kept my hand on the uterus and expressed the placenta twenty minutes after delivery of child.

The uterus was a bit sluggish in contracting, but was never distended, my fingers slipped easily down below the promontory, and the palm of the hand and thumb perfectly controlled the uterus.

After the nurse had washed her I proceeded to insert two sutures for a slight laceration of the perineum, the nurse taking my place in following down the contraction.

Up to this time the patient had been looking and feeling well, talking, and in good spirits As I put in the first suture a woman standing beside her exclaimed, ' She is looking bad: what's the matter with her?"

She had become suddenly collapsed; whisky was administered; strychnine and ether injected hypodermically, and normal saline into the areolar tissue, hot bottles applied, and everything possible was done, but in vain; she died in less than an hour.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

CARCINOMA OF THE BREAST.—MR. EDRED CORNER operated on a woman, æt. 52, who had had a lump in the upper and outer part of her breast for about a year. The lump had given her no pain or inconvenience until three months ago, when she noticed a tightness of the anterior axillary fold whenever she raised her arm. On examination, with the flat of the hand, one felt a mass in the breast towards the axilla; the mass had indefinite margins, and was not attached to the great pectoral muscle, as it could be moved easily in the direction of the muscular fibres when they were put on the stretch by abducting the arm; further than that, it was not attached to the skin; hence, Mr. Corner pointed out, the tumour presented practically no classical signs as they are given in text-books of a scirrhus of the breast; but growths, when they commence in the upper and outer quadrant of the gland, often possess, he said, very peculiar features. A carcinoma extends to a very large extent by the way of the lymphatic vessels. In other parts of the breast the lymphatics of the deep portions of the glands communicate freely with those of the pectoral muscle and of the skin; hence a neoplasm in these situations speedily becomes adherent to the muscle and to the skin which dimples over it; but in the upper and outer quadrant of the breast the lymphatics of the gland communicate with the lymphatic vessels which run straight to the axillary glands; hence a carcinoma in this situation more quickly involves the axillary lymphatic vessels and glands than it does the overlying skin or the deeper lying pectoral muscle. The result of this peculiarity of the lymphatic vessels is that a growth in this situation presents no retraction of the nipple, no dimpling of the skin over it, or any of the classical signs of carcinoma of the breast as usually described except the presence of a hard tumour. In the case of this patient the hardness of a tumour of the breast was obscured by the presence of a large quantity of fat. In the light of the difficulties of ascertaining the exact nature of tumours in the upper and outer quadrant of the breast, a tentative diagnosis of carcinoma had been made. The first step of the operation, Mr. Corner said, must be to ascertain the exact nature of the tumour by the means of an exploratory incision. In making such an incision it was necessary that it should be made of sufficient length to allow the margins of the wound to be everted, so as to show fully the characters of the cut surface of the tumour. In the present case it could be seen that the section showed all the naked eye appearances of a scirrhus—the white appearance, the dense branching arrangement of the fibrous tissue, and the concave surface, etc. The tentative diagnosis of carcinoma of the breast had been confirmed, and now it was necessary to undertake the full extensive operation for its relief.

The incisions Mr. Corner then made extended from the arm above the axilla to below the breast on the chest wall; the edges of the skin along these large incisions were well undercut because the object of modern surgery for the relief of carcinoma of the breast was, he considered, to remove a large area of the fat and fascia, and not so much of the skin as was formerly taught. This was done, and at the same time the sternal half of the pectoralis major was removed and the latissimus dorsi at the back of the wound and the axillary vessels, with the brachial plexus at the top of the axilla, were exposed. The wound was then closed and dressed in the usual way, the dressings being retained in position by a many-tailed bandage, which, he thought, added much to the comfort of the patient and to the convenience of the surgeon if any dressings are subsequently required. No drainage was employed, because he has found that if great care is given to hæmostasis, patients do better if the wound is not drained. Sometimes, in order to remove completely all fat, fascia, and lymphatic glands from the posterior part of the axilla, it was advisable to make a further incision extending from the original one downwards and backwards, so as to turn down an axillary flap of skin; this incision was extremely useful in such cases where it was advisable that the wound should be drained, and this can be done by inserting a small tube in the posterior part of the incision, or by merely inserting the stitches which close it further apart. Mr. Corner said that from a clinical point of view the case he had just operated upon was most instructive. It taught us, in the first place, that malignant disease in its earlier stage was unaccompanied by pain; secondly, it had demonstrated to us yet again that all tumours in the outer and upper quadrant of the breast must be regarded as of most serious import until they have been proved to be otherwise. They may be malignant, although they may present none of the usually accepted signs except the presence of a lump; thirdly, the lymphatic glands early become invaded, which must render the prognosis in these cases more serious than when the growth is in another part of the breast. Thus he would particularly direct attention, and impress upon students the serious significance of all lumps in this part of the breast, and the extreme desirability of their removal with as little delay as possible.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of State Medicine.

Meeting held Friday, February 14th, 1908.

The President, Dr. W. R. Dawson, in the Chair.

ALCOHOL AND MENTAL DISEASE.

The President, after thanking the Fellows for electing him, said that his paper was intended merely as a contribution to a general discussion on alcohol. Apart from personal predilections, the uncertainty existing with reference to the effects of that drug was largely due to deficient appreciation of the influence of individual diathesis and of the varying effects of different doses. On reviewing the evidence, it appears that with normal individuals, under appropriate circumstances, small doses properly diluted and taken with food not too frequently are physiologically beneficial. With larger doses the matter is otherwise. Alcohol was either taken in moderate doses frequently or in large doses occasionally. A drunken bout is not only a microcosm of insanity, but indicates the probable course of chronic alcoholism in the same individual. Different persons show different symptoms. When alcohol is taken more continuously, though in small doses, the same order of degradation is observed —the "high-level" moral and other late-acquired qualities being first affected, then the motor and sensory functions, and, lastly, those of mere nutrition. Such a person is mentally abnormal, and, given a faulty diathesis, is certain to become technically insane, but there is no hard and fast line between the two conditions. Even of the technically insane all do not enter asylums, and, therefore, a complete estimate of the relation of mental disease to alcohol is impossible. Of asylum cases the prevailing opinion seems to be that about 15 to 20 per cent. are due to alcohol, but the influence of the personal equation, the difficulty of ascertaining the facts of each case, the confusion of cause with effect, as well as other circumstances, render it almost certain that this estimate is too high. The regional distribution of insanity does not correspond with that of either alcoholism or drunkenness, and it seems probable that not more than 10 per cent. of the asylum cases are genuinely attributable to alcohol. These, however, probably constitute the smaller part of the cases due to this cause, especially if those in which it was merely contributory be counted. These latter must be numerous, owing to the susceptibility to alcohol of persons with any hereditary or acquired brain weakness. In parenthesis it may be noted that, though there is the strongest evidence of the evil effects of parental alcoholism upon the offspring, the question has really nothing to do with the transmissibility or otherwise of acquired characters, the phenomena being sufficiently explained by the deleterious action of the drug upon the germs of the future individual. Chronic alcoholism produces worse effects than occasional drunkenness, and bad spirits worse effects than pure ethyl-alcohol. As regards the forms of insanity due to alcohol, certain symptoms are suggestive of this cause —viz., impulsiveness, suspiciousness, confusion with hallucinations, loss of memory for recent events, and fabrication of imaginary occurrences. The most purely alcoholic forms are delirium tremens, Korssakoff's psychosis, hallucinatory-confusional insanity, and alcoholic dementia. In neuropathy we have mania *a potu* and chronic alcoholic insanity, including alcoholic mania, melancholia, and paranoia, and the more severe forms of alcoholic dementia. Lastly, we have dipsomania. Pathologically the changes in the more chronic forms are found round the fissure of Rolando affecting chiefly the large pyramids. If alcohol be cut off, the mental improvement is usually rapid, but of the habit itself compulsory prolonged total abstinence is the only cure, though some of the drug and other treatments may assist. The writer hoped that the paper would be discussed.

The MacDermot said he had, during the past seven years as Inspector of Prisons, visited one of the Irish prisons almost every week, and had tried to make himself familiar, as far as possible, with the penal and family records of the prisoners. He had, in addition, superintended the work of the State Inebriate Reformatory at Ennis during the past four or five years. It was from that field of observation—outside the general observations that one makes in the world—that he would speak. Those observations he had tried to reduce to order by bearing in mind two distinct theories on the question of alcoholism. The first was the neo-Darwinian theory, that a great number of the human species had an original taste for alcohol, a taste which, being natural, was not acquired. According to that theory, acquired habits were not transmissible, and since the taste for alcohol was original, the only possible cure which he could see, in accordance with that theory, was the elimination of the drinker, and the only feasible way of accomplishing that end was to expedite the catastrophe by multiplying the number of public-houses. With that theory he disagreed *in toto*. The facts of his experience did not fit in with it in any particular. The other theory had been called the theory of Lamarck—that a taste for alcohol was an acquired habit, and that acquired tastes were transmissible. The adoption of the latter theory would give great confidence and lead to greater interest in all temperance movements. History supplied them with instances of inebriate races which had become temperate, and which were an example of the transmissibility of temperance. His own observations of prisoners had shown him that the examples of the criminal type came mostly from the cities, and that their parents were of inebriate habit; while the prisoners who came from the country were not of the asymmetrical type, and were not the heirs of those transmissible qualities, including intemperance. The public had changed their point of view as regards alcohol; they no longer looked at it from the point of view of the pulpit, or the philanthropist, but from the point of view, so to speak, of the College of Physicians. They all wished for health, strength, and longevity, and when the medical profession taught sound views on the use and action of alcohol, he was satisfied that it would not be the elimination of the drinker which they would see, but the elimination of drink.

Dr. Walter Smith said their chief knowledge of the scientific effects of alcohol was a quite recent growth, and he thought the turning point was reached by Schmiedeberg, who, with unanswerable arguments, demolished the view still held by many, that alcohol belonged to the class of stimulants. Alcohol was an essential member of the narcotic group of substances. That had been a great gain, and had put the medical profession on a better basis. Most medical men were much more cautious now than in his student days about the administration of alcohol, especially in acute disease. They had learned that most diseases got on better without alcohol, and they had learned that its careless use by their profession in the past had hurried many persons to premature graves. At the same time they had to guard against exaggerations and inexact statements appearing in recent writings on the subject, such as that alcohol is one of the most frequent causes of consumption. It was Utopian to expect that legislation would make them a nation of teetotallers. It was a physiological fact of Nature that people would have luxuries. One of the most important questions at the root of the matter was that of the nutritive value of alcohol. Physiologists told them that its possible value as a food was more than discounted by its harmfulness; and it was said that moderate drinking had a most injurious influence on health and life, and that all alcoholic drinks should be avoided. If that was so, he would like to know how it was that the most progressive European nations were moderate drinkers. He believed the truth of the matter was that in limited quantities of alcohol 90 per cent. of it was oxidised in the body and furnished energy. It had been shown by experiment in America that alcohol could replace equivalent quantities of carbohydrates and fats, especially when the supply of these was deficient in their diet. To a person in health, on a sufficient diet, alcohol was absolutely unnecessary, and possibly injurious to some people; but it was idle to deny its possible value as a food in some cases. No one drank pure alcohol, and its effects were infinitely modified by the other substances which were combined with it. It was absurd for a Royal Commission to try to answer the insoluble question—What is whisky? They might as well ask—What is mud? The points which related to the public in regard to alcohol were: (1) Its effects in producing visceral disease, (2) its leading to all sorts of crime, and (3) its influence on the nervous tissue. The latter was a very complicated question, but there could be no doubt as to the deleterious effects of long-continued doses of alcohol on the brain. It was admitted by most physicians that the continued use of alcohol tended to cause glycosuria, which led to various mental symptoms. As regards treatment of alcoholics, he did not at all side with those who maintained that it was dangerous to withdraw alcohol suddenly, and he refused to undertake medical treatment unless he could at once put patients under conditions of abstinence.

Dr. **DONNELLY** said the way to effect permanent good was to reach the coming generation by educating the parents of the present, especially the mothers. A great responsibility rested with the medical profession. In the past it had sometimes used its power, in regard to alcohol, to the detriment of the community, but a great deal of good was being done through the agency of the profession in putting before the people the physiological action of alcohol and the deleterious effects of over-indulgence. It was exceedingly unwise of physicians to permit alcohol as a beverage without marked restrictions as to its discontinuance after a time. It should not be prescribed in any respect except as a drug, and in his opinion should never be given to mothers who were suckling their infants.

Dr. **DELAHOYDE** who confessed himself to have been a life-long total abstainer who had never tasted any liquor that was brewed or distilled, said he did not think that statistics fully represented the amount of insanity which was directly traceable to alcohol. He had known many cases of insanity which had never gone to an asylum or hospital, and which would not be included in the returns on which they based their deductions. He himself, on occasions, prescribed alcohol, but always under strict conditions.

Dr. **FALKINER** agreed with Dr. Delahoyde that the mortality from alcohol was not really stated in the statistics. They had very often to look to the mortality of certain diseases of the nerves and viscera, and of pneumonia, to get a reliable idea of the number of deaths that were directly due to alcohol. In regard to insanity also, statistics were very misleading; he doubted if, in many cases, insanity was the cause of mortality at all. A great number of lunatics died of tuberculous diseases and dysentery. The term "alcoholic poisoning" was a loose one, and he had taken the trouble to get particulars which would enable him to judge whether persons so certified had actually died of acute alcoholic poisoning.

Dr. **STRITCH** said that one of the greatest evils of alcoholism was the indiscretions to which it might lead an individual, and there was little hope for the cure of the chronic drunkard unless they could get his active co-operation.

Dr. **BEWLEY** said that the causation of insanity was complex. Alcohol affected the mind injuriously, but of itself it did not cause insanity unless there was something else present—something which he might call a congenital predisposition to insanity. It was quite impossible to ascertain all the factors or to place much reliance on arguments based on statistics which referred to such complicated matters as alcohol and insanity.

Dr. **WINTER** said that, in his experience, the people who felt most benefit from alcohol were those of a nervous type. If the medical profession was more sparing in recommending alcohol to such people it would do a certain amount of good in battling against the evil done by the drug.

The **PRESIDENT** replied.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD FEBRUARY 27TH, 1908.

The President, Mr. **THOMAS BICKERTON**, in the Chair.

CASES.

Mr. **NIMMO WALKER** showed a case of

TUBERCULOSIS OF THE CONJUNCTIVA

in a boy, æt. 9. The outer two-thirds of the conjunctiva of the lower lid of the right eye was occupied by a raised flat-topped growth, with bright red nodular surface, which did not extend to the palpebral margin; the eye itself was unaffected. The diagnosis was confirmed by the presence of lupus on other parts of the body, from which it was probable that the eyelid had been inoculated. Mr. Walker pointed to the difference between this true tubercular lesion and the common phlyctenular ulcer, which was often called strumous or scrofulous conjunctivitis, but which, in his opinion, was not due to the tubercle bacillus, but was akin to eczema. He proposed to excise the growth, and to graft mucous membrane from the lips to prevent symblepharon and consequent trichiasis.

The **PRESIDENT** remarked upon the rarity of the condition.

Dr. **STOPFORD TAYLOR** suggested treating the condition by means of zinc "ions" from a solution of sulphate of zinc.

Dr. F. H. **BARENDT** suggested that the zinc "ions" should be used for treatment by inserting a zinc needle as the positive terminal into the conjunctiva, and by this method a better result would be obtained.

Dr. J. H. **ABRAM** and Mr. F. T. **PAUL** showed and related a case of

COLLOID CANCER OF THE STOMACH

in a boy, æt. 13½. The patient was admitted into Dr. Abram's ward for pain in the stomach. The history was given that vomiting had begun suddenly three months previously, and had continued, accompanied by loss of appetite and constipation. Nutrition was very poor. The outstanding feature of the case was the great dilation of the stomach, with visible peristalsis. A hard mass was felt lying transversely midway between the xiphisternum and the umbilicus. With diet, etc., vomiting was kept in check, but the boy steadily lost weight, and Mr. Paul was asked to see him. Mr. Paul opened the abdomen and found a large tumour occupying the pyloric region and spreading along the lesser curvature to the cardiac end. The tumour had been regarded as either tubercular or other inflammatory infiltration, causing obstruction, but it had all the appearances of a large carcinoma. Anterior gastrostomy was performed, and the boy made a good recovery, with great relief to his symptoms, but the relief can only be looked upon as temporary. During the course of the operation an infiltrated gland was removed, and the microscopical examination of it revealed the true nature of the tumour as being colloid cancer—a condition of excessive rarity at this age.

Dr. E. E. **GLYNN** said that he had examined some 580 specimens of cancer from the wards and post-mortem room of the Royal Infirmary since January, 1900, all of which, except about 80 of the post-mortem cases, had been verified microscopically. The total number of cancer cases in persons of 30 years and under was 22. Of these, 7 were 25 years and under, while 3 were 20 years and under, including Mr. Paul's case. All these were confirmed microscopically except

3, which were obviously cancer from the post-mortem appearances. The distribution was as follows:—Cancer of the breast, 6; of the stomach, 5; ages, 23, 27, 28, 28, and 13; four being the so-called variety; cancer of the rectum and sigmoid, 4, 2 being colloid, jejunum 1, cervix uteri 1, epithelioma of the scalp 1, testicle 1, penis 1.

The case was also discussed by Mr. Keith Monsarrat and Dr. P. Marsh.

BIER'S METHOD IN DERMATOLOGY.

Dr. **Stopford Taylor** and Dr. **R. W. Mackenna** showed several forms of Bier's vacuum apparatus which they had used in the practice of dermatology. Dr. Stopford Taylor said they had used the apparatus extensively during the last few months with much advantage in cases of lupus, acne, furunculosis, various forms of œdematous eczema, and leg ulcers. They had found a negative pressure of 2½ lbs. per square inch, sufficient to produce a copious discharge of serum from callous ulcers, which is followed by the rapid formation of healthy granulations. Œdematous eczemas drained in the same way rapidly heal up, and the vacuum process applied in cases of lupus, while of great value in itself, is of special efficacy when used in conjunction with the Finsen lamp. The method flushes the tissue from within, and, by bringing serum laden with opsonins to the seat of the disease, aids phagocytosis.

The method was discussed by the President, Sir James Barr, and Dr. Given, and Dr. Taylor replied.

CHOLECYSTITIS.

Mr. **Keith W. Monsarrat** read a paper on cholecystitis. He expressed the view that cholecystitis should be studied, not as an incident in so-called gall-stone disease, but as a well-defined inflammatory visceral lesion, in which infection from the intestinal canal was primarily throughout the causative agent. The formation of gall-stones was one of the results of the infection; once formed, they exerted an important influence on the gall-bladder infection, just as an appendix concretion might be responsible for a marked modification of the result of an appendicitis. Clinically there were two phases of cholecystitis which presented themselves for study, the acute attack and the interval between the attacks. Illustrations were given of the phlegmonous type of attack, of the suppurative and the catarrhal. The two first could be differentiated from the last by the attention to the clinical signs, the importance of this differentiation being that they required operation during the attack, while the last did not. The symptoms during the interval between the recurrent attacks depended upon the lesion left, and varied from a condition of practical health to one of chronic invalidism. Illustrations were given, particularly of cases presenting gastric symptoms. The differential diagnosis of the acute attack and the chronic invalid condition was considered, and the indications for operation discussed.

Mr. **F. T. Paul** thought that Mr. Monsarrat's analogy between cholecystitis and appendicitis was quite reasonable, the essential difference being that one structure was in the direct line of infection, whilst the other was a good deal removed from it. He deprecated cholecystectomy except when absolutely necessary, which was very rarely the case, and he quoted various cases illustrating the varieties of cholecystitis and the occasional difficulties experienced in diagnosis.

Mr. **Douglas Crawford** said that, although the signs of acute cholecystitis occasionally led to a mistaken diagnosis of some other acute disease, as appendicitis, yet the symptoms were so severe that an operation was undertaken. It was different, however, with the more chronic forms of infection of the biliary passages. In these cases gall-stones were almost invariably formed in the gall-bladder, and might give rise to dyspeptic troubles. Such cases require very careful examination, for at any time grave complications might arise, such as perforation of the gall-bladder, or a severe acute infection may be added, with serious, if not fatal, results. He quoted cases illustrating his remarks.

Dr. **Abram** said he was afraid the diagnosis of cholecystitis was not so simple as the paper would suggest. He quoted a case where just such symptoms led to operation, yet the gall-bladder was found perfectly healthy. He agreed as to the *rôle* of infection in the causation of cholecystitis and gall-stones. He had met with one case of cholecystitis due to typhoid infection; the patient made a good recovery without operation. He had seen a case of gall-stones in which operation was necessary. A woman, æt. 35, had typhoid fever at the age of 24; attacks of pain began five years later, jaundice after another year, and it recurred several times. A bacteriological examination of the gall-bladder contents by Dr. E. E. Glynn demonstrated the presence of bacillus typhosus.

The paper was also discussed by the President, Sir James Barr, Drs. Davies and C. Williams, and Mr. W. T. Thomas and Mr. Monsarrat replied.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Pathological Evening.

Meeting held February 7th, 1908.

The President, **Richard Lake**, Esq., F.R.C.S., in the Chair.

The folowing specimens, etc., amongst others, were shown:—

Mr. **Cecil H. Leaf**.—(1) Two specimens of fibroid of the uterus removed by supra-vaginal hysterectomy. (2) Multiple cystic tumour of thyroid removed by operation. (3) Carcinoma of rectum, removed by Kraske's method.

Mr. **McAdam Eccles**.—Specimens illustrating some of the less common diseases of the testis.

Mr. **Pardoe**.—Two specimens of malignant hypernephroma, and microscopical slides.

Dr. **Arthur**.—X-ray diographs.

Mr. **Donald Armour**.—Goître (exophthalmic).

Dr. **A. E. Russell**.—Congenital narrowing of the subclavian artery, simulating aneurysm, associated with angina pectoris.

Mr. **Swinford Edwards**.—Enlarged prostates.

Dr. **Low**.—Pathological specimens:—Tumour of liver; spine showing erosion by aneurysm; intestine showing dysenteric ulceration; pachymengitis hæmorrhagica; aneurysm of transverse arch bursting into œsophagus.

Dr. **Macnaughton-Jones**.—(1) Two specimens illustrating the difference between ovarian and tubo-ovarian blood cysts. (2) A series illustrative of malignant disease of the ovaries. (3) A series illustrative of sclerosis and cirrhosis of the ovaries. (4) Three specimens of primary tuberculosis of the Fallopian tube. (5) Four coloured plates of the female pelvis (showing all the organs). (6) A skiagraph of calculus of the kidney with the removed calculus. (7) A skiagraph of the ankle-joint showing ankylosis (after bullet wound).

Mr. **Aslett Baldwin**.—Horseshoe kidney. Knee-joint showing osteo-arthritis; section of anthrax of cheek due to fly-bite, and other microscopic specimens.

Dr. **Ernest H. Shaw**.—(1) Tuberculous tumours in the brain of a child. (2) Mixed tumour of submaxillary salivary gland. (3) Fibroids of uterus, one calcified. (4) Cystic hæmorrhagic carcinoma of the breast.

Mr. **Keetley**.—Malignant growth of the intestines.

Dr. **Dauber**.—Uterine fibroids.

Mr. **Firth**.—Sarcoma of the intestine.

Dr. **Phineas Abraham**.—Photographs of skin diseases.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday Evening, March 5th.

The Vice-President, Mr. **Andrew Fullerton**, in the Chair.

Colonel Dodd, R.A.M.C., read a paper on the treatment of venereal disease in military practice.

Mr. **A. B. Mitchell** read a paper on duodenal ulcer, which will shortly be published.

Mr. **R. J. Johnstone** showed (*a*) a uterus removed from a case of Cæsarian section; (*b*) a ruptured uterus.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 8th, 1908.

Treatment oe Fœtid Bronchitis.

The fœtidity of bronchitis is caused by microbian infection of the stagnant mucus in the dilated bronchial tubes, and the treatment should have in view the necessity of modifying the condition of the secrection by the aid of antiseptics and facilitating expectoration.

The first is attained by placing antiseptic agents in direct contact with the mucous membrane by means of inhalations, fumigations, or spray.

The antiseptics recommended by Rabé are: eucalyptus, turpentine, thymol, creasote.

Paul prefers combining one or two of these drugs:

Phenic acid, 1 dr.
Thymol, 15 gr.
Proof spirit, 4 dr.
Water, 1 quart.
To be inhaled.

Turpentine has been recommended by Skoda.

Turpentine, 2 oz.
Water, 1 quart.

Instead of inhalations, medicated vapour.

Leyden employs inhalations of oxygen and prescribes phenic acid internally, while Béclerc declares having obtained, in two cases, rapid cessation of the fœtid secretion by intra-tracheal injection of a mixture of oxygen water and menthol dissolved in olive oil.

Several agents as terpin, turpentine, guaiacol, creasote, have been prescribed internally, but the stomach shows intolerance when these substances are continued for some little time. Eucalyptus, tincture of benzoin or hyposulphite of soda are currently employed. Grinbert and Bucquoy are very much in favour of tincture of eucalyptus, 20 drops three times a day in an appropriate mixture or capsules of eucalyptol. Lancereaux prefers hyposulphite of soda at the rate of one drachm a day, which dose should not be exceeded for fear of exposing the patient to diarrhœa.

When the stomach becomes intolerant, the hypodermic method might be utilised.

Guaiacol, 2 dr.
Olive oil, 3 oz.
An injection morning and evening.

The second therapeutical indication, that of facilitating the expulsion of the mucosities is best realised by employing expectorants as ipecacuanha or antimony.

Tuberculous Adenitis of the Neck.

Tuberculous glands of the neck are exceedingly common, and when left to open of themselves or when opened by the bistoury, give rise to those unsightly and indelible scars which compromise the social status of the patient, and this is especially so in the case of girls. For this reason, Dr. Calot, of Berck-sur-Mer, protests strongly against the classical method of removing the gland or of opening and draining the abscess when formed. Neither does he advocate abstention, only for a time, so as to give a chance to general treatment: cod-liver oil, sea air, tonics, etc. If after four or six months no improvement is observed, he prescribes the following treatment which possesses the all important advantage of causing no tell-tale scar.

When the gland is very hard, he injects a modifying liquid to bring about retraction or, on the contrary, suppuration according to the quantity of the solution employed.

To obtain sclerosis and absorption he injects into the gland 4 or 5 drops of camphor and naphthol every three days.

Camphorated naphthol, 1 dr.
Glycerin, 1 oz.

The volume of the gland increases a little after the first injections, and at the end of three weeks or a month it begins to diminish, and disappears completely after four or six months. Seven or eight injections are given in all.

To obtain suppuration he injects from 20 to 40 drops of the same solution every day. In from four to six days the gland begins to soften, and in a few days more the abscess is fully formed.

When the abscess is completely ripe, he draws off the pus by means of a trocar and a small aspirator, and then injects through the same trocar from which the aspirator is detached from half a drachm to one drachm of—

Olive oil, 2 oz.
Creasote, ½ dr.
Iodoform, 1 dr.

The injections to the number of eight are made every four days.

When the abscess threatens to burst spontaneously, he limits the operation to aspiration of the pus only, and without a consecutive injection. In such case the trocar is passed first through the healthy skin, and the aspiration is repeated until the skin over the abscess has recovered its integrity, when the injections are commenced. After the eighth injection aspiration is renewed once or twice, and, the cavity being completely empty, the parts are compressed by a few layers of cotton wool and a bandage, so as to bring in contact the walls of the abscess.

Dr. Calot has treated in this manner hundreds of cases with invariable success, and leaving but the faintest trace of the little operation, to the great satisfaction of the patients and their families.

Sycosis of the Beard.

Calomel, 15 gr.
Oxide of zinc, 30 gr.
Lanoline, 1 dr.
Vaseline, 3 dr.

Or,

Extract of hamemelis, 15 gr.
Camphor, 1 dr.
Chalk, 30 gr.
Black soap, 15 gr.
Lanoline, 1 dr.
Vaseline, 3 dr.

Apply at night. In the day-time this ointment might be replaced by—

Salicylic acid, 6 gr.
Boric acid, 15 gr.
Oxide of zinc, 30 gr.
Vaseline, 6 dr.

Warm lotions of camomile morning and evening, while the beard should be cut close with the scissors.

If the disease is due to a parasite (trycophyton), the above treatment is insufficient; prolonged epilation will be necessary in such cases.

GERMANY.

Berlin, March 8th, 1908.

At the Verein für Innere Medizin, the subject of
Chemical Hypnotics
was discussed. After an introduction from the chemical point of view by Prof. Dr. Thoms, Hr. Ziehen took up the discourse from the clinical side. He restricted his observations to the employment of the chemical hypnotics in nerve diseases, leaving out mental diseases, infectious diseases, etc. No statistics could be compiled, he said, as the cases differed endlessly from each other, and only the impressions produced on the mind of the physician could be dealt with. He included the sedatives in his survey. He discussed the theme clinically, as the bedside phenomena and the chemical composition did not by anv means cover each other. One must rather analyse the nature of the insomnia, and make the choice of the particular hypnotic from the indications afforded by the analysis.

In the first group the bromine salts were the most effective hypnotics, not the hypnotics proper. He gave the bromide of sodium in daily doses of from 1½ gm. to 2 gm. for some days together, and in this way a satisfactory sleep was generally induced in from 8 to 10 days. In obstinate cases a more prompt effect was produced by neuronal or bromural, as bromine developed a stronger action in those combinations. The first, in suitable doses of from 1 to 1½ gm., scarcely ever showed any unpleasant by-effects; neither did it become less active by repetition. Bromural had a similar action, and it was a harmless hypnotic, especially for children. It was allied to the preparations of valerian, which had a certain hypnotic effect in mild cases.

In the second group, that of motor insomnia, hyoscine and duboisine acted very well indeed. They were not given subcutaneously, but per os in doses of 1-3rd to ½ mg. It must be confessed that disagreeable by-effects were sometimes seen with them.

Another group of hypnotics was the aldehyde group. They acted promptly, but their effects soon passed off. The chief representative of this group was paraldehyde, which was given in doses of 3 to 4 gm. It was almost as reliable but not so dangerous as veronal and trional. The danger of paraldehyde was much exaggerated. The speaker had seen a case in which the "kolosalen" dose of 18 gm. was given by mistake, in which complete recovery took place after a prolonged sleep. One drawback was the disagreeable taste of the medicine; this could, however, be almost covered by mixing it with red wine. As its effects were not lasting, it could not be given to patients requiring a lengthened sleep.

Chloral hydrate and its allied substances were near approaches to the foregoing. He would like to expunge the former from the list of hypnotics, as it had a very injurious effect on the stomach, intestines and heart. Of the allied substances, chloralamid had proved its value; from effective doses of 3 to 4 gm. he had never seen any ill effects. He did not give isopral so willingly; even in doses of 1.5 gm. it had a bad effect on the heart. It had, however, the great advantage of rapid action, acting in from 10 to 30 minutes. Nearly allied to this was chloracetone. Dormiol was commendable; up to 0.5 to 1.5 gm. it acted rapidly, and had but little action on the heart.

Another group was the sulphones, sulphonal, and trional, whilst tetronal had proved a failure. The chief advantage of trional was the prolonged sleep that followed its administration. It was a disadvantage that the sleep had often to be waited for, so that no dependence could be placed on it as regarded time; it could not be used, therefore, for patients who slept with difficulty. After doses of 1.5 gm. he had scarcely ever seen any bad effects, especially none on the heart. In France it was often given in conjunction with paraldehyde, and in this combination it acted well and rapidly. A combination of several hypnotics was generally of great service. Very distinct from these chemically was veronal, but its action was very similar. From his experiences with the drug he could only recommend it; it acted well, but very slowly, and the heaviness set up by it frequently lasted all the next day; the dose was from 0.5 to 1.5 gm. A great deal had been published regarding the dangers of veronal, but he had never seen anything of them, certainly none as regarded the heart or kidneys; even in serious cardiac disease he had never seen any injurious effects; death had not followed doses of 8 to 10 gm. The erythema that sometimes followed even moderate doses was rather disagreeable than dangerous.

Trionalosis and veronalosis might follow the prolonged use of these drugs. The remedies should be varied, therefore, but a change from one of them to the other was of no use. Their clinical relationship was also shown in the fact that when one lost its effect through repetition, the effect of the other was lost at the same time.

Out of the urethane group, urethane, and especially hedonal, were to be named. Urethane was no longer worth mentioning; hedonal, on the other hand, was a useful medicine, especially as a temporary exchange with another. It was given in doses of from 1 to 3 gm. and more. It was not as reliable as trional and veronal, but patients got accustomed to it less readily, and it exercised no injurious by-effects.

After veronal, proponal was also to be mentioned. It did not act so slowly as that, in 1½ to 2 hours, but in about one-third of that time, but it was not as reliable as veronal, and it did not, like veronal, act into the next day. In large doses there was no little danger; more than 0.5 gm. should never be given for a dose. As the effective dose was from 0.3 to 0.4 gm., there was very litle margin between the effective dose and one that was dangerous.

In conclusion, he recommended, if narcotics had to be given, that the changes should be rung frequently. The injurious effects that had been reported were often caused by one drug being continued too long. Combinations of drugs were also advisable; by making use of these, custom did not stale so rapidly, disagreeable symptoms were avoided, such as had made their appearance when the dose of the individual drug had been carried too high.

AUSTRIA.

Vienna, March 8th, 1908.

METASTASIS.

At the Gesellschaft, Eiselsberg brought forward a case he had operated on in 1902 by removing a part of the lower jaw for sarcoma. The patient is now 33 years of age with a large tumour behind the right ear, probably a metastatic result of the former operation. A small swelling commenced four years ago, and has gone on gradually increasing till it now reached the size of another head. The Röntgen rays show it to be closely bound up with the bones of the cranium. Both optic nerves are greatly atrophied from congestion, while the vestibular affection of the ear is convincing proof that further operation would be useless.

The Calmette Reaction.

Pirquet showed several children, healthy and strong, who responded to the ophthalmo-tuberculin reaction as practised by Calmette, who drops a small quantity of a diluted tuberculin into the sac of the conjunctiva, which produces a rapid reddening of the membrane in a short time in tubercular subjects. Calmette recommends a precipitate of tuberculin with alcohol after it has been diluted with 20 parts of water, but the "old tuberculin" diluted to a 5 per cent. solution will also act efficiently.

Three to six hours after dropping into the eye, the conjunctiva becomes red, particularly the caruncula lacrymalis and lower lid, which is described as the first stage of the reaction; when the conjunctiva of the bulb is involved, it has reached the second stage; and when exudation appears the third stage. This reddening usually disappears in two or three days. This operation is not without its dangers, as some experimenters have met with conjunctivitis lymphatica as a sequela.

Escherisch thought Pirquet's cutaneous reaction was a much easier and more satisfactory test than Calmette's.

Gastric Carcinoma.

Gohn showed an anatomical preparation from a boy, æt. 13, where the lung had been eaten away by a carcinomatous growth in the stomach. The invasion of the lung seems to have been a year old, as an operation was performed about that time for pyloric stenosis, and jejunostomy performed. Shortly after the operation pneumonia set in. At the post-mortem it was observed that the morbid process had extended from the small curvature and pylorus to the diaphragm, through which it entered the lung.

Adipose Diarrhœa.

Escherisch showed a child ten weeks old at the breast that had suffered from fatty diarrhœa and a severe form of seborrhœa. By reducing the quantity of fat in the milk the child speedily recovered. The milk was first drawn from the breast, put in a centrifuge, and all the fat extracted. Leiner recorded several cases that had come under his own observation, which he had treated successfully with that highly lauded article—buttermilk. Swoboda thought it was sufficient to stimulate the cutaneous surface, which he had always practised with success.

The Relation of Mammæ and Genitals.

Foges related his experiments with animals in extirpating the ovaries before the animal came to maturity. After the operation the mammary glands became stationary or hypertrophied. On the other hand when the uterus was removed, the ovaries and the mammæ remained normal. He concluded that the secretion of the ovaries was necessary to produce the reflex action for the growth of the mammary gland, but not necessarily for the functional production of milk, as the milk could be extracted even in larger quantities after the ovaries had been removed. Halbin said he had brought this subject before the meeting three years ago to show that the placenta had some relationship with the increase of the breast, and that the functional activity of the placenta was adverse to milk secretion, but immediately after its expulsion the lactic function commenced. He also affirmed that the active ovaries inhibited the breast secretion, which now agrees with Foges' experiments that removal of the ovaries promotes the secretion. He can sympathise with Foges' so-called lactation amenorrhœa as a consequence of inactive ovaries, as he was the first to promulgate this hypothesis.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

LOCAL GOVERNMENT INQUIRY AT RUCHILL FEVER HOSPITAL.—A lengthy report has been presented to the Local Government Board by Sheriff Crawford, Prof. Harvey Littlejohn, and Mr. Murray, who recently held an inquiry into the state of affairs existing in this hospital. They report that they are satisfied that the complaints of overcrowding and under-staffing have been substantiated, and that the friction within the staff of the hospital can be traced to these two facts. In 1907 there was a great strain thrown on the hospital by the prevalence of diphtheria, whooping-cough, cerebro-spinal fever and measles. It is not possible to separate the questions of overcrowding and under-staffing, because the management of the hospital has always proceeded on the principle that in times of stress the standard number of patients may be considerably exceeded without danger. The Commissioners point out, however, that cubic space cannot be reduced *pari passu* with age, and that 2,000 cubic feet is not an extravagant allowance for such diseases as diphtheria or enteric, while in measles and whooping-cough the prevalance of broncho-pneumonia is largely influenced by ventilation and cubic space. Again, children require as much, or even more, attention than adults. There is evidence of excessive overcrowding at least in the whooping-cough, cerebro-spinal fever, and measles wards. In May there were 51 patients, adults, and children, 30 of them unconscious, in a ward constructed for 15 beds. In December there were 74 children with measles, many of them suffering from broncho-pneumonia, in a ward of the same size, while in Ward 7, which is a small ward, on one day at least there were 62 patients, causing the air to be polluted and offensive, notwithstanding the excellent ventilation. This overcrowding meant that the floor area was so much obstructed by beds and cots that the nurses could not work without great difficulty; it meant that two children lay in one bed; it made the number of nurses inadequate, with the result that some of the children lay unattended for hours. It was impossible to feed so many at the proper times, and proper cleanliness was impossible. Discussing the question of under-staffing, and the friction that arose in consequence, the report fully admits that the matron had difficulty in getting suitable nurses. As the strain on the hospital increased, the insufficiency of the staff became more and more acutely felt towards the end of 1907. During the absence of the superintendent in September, one of the assistant physicians applied to the matron for extra nurses, and raised the question of the adequacy of the staff in view of the approaching winter. The matron, however, declined to admit that the assistant physicians had aught to do with the staffing of the wards. The Commissioners regard the action of the assistant physicians in going to the matron as an error; they should have waited until next day, when the superintendent was expected home. In her resentment, however, the matron made an even more serious error. Instead of waiting to complain to the superintendent, she went into the city and complained to the Convener of the Hospital Committee. After a conference between the Convener, matron, and medical superintendent, it was agreed that the matron's authority must be supported, and that she should reprimand the nurses, and Dr. Johnstone the assistant physicians. The report goes on to say that there is no evidence that there was any conspiracy on the part of the nurses against Miss Landle, the matron; that she herself was harassed, and was extremely angry, and forgot that she was addressing women who were themselves overtaxed. Dr. Johnstone received the assistant physicians' claim to be consulted about the nursing staff unfavourably, and, in consequence, they appealed to the Hospitals Committee. A truce was patched up, but ultimately the matrons and assistant physicians were not on speaking terms. It became impossible for both to remain in hospital together, and finally the assistant physicians were dismissed. The Commissioners consider that all this unfortunate friction could have been avoided had the superintendent dealt firmly with the state of affairs existing at his return on September 25th. Had he done so, neither the matron's address to the nurses, which created so much ill-feeling, nor the assistant physicians' dealings with the Hospital Committee, which in the long run led to their dismissal, need have occurred. As regards the general question of under-staffing, Dr. Johnstone did not sufficiently realise his responsibilities and duty. In the opinion of the Commissioners, the responsibility for the overcrowding lies with the Medical Officer of Health and the superintendent. During epidemics considerable relaxation of the usual rules as to numbers may be permitted, but at Ruchill the standards were not relaxed, but entirely discarded—the number of beds being multiplied by four, five, and even six. The Commissioners cannot accept Dr. Johnstone's view that his responsibility was limited to making the best distribution he could of patients sent in by the Medical Officer of Health; he ought to have said, "My hospital is full; the wards are full; and I have no others into which I can put additional patients." He might have been overruled, but more likely the Medical Officer of Health would have listened to his representations. On the other hand, Dr. Chalmers had, in the daily returns, means of knowing of the overcrowding. No responsibility attaches to the Hospital Committee, as the subject was not brought under their notice. In conclusion, the reporters state the mistakes made were not due to wilful negligence; that the health of the patients was not seriously affected, and the death rate no more than normal. In a covering letter the Local Government Board agree generally with the findings of the report. They state that, "Apart from the question of administrative responsibility, and of that of the procedure adopted by the resident medical officers, the allegations in question [of the residents] have turned out, on the whole, to be well founded." After reading the whole report, the general conclusion seems to be that the resident medical officers, though they placed themselves in the wrong and rendered their position untenable by mistaken tactics, and in particular by claiming the right to be consulted about the staffing of the wards, have yet done the city of Glasgow good service by exposing an inefficiency in the administration of the Ruchill Hospital which could not have continued without serious disaster. It is true that both the Hospitals Committee and the reporters amply recognise that their dismissal carries with it no imputation of professional blameworthiness—they were rather too zealous servants; but should any of the gentlemen in question desire to continue in the line of professional work they have begun, it is to be hoped that the health authorities in Glasgow will offer them reinstatement in office as vacancies may occur.

BELFAST.

PUBLIC HEALTH.—The number of cases of cerebro-spinal meningitis notified each week continues rather higher than for some months past, but shows no signs of alarming increase. Four cases were notified last week, and eight the week before, and there are at present 23 cases under treatment in the Purdysburn Fever Hospital. In the same hospital there are eight cases of typhus, showing that that disease is rather more prevalent than usual. The death-rate of the city, after touching 30, has fallen to 22.8.—The first report on the working of the Notification of Births Act was given by the Medical Superintendent Officer of Health at a meeting of the Public Health Committee last week. He stated that since the Act came into force 622 births had been notified. Of these 195 had been visited once, and 48 of these were notified to the Women's National Health Association for their health visitors to look after.

SOCIETY FOR PROVIDING NURSES FOR THE SICK POOR.—The annual meeting of this excellent society was held on the 6th inst. under the presidency of the Lord Mayor. The report showed that 1,291 cases had been attended, and 33,909 visits paid. The total number of cases was 168 in excess of the previous year, and the number sent by doctors was 154 in excess, a strong testimony to the value of the work done by the society. A large number of convalescent patients were sent to the seaside, and help in the form of clothes, meat, and milk, and medicine given to many destitute or deserving cases. Dr. R. J. Johnstone, who spoke at the meeting, warmly commended the work of the Society.

LETTERS TO THE EDITOR.

THE PHYSIOLOGICAL IMPORTANCE OF THE CALCIUM SALTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I feel sure you will allow me space in THE MEDICAL PRESS AND CIRCULAR to make a few comments upon the account of my paper read before the Liverpool Medical Institution, and the subsequent discussion, as reported in your issue of February 26th, page 239.

At first I felt almost tempted to congratulate Dr. Gordon Little on *his* paper, for the brief summary of *my* remarks (which I deem quite sufficient) hardly does justice to his criticism.

On thinking the matter over, however, I believe it was *I* who read the paper on experimental work done by myself, and that Dr. Gordon Little very kindly added considerable interest to the meeting by a very able and carefully prepared speech, which was only spoilt by certain remarks which were, I think, unnecessary and unjustifiable; but those present considered, so I am told, that in my reply I satisfactorily answered all his objections, if the other speakers had not already done so, for he was the first of those reported to speak.

In the circumstances I was somewhat surprised to see, in the published account of the proceedings, not only an amended summary of his remarks, but also a reply to my reply! This seems to me hardly "playing the game," even supposing he does wish to depreciate, for reasons best known to himself, the value of my method and work, with which he is so little acquainted practically.

It is not my intention to carry on a controversy with Dr. Gordon Little or anyone else at present, as I hope that my paper will be published *in extenso* in due time, when others interested will be able to judge for themselves; but I think I can claim at least the right to reply to Dr. Gordon Little's remarks, as many men about the country who have taken the trouble to write to me, or to come long distances to learn the method and see the work, may be unduly influenced by his statements, not having heard my paper or reply.

Dr. Gordon Little has never, so far as I know, even seen the method of calcium estimation in blood carried out, nor has he examined the accuracy of it which he so candidly criticised.

If he had done me the honour to bestow the same attention upon my paper as he evidently did upon the synopsis issued beforehand, he would have gathered :—

(1) That I definitely stated that only the ionised calcium was precipitated by my method, but that this calcium was probably the most important as far as rapid tissue changes were concerned.

(2) That I long ago gave up the comparative standard—blood with aqueous solution—mentioned in my original preliminary paper. (*a*) I now only speak of the blood-index, and acknowledge that, strictly speaking, each different solution should be worked out independently. (Further, his objection to an "index" at all, because of the variations, is ridiculous on the face of it. It would be useless to have an "index" if it did *not* vary. Again, the standard blood-index *has* been founded on many hundred blood examinations.)

(3) That the deduction he draws from my observations on menstruating women was drawn by me and mentioned. (How can *he* be so rash, in the face of his remarks, as to draw conclusions based on the method?)

(4) That I did ample justice in my paper to other workers, especially Ringer. (Consequently, it was particularly gratifying to receive myself the appreciation of such an eminent authority on calcium salts in disease as Sir James Barr, and of the other gentlemen who spoke.)

The long discourse on Mörner's paper (*b*) is quite new. In his speech Dr. Gordon Little stated that "someone had, as far back as 1870, shown that after the removal of the calcium salts coagulation still occurred in gelatin." In my reply I said that I doubted if in 1870 it was known that there was calcium in gelatin, and certainly nothing could have been known of its effect upon the setting thereof. Even if its presence were known then, I said I saw no reason to suppose that all the calcium could have been removed in those days, since it is impossible, as far as I know, to do this in 1908 without destroying the gelatin. I see now that Mörner's paper of 1899 is given! This paper deals mainly with the action of *neutral salts* upon gelatin, but as I used oxalic acid (not ammonium oxalate or any neutral salt, as might also have been gathered from my paper), I fail to see that Dr. Gordon Little has made his position any better in this matter by shifting his ground.

But this is not all. A careful examination of Mörner's paper reveals the fact that be specifically states in the text, and in a long footnote, that he has been *unable* to get ash-free gelatin (confirming my statement). His remarks simply refer to ash-rich gelatin, and gelatin from which as much of the "salt" contents as possible has been removed. My contention is thus entirely confirmed. The technique for preventing the coagulation of gelatin by precipitating the calcium will be published with the rest of the paper.

I have no wish to make such an enthusiastic metabolist as Dr. Gordon Little an adversary to my method and work, especially as I believe he has allowed himself to be influenced by others. I hope rather that he will test my statements himself, and bear in mind that I do not intend to invade the field of general metabolism by giving out these incidental observations. Being only a gynæcologist, I am endeavouring to clear up the physiology of my special branch, for, so far, the chemists and physiologists (on whom Dr. Gordon Little thinks the work should devolve) have been unable to find satisfactory solutions to many of the problems involved.

My paper read before the Liverpool Medical Institution was, in fact, a programme for those interested in general metabolism, and founded, as I say, on incidental observations which I could not neglect, and consequently feel constrained to defend.

I am, Sir, yours truly,
W. BLAIR BELL.

Liverpool, March 2nd, 1908.

CHRISTIAN SCIENCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Sewill has so frankly relapsed, in his last letter, from any attempt at argument to the easier method of abusing the plaintiff's attorney, that I am perfectly willing to admit that there is nothing to be gained by continuing the discussion with him. There are, however, one or two points in his last letter I should like to make clear.

He says that with my theology "we have little to

(*a*) "Brit. Med. Journ.," April 20th, 1907, p. 923.
(*b*) Zeit. f. Physiol. Chemie. Band, 28, p. 471.

do." That is a position I am quite willing to accept, but it is an extraordinary one from a gentleman who took the trouble originally to write a letter to your paper of 42 lines, out of which 32 were devoted to what he intended to be an exposure of that theology.

Then he says I admit there is such a thing as incurable disease. Of course, I admitted nothing of the sort; indeed, that all disease is curable is so well known to be the standpoint of Christian Science, I did not think it necessary to elaborate the statement. In the passage to which he refers I was not dealing with the Christian Science view of the case, but with the medical. The medical evidence was to the effect that the case was incurable when it passed under Christian Science treatment. I used this evidence, *inter alia*, simply to prove that Mr. Sewill's contention that the patient had suffered by his case being transferred to Christian Science was untenable. I agree with the statement contained in Mr. Sewill's first letter that God is omnipotent, and consequently I should not dream of limiting the power of God by representing any disease as incurable.

Mr. Sewill talks of the Christian Scientist's ignorance of true science, but it is always a mistake to assume that those who differ from you are more ignorant than you are yourself. As a matter of fact, Mr. Sewill is endeavouring to establish orthodoxy in natural science just as orthodoxy has been established in religion. The idea is not a new one. The mediæval Church made this attempt, and for a time succeeded in it. But, as one of the greatest victims of the attempt is reputed to have said, the world moves, and the attempt broke down.

True science is undoubtedly the effort to demonstrate absolute truth. This is presumably what St. Paul meant in speaking of the *epignosis tou theou*, the full, exact—that is, scientific—knowledge of God. This is what Thomas Aquinas—who, Huxley once hazarded the suggestion, was perhaps the subtlest of all the world's great thinkers, meant when he said that the only absolute science was the science of theology—that is, of the Word of God—while all else was merely relative; and this is what Mrs. Eddy means in writing on page 341 of "Science and Health":—"Sneers at the application of the word Science to Christianity cannot prevent that from being scientific which is based on Divine principle, demonstrated according to a given rule, and subjected to proof."

Mr. Sewill may, as I have already pointed out, maintain that science applies only to secondary causes, and that primary causes are in the category of unprovable assumptions; but I repeat that that is only begging the question, and that so long as you insist on such conditions you will obviously be bound by them. It is very much the frame of mind of the early ecclesiastical thinkers, who insisted that the earth was stationary, and that the sun rose and set. But Mr. Sewill himself speaks of "Divine Providence, the Omnipotent and Omniscient." What, on his own showing, therefore, could be more scientific than the effort to know this aright, and what is this knowledge but the *epignosis tou theou?*—the knowledge, in a word, of the Truth which Jesus said would make men free?

I am, Sir, yours truly,
FREDERICK DIXON.

Christian Science Publication Committee,
23 and 24, Clun House, Surrey Street,
Strand, W.C.,
March 4th, 1908.

THE PHARMACISTS AND QUACK MEDICINES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If the profession which you so ably represent is not duly grateful for the service you are performing by your campaign against quackery, I can, I think, safely assure you that your services are being thoroughly appreciated by qualified pharmaceutical chemists. Every respectable man in our calling will subscribe to the view of this question put forth a few months ago in the *Pharmaceutical Journal* by a well-known writer who has made the subject largely his own. I would like to epitomise and make as my own his statements; they embody the sentiments of us all. The quack medicine trade is hateful to every qualified chemist, who, under present conditions, finds himself compelled to take part in it. From the business point of view, it is almost impossible for the average man in the trade to refuse to participate in a traffic which he knows to be at once fraudulent and cruel. He knows that the vast majority of secret remedies are, when least harmful, mere worthless trash; he knows what is the harm that results from reliance upon bogus cures when organic disease exists; he knows the murderous results of some of them when potent drugs of the wrong kinds are contained in them, such as anodynes and narcotics, which mask symptoms instead of affecting the real disease. Educated chemists must all, as I do, surely detest the quack medicine trade, and would welcome any legislation to check it. From the merely business point of view it seems to me evident that if the quack drug trade were curtailed, the increased demand for legitimate medicines would far outweigh any loss arising from the altered state of the trade. On selfish, not less than on moral grounds, it seems the duty of pharmaceutical chemists to back you up in your fight against quackery; and I hope to see before long some active manifestation of the feelings which, I believe, are sincerely and widely prevalent. There are, I am sure, obvious reasons why I should prefer to withhold my name and subscribe myself,

Yours truly,
M.P.S.

London, W., March 6th, 1908.

DE LAVONDO NEONATORUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Nowadays, if one preach anything but ceaseless lavations, he is dubbed an apostle of filth; yet Aristotle, the wisest of our race, proclaims that wisdom lies in the mean, and not in the extreme, and Bacon teaches us that we are often the slaves of a word like "filth."

I will invoke a third great name to keep me in countenance, and recount that Carlyle tells us it is better to be dubbed a fool because one does not follow a beaten track than to be called wise for following the crowd.

Thus fortified, I assert that the washing of new-born infants is a superstition of the cruellest character, and is responsible for the death, by bronchitis or otherwise, of very many of them.

Kind Nature provides the child with an emollient, unctuous armour—a most admirable shield for its cutaneous nerve endings against the sudden shock of the chill, extra-uterine world—and, instead of allowing it to discharge its beneficent function, and be shed in due course of time, we insist on flaying the infant of it, despite its howls of agony, and inflict awful torture by washing the raw and quivering flesh.

Seriously, I suggest that the practice is cruel and unscientific, and should be stopped.

I am, Sir, yours truly,
J. C. MCWALTER, M.D.Brux., D.P.H.

Dublin, February 29th, 1908.

VACCINATION AND THE MEDICAL PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Alfred S. Gubb, M.D., of Algiers, does not deny my statement that all those members of the medical profession who have studied the subject, and that they are legion, condemn the practice of vaccination, but he says it hardly admits of proof. The thing is clearly proved by the number of medical speakers and writers against it in this and every country where it is practised. It is also proven in another way, viz., by the fact that those medical men who do advocate it have never studied it, and this is proven by the fact of their total ignorance respecting it. From a medical point of view, they know nothing whatever about it, not even enough to enable them to agree on any single one of its aspects, and their method of endeavouring to bolster it up is only by the resort to cooked and false statistics.

Where, I would like to ask Dr. Gubb, are the old time remedies of bleeding, blistering, smallpox inoculating, etc., in daily use as recognised "therapeutical procedures," as he declares them to be? In this country, at any rate, the last named "therapeutical procedure" is a highly penal offence.

For a medical or any other man to compare a purposive blood poisoning like vaccination to "trimming one's nails or picking one's teeth," as does Dr. Gubb, is to "expose himself to the imputation of ignorance if not rank stupidity." No one is compelled, as an alternative to fine and imprisonment, to trim their nails or pick their teeth.

Dr. Gubb is simply "trading on our gullibility" when he asks us to accept, without adducing one particle of evidence in support, such an extravagant statement as that "vaccination has saved, and is saving, millions from a terrible disease."

Dr. Gubb says the "Arabs greedily welcome vaccination now that they have had a few object lessons on the subject." Well, there are those who after having a few object lessons of the wonderful efficacy of dispersing an eclipse of the sun by the beating of tomtoms and blowing of instruments, greedily welcome these remedies. And this is about on a par with the Arabs' welcome of the vaccination superstition.

I am, Sir, yours truly,
J. West.
Bradford-on-Avon, March 3rd, 1908.

CYLLIN AND CRESYLIC ACID.

To the Editor of The Medical Press and Circular.

Sir,—An important caution to medical practitioners is given by Dr. David Sommerville in the *British Medical Journal*, February 1st, 1908, page 300, in regard to the substitution of cresylic acid for the preparation known as cyllin. He writes:—

"In the article on cresylic acid, the British Pharmaceutical Codex states, at p. 15, that cresylic acid enters into the composition of a number of proprietary disinfectants, such as cyllin, creolin, lysol, etc., and that a typical preparation of this class is liquor cresolis compositus, whose composition is described on page 613 as consisting of:—Cresylic acid by weight, 50; linseed oil, 35; caustic potash, 8; alcohol, 4; distilled water to 100. From work that I have done on the chemical and germicidal properties of cyllin during the last five years, I have no hesitation in saying that this statement is at once misleading and dangerous. Cyllin, as prepared for medical practitioners and pharmacists, contains no cresylic acid. As concerns disinfection in medical or surgical practice, the above substitute cannot be used without liability to disastrous results. The Rideal-Walker Co-efficient of cyllin medical is 20.0; the Rideal-Walker co-efficient of the above substitution product is 2.5."

As this matter must be of considerable interest to your readers, we should be grateful if you could find space to refer to it in an early issue.

I am, Sir, yours truly,
(For Jeyes' Sanitary Compounds, Ltd.)
J. T. Ainslie Walker,
Managing Director.
64, Cannon Street, London, E.C.,
February 28th, 1908.

OBITUARY.

SIR ALFRED COOPER, F.R.C.S.

A distinguished London surgeon has passed away in the person of Sir Alfred Cooper, who died at Mentone on Tuesday, the 3rd inst., after having attained the age of 70 years. For some years past he had retired from the active practice of his profession owing to the protracted illness which has just terminated fatally. He was educated at the school of St. Bartholomew's Hospital, and became a member of the Royal College of Surgeons of England in 1861, and Fellow in 1870, having previously obtained the Fellowship of the Edinburgh College. He was for many years one of the Surgeons to the Lock Hospital, a circumstance which served to determine the chief direction of his professional work. His best known works are those on syphilis, upon which he was a recognised authority. He was also at different times Surgeon to St. Mark's and to the West London Hospitals. He was appointed Surgeon-in-Ordinary to the late Duke of Saxe-Coburg and Gotha (Duke of Edinburgh), and received various marks of distinction from Russian and German medical bodies. Sir Alfred Cooper was also Surgeon to the Inns of Court Royal Volunteers, and to the Duke of York's Loyal Suffolk Hussars; and was the author of important works upon the department of surgery in which he chiefly practised. He had been Vice-President of the Royal College of Surgeons, and was a member of many of the medical and scientific societies. Sir Alfred married, in 1882, Lady Agnes Duff, daughter of the fifth Earl of Fife, and he received the honour of knighthood in 1902.

EDWARD DILLON MAPOTHER, M.D., R.U.I., F.R.C.S.I.

We regret to announce the death of Dr. Edward Dillon Mapother, on the 3rd inst., at his London house in Welbeck Street. The more active period of his professional life was passed in Dublin, where he enjoyed a good deal of social and professional distinction. He graduated as M.D. at the Royal University of Ireland in 1857, and took the Fellowship of the Royal College of Surgeons of Ireland in 1862. He was Surgeon to St. Vincent's Hospital, and to St. Joseph's Hospital for Children, in Dublin. He also filled the posts of Professor of and Examiner in Physiology to the college, in which he served the office of President, was Examiner in Surgery to the Queen's University of Ireland, and Surgeon-in-Ordinary to the Lord Lieutenant. He was the author of a text-book on Physiology which passed through three editions, of numerous works on various questions of medicine and of hygiene, and of numerous papers in the medical journals and in the late Sir Richard Quain's "Dictionary of Medicine," in which he wrote the chief articles on the various forms of skin disease. In London he was chiefly known in association with dermatological work.

REVIEWS OF BOOKS.

NISBET'S MEDICAL DIRECTORY. (*a*)

The appearance of a new medical directory is a somewhat notable event in the medical world. The present volume is issued on a plan that differs in treatment from existing and previous publications of the kind. Matter has been edited strictly with a view of keeping down space, and the result is a royal octavo volume of about one and a half inches in thickness. Initials are given in place of full Christian names, and as a rule not more than one appointment and one publication are inserted. Another novel feature is that the names are given in alphabetical order for the whole kingdom, after the manner adopted by the official *Medical Register*. The book is divided into two parts, the first containing a full directory of medical men, while the second is a local list. The price is 7s. 6d., a figure that justifies the publishers' claim that theirs is the cheapest medical directory published. It certainly does not err on the side of diffuseness, which is something to say in these modern days of rush and hurry.

ON TREATMENT. (*b*)

It is obvious that of any class of medical students only a small percentage can become specialists or consultants, and still the training they receive is almost entirely in the hands of specialists and consultants, and in many ways more fitted to produce specialists than general practitioners. For the majority of men an "assistancy" is the only "post-graduate course" which will teach them to corelate the ideas gained in hospital to the exigencies of general practice. To such men a book with the title of Dr. Harry Campbell's latest work, "On Treatment," will be especially welcome. If there is at first some sense

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(*a*) "Nisbet's Medical Directory." London: James Nisbet and Co. 1908. Price 7s. 6d.

(*b*) "On Treatment." By Harry Campbell, M.D., B.S., F.R.C.P. (Demy 8vo, pp. 429). London: Baillière, Tindall, and Cox, 1907. Price 5s.

of disappointment at the absence of detail in the book, no medical man will read it without a feeling of refreshment and real gain. Dr. Campbell's writing abounds in that higher power of common sense which may properly be called wisdom. He touches with no gentle finger the weaknesses of medical education, and points out quite frankly the many items in the student's load of acquired information which are entirely a useless burden; but his advice is no encouragement to the "slacker"; he is told in the same breath what knowledge to acquire in double measure. The chapter on Rationalism and Empiricism is, perhaps, the most interesting in the book; and Dr. Campbell makes an important point when he reminds us that a form of treatment devised by a process of pure reasoning becomes a routine or empirical treatment in the hands of those who use it simply on the authority of the discoverer. It requires some courage nowadays to write, "Concerning treatment by drugs, I strongly advise the physician to give them on the routine principle." But Dr. Campbell makes no statement without giving his reasons, and his arguments, even if not always convincing, are always interesting.

THE PROLONGATION OF LIFE (*a*)

THE critics of Professor Metchnikoff's book on "The Nature of Man" have, at any rate, one point on which they have good reason to congratulate themselves. They have stimulated the distinguished author to reply in book form to their criticisms, and to bring together a number of studies bearing on subjects allied to those previously treated. The result is the present fascinating volume on "The Prolongation of Life." As might be expected from such a begetting, the subjects dealt with are very various, but there is a continuous thread of thought connecting the different sections. Perhaps the most interesting point about M. Metchnikoff's views as a philosopher—and it is, of course, as a philosopher rather than as a man of science we have to deal with him here—is the fact that his optimism is purely naturalistic and at the same time individualist. It has always been regarded as a reproach to the philosophy which has sprung from natural science that it tended toward pessimism in its outlook. Thus, the materialism which, not unnaturally, though hardly logically, grew out of the militant agnosticism of Huxley and Tyndall, has been singularly unattractive.

M. Metchnikoff, however, is a thoroughgoing optimist, though one may have half a suspicion that his optimism is at least as much a result of his buoyant temperament as of his science—that it is, in fact, quite as much subjective as objective. Though it may be, therefore, failing in universality, it is none the less communicable, and no more exhilarating task can be undertaken than the study of M. Metchnikoff's views.

His ideal is the condition he names "orthobiosis," which he describes as "the development of the human life so that it passes through a long period of old age in active and vigorous health, leading to the final period in which there shall be present a sense of satiety of life, and a wish for death." This is probably the ideal of a great many healthy men and women, but nevertheless the author assumes, rather than establishes it, and he can hardly escape the objection that the foundation of his doctrine is rather in individual and personal psychology than in the necessary elements of the rational mind. From another standpoint it may, of course, be said that no ideal is satisfactory which does not include the prospect of a future life.

M. Metchnikoff is proud, and rightly so, of the great strides science has made in recent generations. He believes that the work preventive medicine has already performed is only an earnest of what it will do in the future. He hopes that we may, in time, be able to rid humanity of all the diseases to which it is at present subject. It will be possible also to guard against the various accidents which constantly threaten us. When that era has arrived the only check to human life will be old age, with its natural death. M. Metchnikoff discusses the causes of senility, and argues in favour of the doctrine that the phagocytes, our greatest allies in younger life, turn on us as enemies in old age, and destroy our very vitals. Whence this revulsion? Can it be that the phagocytes are stimulated to this unnatural revolt by any toxin in the body? M. Metchnikoff suggests that, whatever the mechanism may be, intestinal putrefaction, with the consequent absorption of toxins, is a potent factor in the production of senile decay. He argues, with a fair amount of evidence, for some association between a large intestine and shortness of life, and he maintains that in man the large intestine is not only a useless but a hurtful organ. He mentions cases where its absence was followed by no ill effects. As we can hardly hope to rid ourselves of the large intestine, M. Metchnikoff discusses the means by which we may neutralise its injurious influence. If the large intestine were sterile, it would be harmless. Now, it is possible practically to deprive it of its putrefactive flora by introducing large numbers of an organism whose products are fatal to them—the lactic acid bacillus. This can be done either by drinking large quantities of sour milk or by injection of pure cultures of the lactic acid bacillus. Rendering the large intestine innocuous by such means, we may hope, by paying proper attention to general and personal hygiene, to approach more nearly to orthobiosis.

We have developed one of the main ideas in this remarkable book to the exclusion of others. But the reader will be almost startled by the variety of topics with which M. Metchnikoff deals. In addition to studies of senility and longevity, we have an investigation of natural death among plants, animals, and men; a discussion on the psychical rudiments in man; a section on the history of social animals; studies on pessimism and optimism, and on science and morality; and a section of acute criticism of Goethe as man and poet.

On many points of theory and conduct one may differ with M. Metchnikoff's teaching in this book. His logic is faulty, and his conclusions more hypothetical than he admits. In every point, however, one must respect his outspoken honesty and sincerity. He touches on many topics—he has adorned them all.

To Dr. Chalmers Mitchell we are indebted for an English text which rarely betrays that it is a translation. There is a strange blunder on p. 143, where the average annual mortality appears to have been multiplied by ten.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

EDWARD ARNOLD (London).
  The Chemical Basis of Pharmacology. By Francis Francis, D.Sc., Ph.D., and J. M. Fortescue-Brickdale, M.A., M.D.Oxon. Pp. 372. Price 14s. net.

BAILLIERE, TINDALL AND COX (London).
  The Pocket Anatomy. Sixth Edition. Revised and Edited by C. H. Fagge, M.B., M.S.Lond., F.R.C.S. Thirtieth thousand. Pp. 270. Price 3s. 6d. net.
  Aids to Surgery. By Joseph Cunning, M.B. B.S., F.R.C.S.Eng. Second Edition. Pp. 404. Price, Cloth, 4s. net., Paper, 3s. 6d. net.
  The Spectroscope: Its Uses in General Analytical Chemistry. An Intermediate Text-Book for Practical Chemists. By T. Thorne Baker, F.C.S., F.R.P.S. Illustrated. Pp. 130. Price 5s. net.
  Hernia: Its Etiology, Symptoms and Treatment. By W. McAdam Eccles, M.S.Lond., F.R.C.S.Eng. Third Edition. Illustrated. Pp. 234. Price 7s. 6d. net.
  Protozoa and Disease. Comprising Sections on the Causation of Smallpox, Syphilis, and Cancer. By J. Jackson Clarke, M.B.Lond., F.R.C.S. Part II. Illustrated. Pp. 138. Price 7s. 6d. net.
  Minor Maladies and their Treatment. By Leonard Williams, M.D., M.R.C.P. Second Edition, revised and enlarged. Pp. 404. Price 5s. net.

JOHN BALE, SONS AND DANIELSSON, LTD. (London).
  The Pyonex: Its Theory and Practice. By W. B. Rule, M.R.C.S., L.R.C.P. Pp. 572. Price 12s. 6d. net.

BALLANTYNE AND CO., LTD. (London).
  Egypt, and How to See it. Illustrated by A. C. Lamplough. Pp. 208. Price 2s. 6d.

CAMBRIDGE UNIVERSITY PRESS (London).
  The Journal of Hygiene. Edited by George H. F. Nuttall, M.D., Ph.D., etc., etc. Vol 7. No. 6. December, 1907. Published Quarterly. Price 6s. net.

(*a*) "The Prolongation of Life: Optimistic Studies." By Elie Metchnikoff, Sub-Director of the Pasteur Institute. The English Translation edited by P. Chalmers Mitchell, M.A., D.Sc.Oxon., Hon. LL.D., F.R.S. London: William Heinemann. 1907. Price 12s. 6d. net.

The Caxton Publishing Co. (London).

The Edinburgh Stereoscopic Atlas of Obstetrics. Edited by G. F. Barbour Simpson, M.D., F.R.C.P.E., F.R.C.S.E., and Edward Burnet, B.A., M.B., Ch.B. With a preface by Prof. Sir Halliday Croom, M.D., etc., etc. Section 1. In four sections, each containing 25 subjects, with Descriptive Text. Price for the four sections, 84s. net.

Churchill J. and A. (London).

The Care of the Teeth in Public Elementary Schools. By C. Edward Wallis, M.R.C.S., L.R.C.P., L.D.S. Pp. 14. Price 1s. net.

A Manual of Prescribing for Students and Practitioners of Medicine. By C. R. Marshall, M.D. Pp. 373. Price 5s. net.

A Short Practice of Gynæcology. By Henry Jellett, B.A., M.D., B.Ch., B.A.O. (Dublin University): F.R.C.P.I. Third Edition, revised and enlarged, with 310 illustrations. Pp. 518. Price 12s. 6d. net.

Reports of the Society for the Study of Disease in Children. Vol. VII. Session of 1906-1907. Edited by George Carpenter, M.D. Pp. 305. Price 12s. 6d. net.

Lectures on Medical Jurisprudence and Toxicology, as delivered at the London Hospital. By Fred. J. Smith, M.A., M.D.Oxon., F.R.C.P., F.R.C.S. Second Edition. Pp. 463. Price 8s. 6d. net.

The Royal London Ophthalmic Hospital Reports. Edited by Wm. Lang, F.R.C.S.E. Vol. XVII. Part II. Jan., 1908. Price 5s. net

The Clarendon Press (Oxford).

Two Oxford Physiologists: Richard Lower, 1631 to 1691; John Mayow, 1643 to 1679. By Francis Gotch, M.A., D.Sc., F.R.S. Pp. 40. Price 1s. net.

The History of the Study of Medicine in the British Isles. By Norman Moore, M.D.Cantab. Illustrated. Pp. 202. Price 10s. 6d. net.

W. B. Clive (London).

School Hygiene. By Robert A. Lister, M.B., Ch.B., B.Sc., D.P.H. Pp. 360. Price 3s. 6d. net.

Henry Frowde and Hodder and Stoughton (London).

Rotunda Practical Midwifery. By E. Hastings Tweedy, M.D., F.R.C.P.I., and G. T. Wrench, M.D. Illustrated. Pp. 464. Price 16s. net.

Rotunda Midwifery for Nurses and Midwives. By G. T. Wrench, M.D. With Introduction by the Master of the Rotunda Hospital. Illustrated. Pp. 324. Price 6s. net.

Fevers in the Tropics. By Leonard Rogers, F.R.C.P., F.R.C.S., etc., etc. Illustrated. Pp. 343. Price 30s. net.

Life Insurance and General Practice. By E. M. Brockbank, M.D.Vict., F.R.C.P. Pp. 288. Price 7s. 6d. net.

The Garden City Association (London).

Town Planning in Theory and Practice. Papers and Speeches by Mr. Councillor Nettlefold, etc., etc. Pp. 72. Price 1s. net.

H. K. Lewis (London).

Studies in Blood Pressure: Physiological and Clinical. By George Oliver, M.D.Lond., F.R.C.P. Second Edition, enlarged. Pp. 255. Price 4s. net.

The Doctor in the Schools. By Hackworth Stuart, M.D.Lond., F.R.C.S.Edin., D.P.H.Cantab. Pp. 32. Price 1s. net.

An Essay upon Disease: Its Cause and Prevention. By G. E. Richmond, M.D., B.Sc., etc., etc. Pp. 96. Price 2s. net.

Diseases of the Nose and Throat. By Herbert Tilley, B.S.Lond., F.R.C.S.Eng. Illustrated. Pp. 539. Price 14s. net.

J. B. Lippincott and Co. (London).

International Clinics. A Quarterly. Edited by W. T. Longcope, M.D. Vol. IV. Seventeenth Series, 1907. Pp. 308.

Longmans, Green and Co. (London).

The Old Riddle and the Newest Answer. By John Gerrard, S.J., F.L.S. Fifth and cheaper edition. Pp. 121. Price 6d.

Proceedings of the Royal Society of Medicine. Edited by John Nachbar, M.A., M.D., under the direction of the Editorial Committee. Vol I. No. 2. Price 7s. 6d. net.

Proceedings of the Royal Society of Medicine. Vol I. No. 3. Price 7s. 6d. net.

Macmillan and Co., Ltd. (London)

"Confessio Medici." By the writer of "The Young People." Pp. 158. Price 3s. 6d. net.

Methuen and Co. (London).

Functional Nerve Diseases. By A. T. Schofield, M.D. Pp. 324. Price 7s. 6d. net.

Nisbet, James and Co., Ltd. (London).

Nisbet's Medical Directory, 1908. In two parts. Part I.: Directory of Medical Practitioners. Part II.: The Local Directory. Pp. 774. Price 7s. 6d. net.

W. B. Saunders Co. (London).

Treatise and Diseases of the Skin. By Henry W. Stelwagon, M.D., Ph.D. Fifth Edition, revised and illustrated. Pp. 1150. Price 25s. net.

Principles and Practice of Modern Otology. By John F. Barnhill, M.D., and E. de Wolfe Wales, B.S., M.D. Illustrated. Pp. 575. Price 24s. net.

A Text-Book of Diseases of the Nose and Throat. By D. Braden Kyle, A.M., M.D. Illustrated. Fourth Edition, revised and enlarged. Pp. 797. Price 18s. net.

Sidney Appleton (London).

A Text-Book of Treatment. By William Calwell, M.A., M.D., John Campbell, M.A., M.D., F.R.C.S.Eng., and Robert Campbell, B.A., M.B., F.R.C.S.Eng. Edited by R. J. Ferguson, M.D., F.R.C.S.Eng. Part 1: Obstetrics and Gynæcology, by John Campbell. Illustrated. Pp. 279. Price 10s. net.

The Sexual Instinct, its Use and Dangers as Affecting Heredity and Morals. By J. F. Scott, B.A., M.D., C.M. Second Edition, revised and enlarged. Pp. 473. Price 7s. 6d. net.

Gonorrhea, its Diagnosis and Treatment. By F. Baumann, Ph.D., M.D. Illustrated. Pp. 206. Price 6s. net.

A Text Book of Minor Surgery. By E. M. Foote, A.M., M.D. Illustrated. Pp. 752. Price 21s. net.

The Walter Scott Publishing Co. (London).

Euthetic Diseases (The Young Man's Peril). By. R. R. Rentoul. Pp. 39. Price 2s. 6d. net.

John Wright and Co. (Bristol).

First Aid to the Injured and Sick. An advanced Ambulance Handbook. By F. J. Warwick, B.A., M.B., etc., etc., and A. C. Tunstall, M.D., F.R.C.S.Ed. Fifth Edition, revised and enlarged. Pp. 252. Price 1s. net paper, 2s. net cloth.

The Experimental Prophylaxis of Syphilis. By Paul Maisonneuve. Translated by Fernand L. de Verteuil, M.B., M.R.C.S., L.R.C.P. Pp. 102. Price 4s. net.

LABORATORY NOTES.

A POUDRO-PENCIL.

Messrs. Christy have sent us a "Poudro," a little pencil-shaped article which they have devised for containing powder. The original idea was that it should be used by ladies to carry face powder about with them in the purse or in the satchel, but it seems likely to be useful to dentists and medical men, who have to continuously wash their hands. Any kind of powder required can be put in this ingenious little instrument, and extracted by pressing the point on to the back of the hand or wherever required.

ALEXINE.

This is a new preparation from the Paris laboratory of M. Chatelain, and is supplied in the form of pink granules which are slightly hygroscopic. These granules dissolve in water, producing a flesh-coloured opalescent solution, which has a pleasant taste and an acid reaction. The preparation is said to contain phosphoric acid in the free state, together with phosphates of iron and manganese, and our analysis shows this to be the composition. In its free condition, as presented in Alexine, it is claimed that the phosphoric acid is capable of entering into combination with those bases that need this acid, thus furnishing the organs with the means of forming the necessary phosphates. Further, we may add that the acidity of the preparation dissolves certain insoluble phosphates, and thus prevents the accumulation of these insoluble salts in places where they are not desired. The preparation is guaranteed to be accurately standardised, and to be absolutely harmless. The English agents for Alexine are Messrs. T. Christy and Co., Old Swan Lane, London.

STAPHYLOCOCCUS VACCINE.

Messrs. Parke, Davis, have sent in a sample of staphylococcus vaccine put up in convenient form. At the same time they convey the information that they have been appointed sole agents for the sale of the bacterial vaccines now being produced in the Inoculation Department, St. Mary's Hospital, under the direction of Sir Almroth Wright. Besides the staphylococcan vaccine, there are streptococcus, gonococcus, tubercle, and typhoid vaccines. The material is carefully put up in glass bulbs, and a note is added to the effect that typhoid vaccine should be used within three months of its preparation. The prices vary from 1s. 6d. to 5s. per bulb. Arguing from the authoritative source of these vaccines, it is safe to predict for them a large vogue amongst members of the medical profession. We are glad to see it specifically mentioned that the vaccines "are intended to be used solely under the direction of a medical practitioner."

BLACK WASH SOLOID.

Messrs. Burroughs, Wellcome have sent us a sample of soloids of *lotio nigra*. The usefulness of this preparation in a compact form will be sufficiently obvious to all medical men to prevent the necessity for extended comment. The soloids can be carried about in a small quantity, and the only thing required to procure an immediate supply of black wash is to dissolve one of them in the requisite amount of water. The country practitioner will find these tabloids useful in his practice, for there are many conditions in which black wash constitutes a valuable remedy, whereas it has dropped in these latter days into undeserved neglect.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

The Influence of the Central Nervous System in the Causation of Uterine Hæmorrhages.—Ehrenfest (*Amer. Jour. Obst.*, Feb., 1907).—"Intractable uterine hæmorrhage" appears with striking frequency in recent literature as an indication for hysterectomy. This is surprising. Uterine hæmorrhage is not a disease *sui generis*, but only a symptom. There are three theories by which the metrorrhagia is explained. The oldest is based upon the presence of a thickening of the tunica media of the arteries; the second, that it is due to an increase of fibrous tissue of the uterine wall at the expense of the musculature; and the third that it is due to a relative insufficiency of the elastic tissue. In this paper the author shows how functional disturbances of the uterus may be brought about by anomalous impulses transmitted to the genital organs from a normal or diseased central nervous system. After reviewing the literature, and from personal observations, he then draws the following conclusions:—(1) Impulses coming from the central nervous system may alter the normal function of the uterus in regard to both menstruation and labour. (2) The resulting effect may appear either in the form of vaso-motor anomalies (amenorrhœa, menorrhagia or metrorrhagia), or in the form of motor disturbances (sudden cessation or beginning of uterine contractions). (3) With the exception of rather vague reference to disturbances in the vaso-motor system and the uterine tonus, and No. 2 theory above, no explanation is extant of the exact mechanism by which such a nervous influence may cause the symptom of metrorrhagia or amenorrhœa. This mechanism the writer attributes to a locally increased blood pressure due to an abnormally high tonus of the uterine wall. This local increase of blood pressure will result from any tonic contraction of the uterus, which is slight enough not to cause a compression of the arteries, but strong enough to effect a cessation of the rhythmic contractions of the uterus (which help to propel the venous blood), and compression of the thinner walled veins. As a result of this passive hyperæmic condition, and the locally increased blood pressure, therefore, the endometrial capillaries must become dilated, and finally rupture causing hæmorrhage. This rupture seems also applicable to the explanation of menstruation. If, then, this theory of a locally increased blood pressure due to an abnormally high tonus of the uterine wall actually explains some uterine hæmorrhages, it should be possible to explain the sudden cessation of an existing hæmorrhage and of certain types of amenorrhœa. If the impulse from the central nervous system is a strong and firm one, the resulting uterine contraction may completely interrupt the circulation in the arteries, and suddenly stop an existing flow. In this category belong the cases of temporary suppression of menses in the fear of existence of pregnancy. F.

Acute Suppurative Peritonitis and its Operative Treatment.—Wathen (*Jour. Amer. Med. Assoc.*) formulates the following principles for the operative treatment of all perforations into the peritoneal cavity:—(1) Operate as soon as diagnosis is made, and avoid purgation and opium before and after operation. Give no food or liquid, and if there is no gastric perforation empty the stomach by lavage, and remove fæcal matter from the colon by rectal enemata. (2) Operate rapidly, and, if posible, treat the foci of infection by suturing gastro-intestinal perforations or bladder wounds, by cholecystectomy or cholecystostomy, by appendectomy, or by the removal of the uterus or its adnexa, always remembering to avoid peritoneal traumatism. (3) Expose or handle the intestines as little as possible, and do not separate adhesions or irrigate or sponge the peritoneal cavity. Establish drainage from the bottom of the pelvis through a suprapubic incision, and, if indicated, also drain the site of infection, using a large split rubber tube with or without gauze, with the patient in nearly a sitting posture. (4) Pour into the peritoneal cavity before closing the abdominal wound hot horse serum or saline solution to stimulate leucocytosis, and when the patient is in bed use saline by the rectum after the manner of Murphy. Enterotomy is hardly ever indicated; enterostomy is contra-indicated. F.

A Consideration of Neurasthenia in its Relation to Pelvic Symptoms in Women.—Weiss (*Amer. Jour. Obst.*, Feb., 1908).—Too often are patients with vague neurasthenic symptoms, such as headache or slight leucorrhœa subjected to operation in the hope that a cure will result; likewise numberless ovaries are sacrificed on account of ovarian pain where no real pathological condition exists. Not only are the neurasthenic symptoms unimproved, but new symptoms are added to the category which did not exist before the operation. Therefore, it must be remembered:—(1) That neurasthenic pelvic symptoms in women frequently exist without pathological changes in the pelvis; (2) that a careful differentiation between neurasthenia and real morbid anatomy must be made before deciding on the treatment; (3) that this form of neurasthenia is not only unimproved, but frequently aggravated by surgical treatment. F.

The Treatment of Infected Pubiotomy Wounds by Suction Hyperæmia.—Offergeld (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. 6), as a result of his experiments, comes to the following conclusions:—Injuries to the vagina occurring at the time of operation must be regarded as the most dangerous complication of pubiotomy, since the immediate result is that the soft parts, and especially the ends of the bone, are infected, and the symptoms of severe septic infection arise. The different sera have been employed with very little success in these cases. On the other hand, the early induction of venous hyperæmia seems to afford us a most excellent means of not only preventing the latent infection from making itself manifest, but also of localising the disease, and of curing when even the first symptoms of osteomyelitis are present. It is reasonable to employ the suction hyperæmia as a curative agent only when no general infection *viâ* the circulation has occurred. G.

Glycosuria Resulting from Abdominal Tumours.—Evelt (*Monatssch. für Geb. und Gyn.*, Bd. XXVI., Hft. 6) records the case of a woman, æt. 41, who believed herself to be eight months pregnant. She was examined by two physicians, who told her that she was pregnant. She had not missed a period, but the abdomen had latterly become very much enlarged. A physical examination made by the author showed the following:—No colostrum in the breasts. Bimanually a very irregularly shaped tumour was to be felt, which, owing to the presence of nodules and ballotting parts, closely resembled a pregnant uterus. The urine contained a large amount of sugar. A laparotomy was performed, and bilateral ovarian tumours and a myomatous uterus were removed. The convalescence was uneventful. The author came to the conclusion that the only possible cause for the glycosuria in this case was injury to the pancreas. This injury he regards as being compression of the pancreatic duct due to pressure of the large tumours. He advises, therefore, that a diagnosis of diabetes should never be made without first carefully examining the abdomen. It would be a very unpleasant revelation for the physician to find that dietetic treatment was producing no result, which, of course, it could not do, when the diabetes is due to a similar cause as the case now recorded. G.

Forceps for the Sake of the Child.—Leisewitz (*Archiv. für Gyn.*, Bd. LXXXI., Hft. 3).—In the Dresden Klinik from 1894-1907 forceps were used 697 times among 27,238 deliveries. They were indicated 440 times on behalf of the child, 99 times on behalf of the mother, and 158 times on behalf of both. Of the 598 children to be saved, 529, = 88.46 per cent., lived. The causes of death were fracture and compression, and most frequently asphyxia, 46 having died from the last cause. The author believes that some of these children might have been saved by an earlier application of the forceps. High forceps should be no longer employed. Pubiotomy should be performed instead, even by the general practitioner. If he should not be able to perform pubiotomy, it is better to perforate. G.

MEDICAL NEWS IN BRIEF

Royal College of Surgeons of England.—The Negro Races of Africa.

On Friday last, Dr. Frank C. Shrubsall, Hunterian Professor, concluded a series of three lectures on the Negro Races of Africa. The lecturer dealt chiefly with the physical anthropology of these races from the time of the classical period, and recorded the growth of knowledge in mediæval and modern times. The Bushmen-Hottentots and the Negrillos he described as the main types of the shorter race, and the true and mixed negro people as the taller race. Dr. Shrubsall regretted that numbers of negro skulls had in the past been sent to English and other museums without any exact information as to the tribe to which they belonged, and had to be entered in the catalogues simply as "negroes from unknown localities," which has rendered them practically useless for comparative study. With the exception of the skull of the negro he further said that material for the study of the rest of the skeleton was almost entirely lacking.

Dr. Shrubsall described the history of Africa as one of replacement of one racial stock by another more richly endowed. The Bushmen were driven to the uttermost ends of the continent to take refuge in mountain fastnesses in which they were safe until the advent of the European and long range firearms against which their weak bows and arrows were powerless. At the same time the driving away of the great game and its replacement by herds of cattle converted him of necessity from a hunter of the wild animal, free to all, to a hunter of those animals which had taken their place, and as these were the property of the usurpers of his country he was termed by them a robber to be exterminated. Even those who had fled into the desert fastnesses, as yet not used as grazing grounds, had to suffer a further ill from the advent of pastoral peoples. The cattle plague which ruined many of the pastoral peoples also destroyed the majority of the great game, and so helped by starvation to exterminate the original race of South African man.

The Hottentots, driven back before the white man, make a precarious living in Namaqualand, and a few tribes, now all of mixed blood, remain along the Orange River in Griqualand. The unmixed negro is now nearly everywhere driven into the humid, unhealthy forest zone and river marshes, and has been protected therein by acquiring a certain tolerance of some parasitic diseases which take heavy toll of invading higher races. In these fastnesses the negro remains unprogressive, if not retrograde. Now, with the aid of hygienic precautions, the drainage of marshes, the opening up of clearings in the forest, the parasites which have been his protection, or perhaps rather the insects transmitting them to man, are being destroyed, and the higher races are able to live longer and longer periods in the old forbidden land. "This is doubtless all for good," continued the lecturer. "In early mediæval times a high state of culture existed among the mixed peoples in the Central Sudan, and it may be the results of a similar mixture throughout black Africa will lead to the rise of a more progressive people, who will be brought into even closer contact with European civilisation, when, by steamers and railroads, the healthy plateaux are made accessible, and become the seats of the newer Empire, in which each race may play its part."

The Queen's College, Cork.

The triennial visitation of this College was held during the month of February. The visitors were Mr. Justice Kenny, President; Sir Rowland Blennerhassett, Bart.; the President of the Royal College of Physicians; the Vice-President of the Royal College of Surgeons, and Sir John Wm. Moore, M.D. At the close of the proceedings Mr. Justice Kenny stated that the visitors, having gone through the various departments of the College, found it, as a whole, in a highly satisfactory condition. They considered that as much use as possible had been made of the finances at the disposal of the College.

Trinity College, Dublin.

The following candidates passed the Final Medical Examination, Part II., at Hilary term, 1908:—

Medicine.—Charles W. Laird (passed on high marks), Johannes C. Pretorius, Arthur H. Laird, Thomas P. Dowley, Albert V. J. Richardson, William E. Hopkins, William A. Nicholson, Robert de C. Wheeler, James F. Clarke, Herbert V. Stanley.

Alltymynnydd Sanatorium.—Royal Opening Ceremony.

It is stated by a good authority that her Royal Highness Princess Christian has consented to open on July 21st next the sanatorium which has been erected for consumptives at Alltymynnydd, Llanbyther. The West Wales Branch of the National Association for the Prevention of Tuberculosis, of which Earl Cawdor, Lord Lieutenant of Pembrokeshire, is the President, will meet next week to arrange details in connection with the reception of Her Royal Highness, who, accompanied by her daughter, Her Royal Highness Princess Victoria, unveiled the memorial stone in 1906, on which occasion she was the guest of her dear lamented friend, the late Lady Drummond, wife of Sir James Williams Drummond, Bart., Lord-Lieutenant of Carmarthenshire and Chairman of the Sanatorium Committee.

Prudential Assurance.

From the annual report of the Prudential Assurance Company, just received, we learn that the number of life policies in force at December 31st, 1907, was 843,206, assuring with bonus the enormous sum of £93,263,920, and producing a premium income of £4,477,866 per annum. The double endowment table introduced in the year 1903 has proved very successful, there being over 43,000 of these policies in force, assuring over £4,840,000; including these policies, there are 692,474 policies effected under the endowment assurance tables, where the sum assured is payable in the lifetime of the policyholder. The surplus funds in hand, including £266,387 brought forward from last year, are now £1,406,318.

School of Tropical Medicine, Australia.

The Bishop of North Queensland (Dr. Frodsham) has come over to England partly to make arrangements with the schools of tropical medicine in England to send out to Australia a trained man to start the work of the institute which it is proposed to form in Northern Queensland for the study of tropical diseases. It is intended to establish an institute, with laboratory, at Townsville, the Bishop's headquarters, and the principal city in Northern Queensland. The general management will be undertaken by the three Australian Universities having medical schools—Sydney, Melbourne, and Adelaide. The Federal Government of Australia have agreed to subsidise the work at the rate of £450 per annum, and the Government of Queensland will give £250; thus the institute will start with an assured annual income of £700, and this sum will be increased by private subscriptions. The managers of the Townsville Hospital will set aside a building for a laboratory, free of charge. Correspondence relating to the matter may be addressed to the Bishop at the Church House, Westminster.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

DR. HARTLEY.—To lay too much stress upon the incident would be to indicate that our correspondent had acted unwisely in the matter.

WESTERN SUBURB.—The plea, in our opinion, is not a sound one, and should be resisted.

WHAT WE ARE COMING TO.

"Is the room disinfected?"

"Yes, mother; and I have sterilised the curtains, deodorised the furniture, septicised all the fixtures, vapourised the air, washed my lips in an antiseptic solution, and——"

"Have you septicised the mistletoe?"

"Thoroughly, mother; everything is done. Arthur is waiting now in the hydrogen room."

"Then you may go in and let him kiss you, dear."—"Lippincott's Magazine."

FOREARMED.—In view of the probability of all-night sittings at the House of Commons being necessary before very long, it is reported that the Kitchen Committee have unanimously decided to lay in a good supply of Bovril for use of members.

LAYMAN.—Our correspondent should consult his medical adviser, who, if necessary, will recommend a consultant.

PALLIDA MORS.—The statement of the patient should not be accepted without seeking for confirmation from the two medical men concerned.

MEDICAL AID.

A Newcastle correspondent writes: I am told that there are several collieries situated on the outskirts of small villages that have not a medical man living nearer than seven or eight miles, and they are without telephone connection. It is true there is the country post office for telegraphing, but even this is closed at 8 p.m., and the operator is not always available. To make matters worse, not one of these isolated collieries has a single person connected with it that knows anything about ambulance or first-aid work. There is no reason why there should not be a telephone to the nearest doctor, or that a section of the men should not be taught the principles of rendering first aid to the injured.

STUDENT.—The matter is one which we think had better be referred to the Dean of the medical school to which our correspondent belongs.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 11TH.

ROYAL SOCIETY OF MEDICINE (NEUROLOGICAL SECTION) (20, Hanover Square, W.).—5 p.m.: Clinical Meeting. Dr. W. J. Harris, Dr. P. Weber, Dr. E. Jones, Dr. P. Stewart, Dr. J. S. Collier, and others: Cases. Patients in attendance at 4.30 p.m.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Prof. R. Thompson: The Anatomy of the Long Bones relative to Certain Fractures. (Hunterian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. M. White: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

THURSDAY, MARCH 12TH.

ROYAL SOCIETY OF MEDICINE (OBSTETRICAL AND GYNÆCOLOGICAL SECTION) (20, Hanover Square, W.).—7.45 p.m.: Dr. W. C. Swayne, Dr. G. Anderson, and Dr. Macnaughton-Jones: Specimens. Dr. A. Andrews and Dr. D. Maxwell: A Case of Difficult Labour with Remarks on the Frozen Sections of the Uterus. Dr. W. C. Swayne: Myomectomy during Pregnancy. Dr. J. H. Dauber: Large Retro-peritoneal and Subligamental Fibroid complicating Pregnancy.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture:—Dr. A. J. Whiting: Angioneurotic Œdema as a Familiar Cause of Sudden Death.

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: Ul-erythema—I., Centrifugum; II., Telangiectic; III., Ophryogenes.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street).—4 p.m.: Lecture:—Mr. A. Lane: Fractures in Children.

FRIDAY, MARCH 13TH.

ROYAL SOCIETY OF MEDICINE (CLINICAL SECTION) (20, Hanover Square, W.).—8.30 p.m.: Mr. T. H. Kellock: A Case of Hermaphroditism in which the Uterus occupied the Sac of an Inguinal Hernia. Dr. F. P. Weber: A Case of Angina Pectoris with Aortitis. Dr. S. W. Carruthers: A Case of Purpura Hæmorrhagica with Fatal Result from Cerebral Hæmorrhage. Dr. J. P. Parkinson and Mr. J. S. Horsford: A Case of Cerebellar Tumour with Proptosis.

INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH.—Dr. E. W. Hope: The Results of the Methods adopted in Liverpool in the Direction of removing Insanitary Property and providing Dwellings for the Dispossessed. Followed by Discussion.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Prof. W. S. Handley: The Natural Cure of Cancer. (Hunterian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. E. Clarke: Clinique. (Eye.)

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—3.30 p.m.: Lecture:—Mr. P. Baly: A Few Points in Preventive Dentistry and the Care of the Teeth.

MONDAY, MARCH 16TH.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Dr. F. A. Bainbridge: The Pathology of Acid Intoxication.

Appointments.

DILLON, M., L.R.C.S.Irel., L.A.H., Certifying Surgeon under the Factory and Workshop Act for the Rathmore District of the county of Kerry.

EDINGTON, D. C., M.D.Edin., Certifying Surgeon under the Factory and Workshop Act for the Penrith District of the county of Cumberland.

FARRIES, JOHN STOTHART, L.R.C.P. and S.Edin., Medical Superintendent of the Sandwell Hall Asylum for the Feeble-Minded, Handsworth, Staffs.

HARDY, ARTHUR REGINALD, L.M. and S., L.S.A.Lond., Resident Medical Officer at the Gateforth Open-air Sanatorium (near Selby) in connection with the Leeds Tuberculosis Association.

HARMAN, G. R., L.M., L.S.Dub., Certifying Surgeon under the Factory and Workshop Act for the St. German's District of the county of Cornwall.

MOORE, P. M., M.B., B.S.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Strangford District of the county of Down.

MORTIMER, JOHN, M.B.Lond., M.R.C.S., Honorary Consulting Surgeon to the Exeter Dispensary.

THOMAS, FRANK LESLIE, M.B., B.S.Lond., L.R.C.P., M.R.C.S., Medical Officer to the Barnstaple Union.

Vacancies.

North Riding Lunatic Asylum, Clifton, York.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, furnished apartments, washing, and attendance. Applications to the Medical Superintendent.

Devon County Asylum, Exminster.—Third Assistant Medical Officer. Salary, £140 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Asylum, Exminster.

Hampshire County Council.—County Medical Officer of Health. Salary, £700 net. Applications to H. Barber, Clerk of the Council, The Castle, Winchester.

Bucks County Education Committee.—Education Medical Officer. Salary, £300 per annum. Applications to C. G. Watkins, Education Offices, Aylesbury.

Saint Bartholomew's Hospital, Rochester.—House Physician. Salary, £110 per annum, with board and residence at the Hospital. Applications to Thos. Crockford, Clerk to the House Committee.

Norfolk County Asylum, Thorpe, Norwich.—Junior Assistant Medical Officer. Salary, £150 per annum, all found except liquors. Applications to the Medical Superintendent.

The Royal National Orthopædic Hospital, 234, Great Portland Street, W.—House Surgeon. Salary, £250 per annum. Applications to the Secretary.

Mullingar District Lunatic Asylum.—Resident Junior Assistant Medical Officer. Salary, £100 a year, increasing to £150 per annum. Immediate application to Arthur Pinegan, Resident Medical Superintendent. (See Advt.)

Royal Victoria Eye and Ear Hospital, Dublin.—House Surgeon. Salary, £40 per annum, with full board and residence. Applications to Edward Parker, Registrar. (See Advt.)

Births.

ATKINSON.—On March 1st, at 33, Church Street, Saffron Walden, to Dr. and Mrs. H. W. Atkinson—a daughter.

HOBBS.—On March 6th, at Burke House, Beaconsfield, the wife of Geoffrey Charlstrom Hobbs, L.R.C.P., L.S.A., of a daughter.

MILLIGAN.—On March 7th, at Ardmae, Northampton, the wife of R. A. Milligan, M.D., of a daughter.

Deaths.

MACLEOD.—On March 3rd, Murdoch Donald Macleod, M.B., of Beverley, East Yorks, late Medical Superintendent Officer of the East Riding Asylum.

MAPOTHER.—On March 3rd, at 16, Welbeck Street, London, Edward Dillon Mapother, M.D., late President of Royal College of Surgeons, Ireland, aged 72.

COOPER.—On March 5th, William Bertram Cooper, M.R.C.S., L.R.C.P., of 19, Sutton Court Road, Chiswick, aged 39.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Education and Co.

ONE of the latest of American fads which it is proposed to introduce over here is what is called "Co-education," and, as in all similar movements, the pioneers as a whole seem to be as wanting in humour as they are filled with enthusiasm. The secretary of the "Co-educational Public Schools Trust, Ltd.," has sent us a report of a recent meeting held under its auspices at Highgate, at which various ladies and gentlemen expressed their views on the subject. Mr. W. H. Dickinson, M.P., who presided, made the remark that people were afraid of the movement mainly because of its name, and that all the evidence he could obtain from America was in favour of co-education. This very noncommittal attitude formed a marked contrast to that assumed by the next speaker, a lady, who read a paper to prove that co-education was the one preventive of the great evil existing in public schools for boys! We have not before us the evidence on which this view is based, but simple-minded folk are apt to think that if boys and girls are brought up in big schools together, the deplorable homo-sexual practices which are carried on in some boys' schools are likely to be replaced by bi-sexual ones, with even more disastrous consequences.

Atheism v. Rheumatism.

A GENTLEMAN from Balliol College, Oxford, went one better even than this by declaring that association of the sexes was a law of the Creator; that there could be no morality if His laws were defied; and if there were no morality there could be no religion. From this syllogism it would seem to follow that this country, and most others, except a few favoured spots in America, have been without religion for ages unknown. From this dismal retrospect he absolved "the Ancients," who, he said, had given us the greatest literature, art, and philosophy, and yet educated their boys and girls together. The only "ancients" we remember who practised co-education were the Spartans, and these, alas! are not Spartan days. When, however, we recollect that in that State the girls were brought up with the boys, and accustomed to run and wrestle naked, we feel inclined to agree that in this climate the cause of morality would not be likely to suffer by adopting such practices over here, however much bronchitis and rheumatism might be thereby induced. Perhaps, however, the most unanswerable argument used was that employed by another gentleman, who said he had been converted to co-education by his daughter, who had no brother and was given the choice of her school. The young lady blushingly plumped for a mixed one, as she wanted "to find out what boys were *like*." A similar desire in our common mother, we reflect, "brought sin into the world, and all our woe."

Calls by Midwives.

WE have received another report of a much more interesting and practical character. It is issued under the direction of the Council of the London and Counties' Medical Protection Society, and embodies the result of several hundred inquiries they have made of medical men as to the working of the Midwives Act. The points as to which questions were put were: (1) the number of cases in which the practitioner had been summoned by a midwife; (2) the payment received for such cases; and (3) the nature of the difficulty for which their services were required. A large number of replies were received, and digested. The conclusions reached are, briefly: that conditions vary very much as to midwifery practice in different parts of the country; that in more than half the cases the practitioners were not paid, and that in the rest the fee averaged about 9s.; but of these fees only a few were received from the patient or midwife, the majority being paid by boards of guardians, provident dispensaries, and similar bodies; and finally that nearly all the cases were very serious and required operative interference for delayed or difficult labours.

Quem Deus.

WE beg to congratulate the London and Counties' Medical Protection Society on having put into more or less concrete form the opinions which medical men have hitherto hazarded, and we think the profession generally will desire to thank them for the labour their valuable task has involved. We heartily sympathise with those of our colleagues of whom the report says: "It is apparently the more galling to medical practitioners to be called on to assist midwives in difficult emergencies without payment, because they often regard the midwives as competing with them for midwifery practice, and doing so with the advantage of charging lower fees and of being able to advertise for patients with impunity." We hope that this report will reach those benevolent ladies and gentlemen who like to show their benevolence at the expense of the practitioners in poor neighbourhoods. The inevitable sequel of their action in training midwives and sending them out without medical control to practice on poor women is, not only that the medical man who finds it hard enough to make a living has most unfair competition to face, together with the insult of having to attend gratis at the call of his rivals when they get into difficulties, but that the poor are deprived of proper skilled attention at confinements, and many of them and their babies perish in consequence.

Unusual Counter-claim.

AN amusing case was heard before the sheriff in a county town in Scotland recently. A medical man was suing an hotel proprietor for non-payment of a bill for two years' medical attendance, amounting to £17 10s. 6d., and the defender disputed the amount and counter-claimed £3 0s. 2d. for "refreshments." There was no reasonable evidence against the amount of the bill, the chief grievance of the defender being that he had to pay 3s. every time the doctor peeped in, asked how he was, and looked at his tongue. For all the good these visits did him, he said, he might just as well have asked to see the doctor's tongue. The sheriff, however, pointed out that the doctor's books were well kept and showed all the visits, whilst as the pursuer had to come three miles to see his patient, he would not hold that 3s. a visit was an exorbitant charge. On the question of the counter-claim, the pursuer said he was charged for more liquor than he had consumed in all his days, but as it seemed that, in the words of the defender, he had sometimes had "a little bit to eat and something to wash it down with," the Sheriff eventually gave £2 against the doctor. Among the curiosities of medical appearances in the law courts we never remember "refreshments" being pleaded as a set-off against a bill for attendance.

Marylebone Mews.

AT the present moment there is some agitation going on as to the right of Lord Portman, who owns much property in the borough of Marylebone, to close certain mews on his estate and to use the ground for the purpose of building flats. As to the legal aspect of the case, we must leave that to the lawyers who advise the Council, but we most cordially endorse the medical view, put forward by Dr. Fletcher Little and others, that it would be most imprudent, from considerations of health, to close these fairly open spaces and build high blocks of flats on them. It is a palpable fact that a man must live somewhere, and that he needs a certain amount of elbow-room. It is not so well known, but none the less the fact, that the higher the density of the population, the higher the death-rate. London, especially the "inner ring," is already disgracefully over-crowded, and it needs all the air-space that can be granted if it is to maintain even the present standard of health. Every inch of ground built over in the centre of London is a nail in someone's coffin, and we can hardly believe that Lord Portman, who has done so much for the people on his London estate, can realise the toll in life and suffering from tuberculosis and other diseases that the building over of the present open spaces would involve.

LEADING ARTICLES.

THE SCIENTIFIC STUDY OF DEATHS UNDER ANÆSTHESIA.

IN the history of medicine it is often interesting to note for how long a time the scientific mind is content to accept an unfounded formula as an established proposition. After generations, or, it may be, centuries, of slumbering acquiescence, some master mind exposes the frailty of the orthodox belief, and the way is opened up for the discovery of the actual underlying laws. Something of this kind appears to have happened with regard to the subject of deaths under anæsthesia. Dr. F. J. Waldo, the well-known City of London Coroner, has written an article upon this most important matter, and deals with it in his usual trenchant and well-informed method. His article is published elsewhere in the present issue of THE MEDICAL PRESS AND CIRCULAR. If it were endeavoured to sum up the result of his investigation of the actual facts of the case, it could be tersely expressed in the manner of the famous chapter of "The Snakes in Iceland," namely, "There are no snakes in Iceland." There are, in effect, no statistics of deaths under anæsthetics worthy the name. The mortality from that cause in England and Wales, as reported by the Registrar-General, is gleaned from two sources, namely, reports of coroners' verdicts, and the death certificates of medical practitioners. These sources of information are absolutely inadequate, so far as they include anything remotely resembling any accurate survey of the total number of deaths during anæsthesia. Many coroners do not hold inquests upon cases of the kind that are reported to them, so that these particular occurrences are not brought to the notice of the Registrar-General at all. Moreover, the returns of the coroners are so unmethodical as to be practically useless for any comparative analysis. Thus, during the years 1902 to 1906 there were a total of 786 such deaths, but in no less than 204 of them there was no mention of the particular drug that was administered. It is, further, a fairly self-evident fact that the majority of cases of death under anæsthesia that come before the public occur in hospital practice. This observation brings us to the further important consideration, namely, that such fatalities in private practice for the most part escape formal notice, either by the coroner or the registrar of deaths, simply because, for obvious reasons, the private practitioner is anxious to avoid publicity, both on his own account and in order to shield the susceptibilities of his patients. Another fallacy arises from the fact that it is open to the individual judgment of the person certifying to omit any reference to deaths occurring at the commencement or end of general anæsthesia. For these and other clearly stated reasons the conclusion is inevitable that no statistics that are worth an instant's serious consideration are issued by the Registrar-General of England and Wales. Startling as this condition of affairs may be to the average easy-going citizen, it is nothing when compared with the corresponding figures of the Registrar-Generals of Ireland and of Scotland, where the attempt at a return is simply grotesque. In the face of these statements the man in the street will naturally ask, what is the worth of the familiar statistics given every week in the coroners' courts of the United Kingdom, whereby it is confidently asserted that the percentage of deaths under chloroform is such and such a figure, under ether another figure, and so on. As a matter of calm, sober judgment, it may be they are absolute assumptions, the result of mere guesswork, and that they no more represent the truth than the farrago of fraudulent nonsense of a specious quack pamphlet conveys the established axioms of modern medical science. The man in the street may well ask why, if that be the case, the medical profession have allowed him to be so long misled by statements that had all the appearance of authoritative professional utterances. Nay, more, the average medical man may well rub his eyes with surprise as he realises the Rip Van Winkle sleep into which he has allowed himself to be betrayed. If we mistake not, the article which we publish to-day will set the ball rolling in the right direction so far as the scientific study of anæsthetics is concerned. Hitherto we have had too much of collective and private investigation, and too little of scientific method in dealing with this important subject. How many medical men are ready to say with confidence that this or that anæsthetic drug is safer than any other. What are the data upon which such a conclusion can be logically founded? If Dr. Waldo be correct, no such data are in existence, and until some comprehensive scheme for obtaining trustworthy statistics can be secured, it will be impossible to make the first necessary step in any scientific investigation. In the few hospitals where anything like an accurate record is kept of cases of anæsthesia there is reason to believe that not a few administrations escape record. Dr. Waldo's recommendations are no less to the point than his conclusions. He suggests that every case in which a general anæsthetic is administered should be reported to some recognised authority, and that full details of every fatal case occurring, whether in hospital or in private practice, should be reported by the administrator, and that a subsequent public inquiry be held by the coroner. The familiar suggestion of a Royal Commission is appended, and it seems not unlikely that in the present instance it would be highly desirable not only in the interests of the community at learge, but also for the advancement of medical science. In any case, the cloud of ignorance that at present surrounds the whole tragedy of fatal anæsthesia constitutes a standing reproach to the philosophy of modern scientific medicine.

CURRENT TOPICS.

An Unhappy Slander Case.

The medical profession in Brighton has been ruffled by a particularly unhappy action for slander, which has resulted in a verdict for £100 damages. The plaintiff, Mr. Cecil Edwards, was appointed anæsthetist to the Sussex County Hospital at the end of 1906, but his election was distasteful to one of the surgeons, Mr. Arthur Buck, who later figured as the defendant in the action in question. The evidence in the case was voluminious, and an array of counsel appeared on either side. After a careful examination of the newspaper reports, it seems impossible to avoid the conclusion that the defendant was never reconciled to the fact of the plaintiff being elected to the position of anæsthetist to the hospital, a candidature which he had from the first opposed. Further, the evidence appears to have shown that the defendant had on specific occasions attributed incompetency to the plaintiff. Indeed, he had himself admitted that he would not perform an operation for £500 if plaintiff were the anæstheist. One incident that cropped up again and again was the turning blue in the face of a patient when under the influence of an anæsthetic given by plaintiff. Most medical men will probably agree that the true test of the competency of an anæsthetist is not the occurrence of a fleeting complication of that kind, but the way in which it was met, and the outcome of a series of administrations. There was not a shred of evidence forthcoming as to incompetence gauged by the standard of fatal results. The whole incident is sordid and unworthy of the goodwill that should reign amongst fellow-workers in a great and humane profession, whose work is conducted in the midst of the doubts and difficulties inherent to a science that is so far inexact and hoodwinked by the baffling barriers of unmastered natural laws. Anæsthetists are mortal no less than surgeons, and both look to their profession for a livelihood. An accusation of incompetence spells ruin to a young medical man, and the jury appear to have recognised the justice of the legal appeal in the action under notice, the necessity for which should never have arisen under conditions of ordinary professional tolerance and ethical sanity.

A Coming Franco-British Exhibition.

A circular letter has been going the round of the Press, both in London and the provinces, calling attention to the desirability of Great Britain being adequately represented in the forthcoming Franco-British Exhibition. Amongst many arts, crafts, and callings, the "art of medicine" is specifically mentioned as falling under the section of the liberal arts. According to the statement of Mr. Boverton Redwood, the chairman of the Exhibition, who writes from 56 Victoria Street, London, S.W., there are many ways in which that particular sub-section may be illustrated. "I need not dilate," he writes, "on the marvels of modern surgery and bacteriological research, but I may say that we hope to secure an instructive display of the latest appliances for obtaining aseptic conditions, and of the ingenious apparatus now employed in the culture and study of micro-organisms." The idea thus outlined is somewhat novel. There will be little difficulty in obtaining the help of the leading instrument makers, and possibly of some of the scientific laboratories. To make a public display of the marvels of modern surgery, however, would certainly not be in accordance with the traditions of medical men on this side of the Channel. In France orthodox opinion in these matters is less strict, and there is apparently no ethical objection to a well-known surgeon being reproduced *coram publico* on the cinematograph when performing a surgical operation.

The United Hospitals Conference.

The United Hospitals Conference is announced to take place on April 1st and 2nd. On Wednesday the session will be from 2 p.m. to 6 p.m., and the subjects for discussion will be motions and announcements of proposals before the last conference; payment for hospital patients, the prevention of abuse; and the mode of election of honorary staffs of hospitals. To dispose of these important subjects within the short space of four hours is a somewhat formidable essay. Our old friend the provident dispensary appears under the sub-section "Co-operation of provident dispensaries and analogous institutions with hospitals, *i.e.*, in the question of prevention of abuse." It will be interesting to learn the definition of "analogous institutions." On the morning of Thursday, April 2nd, from 10.30 a.m. to 1 p.m., will be discussed: (1) cottage hospitals; (2) the organisation of county guilds for the support of hospitals, as an alternative to the extension of the work of the "League of Mercy in the provinces"; (3) desirability of provincial hospitals adopting the system of uniform accounts recommended by the King Edward's Funds. Thursday afternoon provides a further relay of subjects, including the direct representation of the medical profession on the boards of management of hospitals; inclusion of tuberculosis as a notifiable disease, and its hospital isolation. We note a commendable absence of names, but nevertheless the majority of delegates will not be at any great loss to trace the underlying forces that determine the direction of many of the topics set forth for discussion.

London's Recognition of Miss Florence Nightingale.

By conferring upon her the freedom of the City, Londoners have formally recognised the great debt owed to Miss Florence Nightingale by the community. Owing to her advanced age the presentation was made by proxy through her nearest relative, a nephew, Mr. Shaw Nightingale. The ceremony was conducted in the Council Chamber of the Guildhall on the 16th inst., and was attended by the Lord Mayor, Aldermen, and Council in their robes. The well of the chamber was peopled with distinguished visitors, while the gallery was filled with nurses and fifty girls from the City of London Schools. The honour thus bestowed upon a great pioneer undoubtedly recognises a debt to one of the benefactors of humanity. In its way, modern nursing has done as much to alleviate the suffering of mankind as the discovery of chloroform, or the introduction of aseptic surgery. Yet all these three boons have come to us within the space of a few generations. The work that Florence Nightingale set rolling some fifty years ago in the Crimea has already achieved world-wide results. Who then would have dreamed of the marvellous immunity from camp sickness and the reduction of deaths from wounds to well nigh vanishing point that attained its scientific acme in the Japanese army during their recent campaign? All medical men will unite with one accord to do honour to the woman whose prophetic vision and genius achieved a vast revolution in the art of practical therapeutics, and out of the horrors of war created one of the most beneficent and peaceful of all callings that can minister to suffering humanity.

The Registration of Deaths from Alcoholism.

It is doubtful whether any scheme of national registration of deaths, however well conceived, would ever be wholly successful in obtaining an adequate record of causes. Such conditions as syphilis, insanity and alcoholism, for instance, would always present insurmountable obstacles in the path of conscientious medical testimony, that is to say, while the practitioner is dependent on his popularity and tact for the retention of the practice which supplies him with bread and cheese. What can be easier than to certify that death is due, let us say, to cirrhosis of the liver, and to leave unnoted the primary cause of alcohol or of syphilis? Moreover, there is the feeling in the breast of every man which is crystallised in the maxim, "*de mortuis nil nisi bonum*," and which we are given to think must reign supreme in the heart of every worthy member of the medical profession. A little while since a prominent Leeds practitioner declared that none of his brethren would be heartless enough to sign a certificate stating that a person had died from alcoholism. That, of course, is a somewhat extreme view, and we must dissent from the further reported statement that no man ever signed such a certificate except in the case of patients in public institutions. If that be the case the quality of the humanity upon which so much emphasis is laid seems to be somewhat lacking in the true ring. Every student of statistics recognises that there are serious fallacies surrounding the Registrar-General's figures regarding alcoholism.

Degrees for Pharmacists.

There will be little disagreement with the opinion of the Executive Committee of the General Medical Council as expressed to the Privy Council, that "it is highly inexpedient to institute in the faculty of medicine a pharmaceutical degree which contains no qualification in any branch of medicine." We suppose there is no use in hoping that the modern rage for degrees will find a check until, by their very multiplicity, they defeat their own object. It is perhaps a natural result of the increasing tendency of our universities to become superior technical schools that degrees should be conferred on those proficient in all sorts of crafts, and not merely on those who have cultivated letters or science. However, when graduates become as plentiful in these countries as were colonels in the United States a couple of decades ago, the title will be no distinction, and perhaps degrees will become obsolete. In the meantime, since in some professions degrees are a badge of right to practise their calling, we have some reason to protest against any confusion between one degree and another. Universities must be popularised, but the popularisation must be done with due regard to the rights of existing graduates, and a colourable imitation of the letters of the degrees in medicine would seem to be an infringement of the rights of medical graduates.

The Dearth of Assistant Medical Officers under the Metropolitan Asylums Board.

Good people who, on the score of economy or through any other motive, ignore mundane conditions, are awakened sooner or later from their blissful dreams by finding the world to be a place run on mundane lines. For many years the Metropolitan Asylums Board have treated their Assistant Medical Officers with haughty disdain, paying poor salaries, offering practically no prospects, and housing them at about the standard of an artisan. To make their lot even more enviable, when the hospitals were slack they have dismissed the officers, not actually, indeed, at the moment, relying on being able to draw a fresh supply from the open market in time of need. At last the worm has turned, and medical labour has shown itself not to be so "fluid" as the gentlemen on the Embankment supposed. Indeed, the Board are now complaining that there is such a shortage of officers that they cannot obtain a sufficient number to fill vacancies as they occur. This is excellent news. Public bodies never feel any representation so much as the cold-shoulder, and, as was the case with the Army Medical Service a few years ago, the Metropolitan Asylums Board are finding that they will have to add to the inducements of their medical service if they wish to obtain medical officers. Hitherto, we have been speaking from the point of view of medical men, but we place even above their interest that of the patients. If a proper number of candidates are not forthcoming, and if those who do come forward are not eligible, the patients' interests must suffer severely. Well qualified, diligent and skilful men are not picked up every day in any profession, and the Board, if they are anxious to do their duty by the patients, is not merely to pose as rate-saving statesmen, will lay themselves out to obtain the best quality of medical officer.

A Public Health Bill for Ireland.

We understand that the Irish Committee of the British Medical Association, a committee formed some time ago in order to meet the frequent complaints that the Association took no interest in Irish affairs, is considering at present the drafting of a Public Health Bill for Ireland. The object of the Bill is to codify the various Public Health Acts at present in force, and to provide for a more efficient sanitary executive. It is proposed that wholetime superintendent medical officers of health be appointed for counties and county boroughs, the dispensary medical officers to continue to act, if they so choose, as district medical officers of health. In addition, it is proposed to give greater powers for the erection of sanatoria, and the establishment of bacteriological laboratories. There is no doubt that these reforms are urgently needed, and having a Bill drafted may be of assistance to the Government if it should find time to legislate in regard to sanitary affairs in Ireland. If the British Medical Association had the power its numbers and wealth entitle it to be, it could command legislation, but unfortunately experience has not taught us to expect much from its exertions in regard to Irish matters. The framing of the present measure is, we cannot help suspecting, an attempt by the Irish Committee to show that it is doing something.

PERSONAL.

We understand that Mr. John Poland, F.R.C.S., late Senior Surgeon to the City Orthopædic Hospital, has resigned the post of Surgeon to the Royal National Orthopædic Hospital, to which he was recently elected.

The late Mr J. R. Turle has left £10,000 to the London School of Medicine for Women; a similar sum to the Metropolitan Convalescent Institution; and a sum of approximately equal magnitude to the New Hospital for Women (Euston Road).

Colonel J. Turton, V.D., R.A.M.C. (Vols.), is nominated for the appointment of Principal Medical Officer, Home Counties Division, of the Territorial Army.

Surgeon-Colonel G. S. Elliston, V.D., is nominated for a similar honour in connection with the East Anglian Division, and Surgeon-Colonel J. Raglan Thomas for the Wessex Division of the same force.

Surgeon-Colonel Sir Charles Cuffe, K.C.B., President of the Irish Medical Schools' and Graduates' Association, presided at the annual dinner of that body on March 17th at the Hotel Great Central.

Dr. Alfred Lingard, who has been Imperial Bacteriologist to the Indian Government for nearly twenty years, has just retired from his post.

Mrs. Bell Pettigrew is presenting the sum of £6,000 to St. Andrew's University to found a museum in memory of her husband, Professor J. Bell Pettigrew, who for 33 years was Chandos Professor of Medicine and Anatomy in the University.

Dr. John B. Hellier has been appointed Professor of Obstetrics at Leeds University.

Surgeon-Major C. R. Laurie, Army Medical Reserve, has been promoted to be Knight of Grace of the Order of the Hospital of St. John of Jerusalem in England.

Dr. J. Charlton Briscoe has been elected an Assistant Physician to King's College Hospital.

Dr. Duncan Forbes, Medical Officer of Health for Cambridge, has been elected to succeed Dr. Arthur Newsholme as Medical Officer of Health for Brighton.

Mr. Andrew Carnegie has given 500,000 marks (£25,000) towards the 1,000,000 marks required for the "Robert Koch Stiftung," a fund founded to celebrate the 25th anniversary of Professor Koch's discovery of the tubercle bacillus, and to encourage research into tuberculosis prevention.

We regret to learn of the death of Dr. James Barrett, the well-known Melbourne practitioner and father of Dr. John Barrett, the great Australian cricketer.

Lieut.-Col. G. Scott, retired list, has been appointed staff officer to the P.M.O., Highland Division, Territorial Force.

Dr. R. Ashleigh Glegg, County Medical Officer of Ayrshire, has been appointed Medical Officer of Health and Chief Medical Inspector of School-children for the Parts of Lindsey.

The Home Secretary has appointed Dr. Mary Gordon, of 152, Harley Street, to be an Inspector of Prisons and an Assistant Inspector of State and Certified Inebriate Reformatories.

The Council of the British Association for the Advancement of Science has nominated Professor J. J. Thomson, F.R.S., Cavendish Professor of Experimental Physics in the University of Cambridge, to be president of the meeting of the Association to be held at Winnipeg next year.

Lord Strathcona presided on the 11th inst. at a dinner given by the Royal Institute of Public Health to members of the International Congress on Sleeping Sickness. The dinner was at the Hôtel Metropole, London, and amongst the guests were Professor Koch, Professor G. Sims Woodhead, Mr. Henry Morris, Colonel D. Bruce, Professor Santoliguido, Dr. L. W. Sambon, Colonel Lantonnois, and Professor G. H. F. Nuttall.

Mrs. Scharlieb, M.D., has been presented with her portrait, painted in oils, on behalf of 300 subscribers, in recognition of her pioneer work on behalf of women.

At a meeting of the Executive Committee of the West Wales branch of the National Society for the Prevention of Tuberculosis, held at Carmarthen, on Saturday evening, a letter was read from Earl Cawdor stating that he had received an intimation from Princess Christian that she would prefer to go to South Wales on Saturday, July 18th, and open the sanatorium for consumption at Alltymynydd, Carmarthenshire, on Monday, July 20th. The princess will be the guest of Earl Cawdor, at Stockpole Court, Pembrokeshire.

Dr. O'Connor Donelan has been appointed to succeed the late Dr. Conolly Norman as Medical Superintendent of the Richmond Asylum. Dr. Donelan has been in the service for about 15 years, and has been for some time in charge of the Portrane Branch Asylum. Dr. H. M. Cullinan, the Senior Assistant at Richmond Asylum, has been appointed Superintendent at Portrane.

A CLINICAL LECTURE

ON

SUDDEN DEATH.

By PROFESSOR ROBERT SAUNDBY, M.D., M.Sc., LL.D., F.R.C.P.,

Senior Physician to the General Hospital, and Professor of Medicine in the University, Birmingham.

The Church Litany contains a prayer for deliverance from the perils of battle, murder, and *sudden death*.

By sudden death is generally meant death which comes unexpectedly, or, if we may elaborate a little, we may say that has not been preceded by warning symptoms of its approach.

This prayer expresses a feeling which is widespread, yet, on reflection, as death is inevitable and must come to all of us, it is most merciful when it comes unawares and all is quickly over. As one gets to a time of life when necessarily the portion of existence left can only be short in comparison with that which has passed, the least reflective person may sometimes wonder in what way he shall make his exit from the stage on which he has played his little part, and would probably like to think that when the time comes he will not be long about it. I admire and envy my old friend and master, the late Professor Annandale, who only a few weeks ago, after a full day's work, having operated at the Royal Infirmary in the afternoon, was found next morning dead in his bed. In such a death, sudden though it be, there is nothing terrifying; he had done his duty up to the last, and lay down to rest from his labour. Why should we murmur if his sleep was that from which there is no awakening? He was æt. 68, so had lived nearly the allotted span of human life, and he went to his long home without knowing the weakness and infirmity of old age.

But sudden death raises certain civil and professional questions with which we, as medical practitioners, have to deal.

In our capacity of private medical advisers we are expected to foresee and forewarn against this danger, and, armed with the authority conferred on us by the law, it is our duty to give a satisfactory explanation when we can, and to aid the officers of justice in discriminating between deaths due to natural causes and those which are the consequences of crime. Hence we are called upon to familiarise ourselves by observation so far as opportunity is afforded us, and by reading and study which are open to all of us with those natural causes by which life may be unexpectedly ended.

Sudden death may occur—

1. In the course of acute disease.
2. In the course of chronic disease.
3. In apparent health.

We may leave out of account for the present all those cases where death is caused by injury or shock, for interesting as they are, they would carry us too far and exceed the limits of time at my disposal.

1.—In Acute Disease.

Death in acute disease may be tragically unexpected, and there are few circumstances under which it comes with a greater shock to relatives and to the medical attendant. Perhaps the best and commonest illustration is seen in diphtheria. I remember such a case when I was a student, and the impression then made is indelible. One of our house-physicians, a strong, healthy young man, caught diphtheria in the Infirmary; he was getting better, when he sat up in bed and died suddenly. I had a similar case at the old Hospital where the patient did not sit up and every precaution was taken. There had been no evidence of heart weakness, and I had remarked on the absence throughout of serious constitutional symptoms, although the throat condition was well marked.

Such sudden deaths occur in other acute diseases, especially in typhoid fever and pneumonia, but, happily, they are rare.

2.—In Chronic Disease.

This is a chapter which might be extended to very great length if I were to enumerate all the conditions under which it occurs. I do not here include cases in which there has been no previous illness, where the evolution of the disease has been latent, those will come in the next series; but I refer to patients who are known to be suffering from some chronic disease but death is not expected, as, for example, in chronic phthisis, where a sudden rupture of an aneurysmal dilatation of a vessel in an old pulmonary cavity may cause sudden death. I remember seeing a lady a good many years ago who was suffering from fibroid phthisis, a very chronic form of the disease, which often lasts twenty or thirty years, and I had laid stress upon this favourable aspect of the case to her husband. The next day a sudden violent hæmorrhage carried her off, and since then I have guarded myself in my prognosis against this accident.

In phthisis, too, sudden death may occur from embolism or from syncope, and either may cause death in cancer.

The liability of the subjects of heart disease to die suddenly is generally admitted, but it is chiefly where the aortic valves are incompetent that this occurs. The late Dr. Tilbury Fox, the well-known skin specialist, died in this way at a comparatively early age. He and his wife had run over to Paris for a short holiday, and while there one night he woke her from her sleep, asked her to kiss him, and died. Some pang there may have been that roused him and gave the opportunity for that brief parting, or he, too, would have been one who died in his sleep. But sudden death may occur in other forms of heart disease. I have seen a case of mitral stenosis lying quietly in bed in the ward suddenly attacked by acute œdema of the lungs, and die in a few minutes. Of the suddenness of death in angina pectoris we are all sufficiently aware.

I do not need to lay stress on the risk of rupture of an aneurysm, although it is comparatively rare; or to the possibility of death resulting from a ruptured varicose vein. But the danger of sudden death in phlebitis is not fully appreciated, or we should not have had to regret the untimely death of Sir Richard Thorne Thorne who could not be persuaded to rest while suffering from an attack of gouty phlebitis of the femoral vein.

Death may occur suddenly from the rupture of varicose, submucous œsophageal veins in cirrhosis of the liver, and, indeed, it came in this shape, without warning at Bath railway station to the great Dr. Todd, the apostle of alcohol in the treatment of acute disease, perhaps the victim of applying his own prescriptions inopportunely to himself.

Intestinal obstruction may cause sudden death in old incarcerated hernias, from the presence of adhesions set up by pelvic inflammation, from chronic appendicitis, from ulcer of the stomach, from impaction of a gall-stone; in all these cases however, there are symptoms of severe abdominal pain and vomiting, so as to suggest poisoning. The late Surgeon-General Harvey, Director-General of the Medical Department of the Army in India, had suffered for years from chronic dysentery with resulting matting together of the intestines and chronic obstruction. He came home to seek advice, but was dissuaded from an operation. He reached Bombay on his return to India safely, but in the train journey to Simla was attacked by symptoms of acute obstruction, and although the abdomen was opened it was too late to save the life of one who was an ornament to the Service and the friend of everyone who knew him.

Rupture of the spleen is another frequent cause of sudden death in malarious countries, where this organ becomes enlarged, hard and brittle, so that a blow or a fall or even a sudden effort may be sufficient to burst the capsule.

Chronic Bright's disease is accountable for many sudden deaths by apoplexy, by epileptiform attacks, followed by coma and death, by severe and fatal dyspnœa; less common are acute œdema of the larynx and acute œdema of the lungs.

It is also well known that the lives of diabetics hang by a thread. Such a patient runs to catch a train, sinks exhausted into a seat and dies from heart failure, or after the fatigue of a moderate walk or the shock of a small operation such as the extraction of a tooth, or some emotional excitement, is seized with abdominal pain, rapid pulse, and breathlessness, followed by coma and death. With all these your text-books have made you familiar.

We all know, too, that persons suffering from Graves' disease, from disease of the middle ear, from acromegaly, from bulbar paralysis, and from various forms of insanity are liable to sudden death, and that life insurance companies rightly refuse to take these risks.

3.—In Apparent Health.

But now let us pass before all my time is exhausted to the most startling and most tragic cases where death comes suddenly and unexpectedly to persons in apparent health, and let us consider some of the conditions in which that may occur.

When I was pathologist to this institution, a man who was walking rapidly along Summer Lane about 1 o'clock in the day, was seen to stagger and fall; he was picked up and brought into the hospital, which was only a few yards away, but when seen he was quite dead. I made an examination of the body and found nothing in the abdominal or thoracic organs to account for death, so I cut out the larynx with the tongue and the neighbouring soft parts and drew them down. When I had done this I saw lying over the opening of the larynx and firmly plugging it a large piece of unmasticated beef steak, which I suppose the man was eating as he hurried back to his work, and which, being tough, he had probably bolted. Such cases are rare, but it is well to know that death may be caused quite suddenly in this way, apparently from inhibition of the heart, for mere asphyxia would be far less speedy.

Some years ago a well-known English actress went to Paris for a short holiday, and took a drive in the Bois de Boulogne; while taking tea at the restaurant by the Cascade she was seized with sudden pain in the abdomen, turned pale, and died. A post-mortem examination showed rupture of a tubal pregnancy, a fact which was suppressed, as the lady was not living with her husband, and death was attributed to "internal hæmorrhage."

Brouardel relates the case of a tripe-seller, æt. 20, who fell down dead while serving a customer; both lungs were found to be riddled with tubercles, but there had been no symptoms of the disease during life.

An engineer, employed at a colliery near Rowley Regis died suddenly, and I was asked to make a post-mortem examination. He was supposed to have been in perfectly good health, and had not been absent from his work for a single day during the previous two years. I found his stomach distended with blood from a ruptured varicose œsophageal vein, and his liver in a state of advanced atrophic cirrhosis, but there was no ascites.

A man came to me in the out-patient room complaining of pain in the back; I sent him to undress, but soon after, hearing the sound of a fall, I went to him and found him dying; in a few minutes all was over. At the examination of the body we found a small aneurysm of the thoracic aorta not larger than a walnut; its posterior wall was formed by the muscles lying over the spinal column, while there was a round atheromatous ulcer in the posterior wall of the aorta about as large as a florin; the aneurysm had given way laterally, and the blood had poured into the cavity of the thorax.

A few days ago a man was walking past the General Post Office when he was seen to fall, and the policeman who ran to assist him found him dead. He was brought to the hospital. On examining the body, a rent was found in the wall of the left ventricle half an inch in length; there was atheromatous blocking of a branch of the coronary artery and fatty degeneration of the muscle supplied by this branch.

The Comte de Chambord, whom some Frenchman called Henry the Fifth, died suddenly, and at the post-mortem examination the œsophagus was found deeply ulcerated, for which no explanation was forthcoming. A less august personage, Chas. B., æt.36, was locked up at 11.30 p.m. by the police for being drunk; his cell was warm, and he had two blankets; at 2 a.m., he had some hot coffee; at 6 a.m., he complained of feeling ill, and at 7, as he was worse, he was brought to the hospital. When admitted, he was unconscious, cyanosed, and breathed stertorously; he died an hour later. The post-mortem examination showed acute sloughing of the œsophagus, which was attributed to some corrosive poison, but there was no evidence to show that he had obtained any. Was our pathologist right, or is there, as Brouardel appears to believe, some unknown cause of acute œsophageal inflammation ?

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Leon Blum, M.D., Chief of the Laboratory of the Medical Clinique at the Medical School of Strasburg. Subject : " The Value of Laboratory Methods in the Diagnosis of Typhoid Fever."*

ORIGINAL PAPERS.

DEATHS UNDER ANÆSTHETICS.

BY F. J. WALDO, M.A., M.D.Cantab., D.P.H.,

Coroner for the City of London, &c.

THE problem of deaths during anæsthesia arose soon after the introduction of that comparatively modern method of suspending consciousness for medical and surgical purposes. In the following brief examination it is proposed to deal with general anæsthesia produced by the inhalation of volatile drugs, as distinct from partial anæsthesia produced by the injection of drugs either locally or into the spinal canal, or by such mechanical agencies as freezing, or electrical currents. There is no particular need either to define general anæsthesia or to enter into the physiological action of the various drugs used for the purpose of suspending consciousness, neither is it proposed to enter into the debatable ground of the causation of death in fatal cases of anæsthesia. The main object in view is rather to ascertain, so far as may be possible, (1) the facts of the mortality due to that cause, and (2) to examine the machinery whereby statistics of the kind are officially presented to the Registrar-General of England and Wales.

(1) The mortality from deaths under anæsthesia so far as available from present statistics.

The annual reports of the Registrar-General for England and Wales for the years 1902, 3, 4, 5 and 6 give a total of anæsthetics for operations :—1902, 148 ; 1903, 146 ; 1904, 154 ; 1905, 155 ; 1906, 183 ; total, 786 ; or an annual average of 157.1 deaths. In these 786 deaths the anæsthetic used was—Ether alone, 41 ; chloroform, 479 ; nitrous oxide, 11 ; nitrous oxide and ether, 3 ; A.C.E. mixture, 16 ; chloroform and ether, 17 ; ethyl chloride, 15 ; atropine, 1 ; drug not stated, 204 ; total, 786.

It is obvious from a mere glance at these returns that they are not of much use from a statistical point of view. They merely show that a certain number of deaths takes place every year during general anæsthesia. The fact that the precise drug used has not been reported in 204 cases, or about 25 per cent., renders the figures useless so far as indicating the relative danger attached to individual drugs. Nor is the practical value of the return enhanced if we turn to the second point, namely :—

(2) The machinery whereby the statistics of the Registrar-General are obtained.

The sources of information as to deaths under anæsthesia are gathered from two sources : first, the copy of verdicts sent by coroners to the Registrars of Deaths and by them to Somerset House ; secondly, death certificates by medical practitioners. Both these sources of information are open to serious fallacies so far as the conveyance of anything like an adequate representation of the actual deaths under general anæsthesia that takes place annually in England and Wales.

(*a*) *Coroners' returns.*—It by no means follows that a coroner holds a public inquest into the cause of every death reported to him as occurring under anæsthesia. At the same time the practice of holding an inquest under such circumstances is undoubtedly more common than it was a few years ago. In the annual report of the Coroners' Society for England and Wales for 1902–3 it was specifically advised that " inquests should be held on all deaths occurring whilst under the influence of an anæsthetic irrespective of whether the friends of those specially concerned in the administration of the anæsthetic and the operation were satisfied in every way or not." As a matter of fact a certain number of coroners in England and Wales are not members of the Society. In any case it may be safely assumed that in a proportion of cases which it is impossible to estimate inquests are not held by coroners upon deaths reported to them to have occurred under anæsthesia.

(*b*) *Death certificates by medical practitioners.*—Judging from the reports of cases in the public newspapers the majority appear to come from public hospitals. Bearing upon this point is a recent statement of Mr. Troutbeck, the Westminster coroner. Of 174 deaths reported to him during the past six years as occurring under anæsthesia only three came from private as apart from hospital practice, It seems unlikely that the brunt of this particular form of fatality should fall thus disproportionately upon hospital patients. We are therefore lead to the conclusion that it is not the general custom to report deaths under anæsthesia in private practice to the coroners. There are various reasons why the friends no less than the medical men concerned in these painful circumstances should be anxious to avoid publicity. Moreover, evasion is not a difficult matter. In one case brought under my own notice as coroner, death was certified as due primarily to shock after operation of excision of eye-ball, and secondarily to heart failure. As a matter of fact the patient died five minutes after cessation of anæsthesia, from the effects of which he was stated to have partially recovered. By a simple extension of this process it is easy enough to attribute a large number of cases of death to causes other than those of the anæsthetic. Then, again, the medical man is not compelled by any statutory obligation to report cases of death under anæsthesia to the coroner, and it is natural that he should take advantage of the fact to avoid publicity of an unpleasant nature. It is open to question whether he is not bound in common law to report such a death along with all others of a violent or an unnatural kind. But the general practitioner or the operating surgeon anxious to avoid publicity are not likely to trouble their heads about legal niceties of that kind, even if aware of their existence. We may, therefore, conclude that the machinery whereby the information of the Registrar-General is collected is inadequate and defective, both as regards coroner's verdict and death certificate. Some of the foregoing points are borne out by my own experience as coroner for the City of London and the Borough of Southwark. From the non-residential character of the City and the fact that the great majority of Southwark residents are of the hospital class, the proportion of patients undergoing private operations is necessarily small. As a matter of fact, no case of fatal anæsthesia in private practice has been reported to me during an experience of 6½ years. On the other hand, the fact that my jurisdictions include two of the largest general hospitals in London offers some other returns of special interest.

During the time mentioned in one hospital which we will call A, 39 inquiries of the kind, in the other which we will call B, 21. The beds were about equal in number in the two institutions. With regard to statistics, the methods of B are much more ample than those of A. For instance, A keeps no official record of many of the administrations, such as those given by the house residents for the visiting surgeons, or by juniors acting under one of the special anæsthetists.

The name of the administrator is entered, but no account of the anæsthetic given, in the case of operations in the surgery or in the obstetrical department. In the dental and throat departments the name of operator, administrator and drug used are entered. There appears to be no definite system whereby an accurate account is kept of the number and essential details of all anæsthetics administered within the walls of the hospital.

In B, on the other hand, the system is much fuller. An endeavour is made to enter details of every anæsthetic administered within this institution. A register of deaths under anæsthetics is kept, with fairly full details, except that the name of the operator is omitted. Inquests have shown all deaths save two occurred under special anæsthetists, of whom two are resident and three visiting. That the system of administrative control is not perfect, however, is shown by the fact that one death under chloroform was not reported to me as coroner. The death in question was certified as shock after operation of excision of eye-ball. The account of the death furnished to me privately was that the patient "died five minutes after the cessation of the anæsthetic, from the effects of which he had somewhat recovered."

Clearly no sound conclusions can be drawn from any comparison of the results obtained from these two institutions, which, it may be assumed are fully abreast, if not in advance of, the majority of the hospitals of the United Kingdom in these matters. Indeed, we shall not be far wrong, in my opinion, if we assume that little is known as to the relative mortality and the actual facts of deaths during anæsthesia occurring in hospital practice generally in England and Wales, and practically nothing of the facts in private practice.

During the last 6½ years I have held inquests upon 63 deaths during anæsthesia. These all occurred in hospitals, and were distributed as follows;—

Number of Deaths.

In A (General hospital)	39
„ B do.	21
„ C (Special hospital)	2
„ D do.	1
	—
	63

It is my practice to hold a public inquiry in every case of the kind reported to me. The Coroners' Act, 1887, directs the coroner to hold an inquest in all cases in which he is of opinion there is reasonable cause to suspect that such person has died a violent or an unnatural death. There can be little doubt as to the proper legal course to be pursued by the coroner, but he is powerless without the co-operation of medical men. So long as there is no properly recognised statutory obligation upon medical men to report fatal cases of deaths occurring under anæsthesia, so long it will be impossible to obtain any adequate idea of the extent to which such fatalities occur in medical and surgical practice.

Imperfect as these particular returns are for England and Wales they are infinitely superior to those available in the case of Scotland and Ireland.

In Scotland one only source of information is the annual report of the Registrar-General. It has been the custom to classify all cases of deaths under anæsthesia under the heading of violent deaths, and the sub-heading poisons and poisonous vapours. In 1905 the body of the report specifically mentions that "among the accidental deaths from poisons there were 17 from chloroform and 1 from ethyl chloride." The official report for the year 1906 is not yet available. The method of the investigation of violent or unnatural deaths in Scotland being by private inquiry of the Procurator-Fiscal is hardly favourable to a full statement of the facts with regard to so delicate a matter as that of fatal anæsthesia. The general proportion of deaths to administrations has been to some extent, even if roughly, ascertained by the experience of other countries. Taking the average deaths for England and Wales and allowing for difference of population, and assuming, as we may fairly do, that anæsthetics are no less universally employed in Scotland, we may safely conclude that the following figures of the Registrar-General for the years 1902, 3, 4 and 5 understate the actual facts of the case:—

	1902	1903	1904	1905
Chloroform	14	17	16	17
Ethyl chloride ..	0	0		1
	—	—	—	—
	14	17	17	18

It will be noted that no mention is made of deaths under ether or anæsthetics other than chloroform and ethyl chloride.

When we turn to Ireland the returns are still more obviously misleading. In the year 1906 there is one death officially attributed to chloroform by the Registrar-General. In 1905 and 1904 three are reported under the same heading for each year. In 1903 two are reported under chloroform and one under anæsthetic.

Conclusions.

(1) That present available data as to deaths during anæsthesia are so imperfect as to be useless for the purposes of formal investigation. (It follows that the so-called statistics and published figures regarding that class of mortality are worthless and misleading.)

(2) That the Registrar-General's returns of such deaths are for the most part obtained from coroners' reports of deaths occurring in hospital practice.

(3) That only a small proportion of deaths under anæsthesia in private pratice ever come to the notice of registrars or of coroners.

(4) That imperfect as are the returns for

England and Wales, those of Scotland and Ireland are still less trustworthy.

(5) That with such imperfect data it is impossible to form any trustworthy conclusions either as to the absolute ratio of fatalities to administrations or as to the relative proportion of deaths to administrations in the case of particular anæsthetic drugs.

(6) That it is highly desirable to arrive at satisfactory conclusions regarding all deaths under anæsthesia both for the safety of the public and for the furtherance of scientific knowledge.

Recommendations.

(1) That no general or local anæsthetic shall be administered by any but a duly qualified medical man, except under most exceptional circumstances, which shall be duly reported to some recognised official authority.

(2) That full details be reported by the anæsthetist of all administrations of anæsthetics, whether in hospital or in private practice, including date, name and address of patient, of operator and of administrator, nature of operation, the drug used and other pertinent details.

(3) That a register of all administrations of anæsthetics be kept in all medical charities, poor-law infirmaries and other public institutions.

(4) That so far as possible special skilled anæsthetists be appointed to all hospitals and infirmaries, and that resident anæsthetists be provided in the larger institutions.

(5) That when the administration of an anæsthetic is entrusted to a junior qualified man he should be supervised by a skilled anæsthetist, except where he can produce a certificate of special skill and experience as an administrator, or where a skilled anæsthetist is not available.

(6) That notification be made to the coroner of all deaths occurring at any stage of general anæsthesia by the anæsthetist or by others concerned.

(7) That coroners be required to hold a public inquiry into all cases of death during anæsthesia, and that they make a detailed report to the Registrar-General, together with the verdict.

(8) That a Royal Commission with advisory powers might with advantage be appointed to inquire into the present facts of deaths under anæsthesia, together with the official machinery available for registration.

SOME OBSERVATIONS ON A CASE OF

TWIN ABORTION WITH DOUBLE PLACENTA PRÆVIA AND A REMARKABLE CONDITION OF CERVIX.

By R. J. KINKEAD, M.D.Dub.,

Professor of Obstetrics, Queen's College, Galway; Physician and Gynæcologist to the Galway Hospital; Fellow of the Royal Academy of Medicine in Ireland, &c., &c.

Some five years ago Mrs. H——, æt. 38, was admitted to the Galway Hospital suffering from metrorrhagia; she had had several children, and some miscarriages, in rapid succession.

I curetted her and swabbed out the uterus with liq. ferri perchl.; the bleeding ceased, and the next menstrual period being moderate, she was discharged; the succeeding one, being profuse, she came back to the hospital. I again curetted, with, however, only partial benefit; the uterus was soft, flaccid, and seemed to have lost all contractile power; there was an almost constant dribble, with occasional gushes of blood, and the patient was profoundly blanched.

I succeeded in stopping the bleeding by repeatedly swabbing out the uterus with iodised phenol, and occasionally plugging the cavity with gauze.

For the five years following her discharge from hospital she enjoyed capital health. She then became pregnant, and aborted at three and a half months.

She was attended by an experienced maternity nurse, who gave me the following history: That ten days previously the patient had expelled a fœtus without much pain or loss of blood, and she believed that the afterbirth had all come away; for eight days the patient had gone on well, and all discharge had ceased, but two days ago some slight hæmorrhage had recurred, and she insisted on going to the hospital.

She came in next morning. When I saw her at my visit she complained of having had much hæmorrhage during the night, and the ward nurse in charge told me there had been sharp bleeding since her admission.

The vagina was full of clots, there was a free discharge of blood from the uterus, the os externum dilated to the size of a two-shilling piece, was occupied by, and had protruding from it, placental tissue; the cervix all round and up to the vaginal insertion had a very peculiar roughened feel.

The thighs and pudendum were well washed with soap and water, the vagina was cleansed of clots, irrigated with Condy's fluid and water, and a couple of sterilised plugs were introduced to control the bleeding during the completion of preparations for operation.

Ether was administered by Dr. Rouse, house surgeon, and on removal of the plugs the vagina was again irrigated.

On exposing the cervix a, to me, novel condition was brought to view; the portio vaginalis was a dark blue colour, caused by a mass of veins passing upwards all round it, from the margin of the os externum, and vanishing from sight under the vaginal attachment; the veins, turgid with blood, were about the size of a No. 2 catheter, and so close together as to appear to be touching each other.

The os was seen to be filled with placental tissue.

On removal, with the speculum forceps, of some of the protruding mass, a bag of membranes presented. I introduced a flushing curette, and removed a male fœtus placenta and membranes; this placenta was attached posteriorly and partly laterally to the lower uterine segment; the implantation of the other placenta had evidently been partially central, for while the greater portion of it was firmly adherent to the edge of the os internum and to the lower uterine segment, the remainder of it, which hung down into the cervix and protruded from it, had evidently covered the os internum.

I failed to remove the latter placenta, that of the fœtus expelled ten days previously, by downward strokes of the curette, and only succeeded in separating it by getting the edge of the flushing curette under the portion lying loose in the cervical canal, and peeling it off by pushing upwards.

It would have been impossible to use a vulsellum or sharp hook to draw down and steady the uterus without wounding the veins covering the cervix, so I had to dispense with their aid.

The progress of the patient was entirely satisfactory, and she was discharged from hospital on the eleventh day.

The case was an uncommon one—fortunately or unfortunately, an abortion of twins is not an everyday occurrence. Referring to twin pregnancies, Jellett says, "it is only natural that while the placental area is increased in size, the proportion of cases in which that area extends into the lower segment will also be greater." Here, however, it is not a question of extension, but of implantation, and therefore I may regard the placenta prævia as unusual, unless the late Robert Barnes' suggestion be correct that placenta prævia is a frequent cause of early abortion.

That for the eight days following the expulsion of the first fœtus there was no hæmorrhage seems strange; but it appears to me to have been due to the firm attachment of its placenta, and to the pressure of the second ovum on the denuded area on its side of the os, and that the bleeding which after this time set in resulted from the partial separation of this second ovum.

The condition of the cervix, dark blue in colour, actually clothed with veins radiating upwards from the margin of the os externum, was the most interesting and uncommon feature of the case, and one which, so far as I am aware, has not been described before.

That it was due to the location of the placentæ seems to be proved by the following facts:—

There had been no symptom of varicosities of the veins of the broad ligament, nor was there anything connected with her health before, or during her pregnancy, likely to produce them. On removing the gauze plug, on the day after the operation, the veins, though still visible, were much less distended; and when examined the day before her discharge from hospital the veins had vanished and the cervix had resumed its normal appearance.

The question arises was this venous development peculiar to the case, or is a similar state, though in a lesser degree, usual in the early months of pregnancy in single placenta prævia.

In cases where pregnancy progresses to the later months, owing to the growth of the uterus and cervix, the veins would be separated from each other, and when hæmorrhage sets in a speculum is rarely if ever used, while on digital examination nothing may be observed but a peculiar feel of the os and cervix due, as Leishman remarks, "to the unusual thickening of the cervix, which is permeated with large vessels for the placental circulation."

With regard to the early months of pregnancy, he says, "there are no symptoms which enable us to recognise the condition in question, and if hæmorrhage should take place it will probably be followed by abortion, in the course of which nothing occurs likely to direct our attention to the peculiar nature of the case."

Moreover, with a single placenta the venous covering would be confined to that portion of the cervix, corresponding to site of the placental implantation, and thus if it were necessary to use a speculum to remove the ovum or placenta the veins might easily escape observation—especially if situated posteriorly or laterally.

THE NATURAL CURE OF CANCER. (a)

By Professor W. SAMPSON HANDLEY, F.R.C.S.,

Cancer Research Laboratories, Middlesex Hospital.

The Lecturer began by showing that the spread of cancer in the body was brought about mainly by a process of tendril-like growth of lines of cancer cells along the lymphatic vessels, a process to which he had given the name of permeation. He next referred to the recorded cases of the spontaneous cure of fully-developed cancer, and pointed out that, though such cases were very rare, the complete natural cure of cancer, as illustrated in what was called "atrophic scirrhus," was by no means an exceptional event. After alluding to the records of incomplete natural cure of cancer, as illustrated by the disappearance of the original growth or of its satellite nodules, the Lecturer proceeded to show that curative or regressive processes occurred normally in cancer—that there was nothing exceptional or anomalous in cases of natural cure. Lymphatic vessels along which cancer cells had grown were ultimately converted into fibrous cords in which no trace of cancer remained. Small particles of growth lodged in the arteries of the lungs suffered destruction in a similar way. Larger masses of cancer tended to degenerate from their centre to their circumference, with the ultimate result that they were replaced by a fibrous scar containing no cancer cells.

The process of repair commenced in the oldest portions of the growth, and spread centrifugally from that point, but it rarely overtook the growing edge of permeation, and was consequently as a rule ineffective to save the patient's life. It was a purely local process, and dependent upon degeneration of the cancer cells, and did not indicate the acquirement of any such blood-immunity as was found in fevers. Nevertheless, the recognition and study of Nature's mode of cure might have very valuable results.

Professor Handley asserted that it was absolutely certain that many cancer remedies had acquired a reputation simply from the observation and misinterpretation of the results of the natural curative or reparative process. Nothing had yet been discovered which could replace surgical measures, and there was some evidence to show that, even in cases where the growth could not be completely removed, Nature might be enabled through the operation to deal successfully with the remainder. The natural mode of cure in cancer involved destruction of the lymphatic cells, and consequent obstruction to the flow of lymph. Extremely painful swelling of the arm, for instance, frequently occurred in breast-cancer, and was the cause of much of the suffering connected with that disease.

As a result of his work in the cancer research laboratories of the Middlesex Hospital, he had been able to devise a simple operation for the relief of this condition. The method consisted in draining the swollen arm by a number of buried silk threads, which carried away the excess of fluid by capillary attraction. The attitude of the public to cancer research was as that of a man who sowed wheat in October and expected to reap in January. On the other hand, there was the indifference of the pure scientist, for whom absolute intellection was the absolute goal, an attitude of mind which, he said, had received rebuke from Mr. Arthur Balfour. Pending the achievement of larger results by methods yet in their infancy, he was glad to be able to produce a minor instance of the immediate fruition of cancer research.

ARTERIO-SCLEROSIS AND PHYSICOTHERAPY.

By Dr. J. A. RIVIERE,

Paris,

Editor-in-Chief of the "Annales de Physicothérapie"

[Specially Reported for this Journal.]

It is in the visceral arterioles that sclerosis of the arteries generally commences. This peculiarity explains the grave trophic disturbances which are implanted in the most important organs, the gastro-hepatic disorders, the cerebro-spinal affections, and finally, the fatal symptoms that sometimes supervene in subjects who have only just passed their fiftieth year and who are at the time in robust health. However, it is acknowledged that arterio-sclerosis generally comes on in a latent manner, causing those often indefinite visceral affections which, through their very indefiniteness, are often wrongly treated; and as their diagnosis is doubtful, the therapeutical measures are in consequence faulty. To the works of Lancereaux, already of ancient date, we first owe this pathological conception.

(a) Abstract of the Hunterian Lecture delivered at the Royal College of Surgeons, England, Friday, March 13th, 1908.

Heredity seems to play an important part in the etiology, but it is generally confounded with arthritic bradytrophy. Amongst the previous illnesses of the patient are especially found influenza, hæmorrhoids, frequent epistaxis, eczematous and herpetical eruptions, early baldness, loss of teeth. Certain acute and chronic infections, such as influenza, typhoid fever, syphilis, poisoning by tobacco, by alcohol, by lead, and by the alimentary toxins, the effect of a too generous diet, undoubtedly hasten sclerotic degeneration of the arteries. Angio-sclerosis explains the gloomy, morbid career of some rich families, the members of which are struck down by angina pectoris or by cerebral hæmorrhages long before the usual term of human life. How many persons only forty years of age, seemingly in good health, carry about their death sentence? For this reason it is as well to be able to distinguish the first symptomatic manifestations of the "presclerous" period (Huchard) before the obliterating lesions render our most skilful treatment illusory.

Therefore, curative physicotherapy should be commenced as soon as myasthenia, local poisoning, cramps and tinglings of the limbs, alternate flushing and pallor, polyuria with traces of albumin, headache with vertigo, nervous irritability, mental debility, failing sight and hearing, proclaim an arterial hypertension easily confirmed by the sphygmomanometer, the instrument so highly perfected in modern times (Gros Vaquez). Physical agents also are successfully employed against repeated attacks of bronchitic asthma, tachycardia and arhythmia, gastro-intestinal atony accompanied by gastritis, colitis, or biliary lithiasis. However, it is more often by sensory troubles, such as grimacing, slow speech, amnesia, a feeling of distress, sudden impressions, loss of the power of equilibrium, a sensation of insecurity, and that state (so evident to the patient's friends) of curious depression in regard to physical and moral activity, accompanied by tremors, awkward and stumbling gait, etc., that we are put on the track of the correct diagnosis—arterio-sclerosis. The French clinical school, and notably Professor Landouzy, has laid stress on these facts, on which we need not further dilate.

Now, it will be found that if a hypotensive physicotherapy of sufficient duration be carried out, a progressive retrocession of all these symptoms will result. According to the opinion of the highest authorities, the intelligent combating of this purely functional phase of the disease prevents the lesional and obliterating dystrophy from obtaining a firm hold. There can be no doubt of the existence of a pre-sclerous—that is to say, a premonitory—period. Who does not remember the experiments of Yosué, who reproduced in an animal the lesions of atheroma by causing, through adrenalin injections, a slightly prolonged period of arterial suppression.

In analysing the pathogeny of the initial phase, it will be seen that most of the functional troubles give notice of a notable condition of epithelial insufficiency. The chief mission of epithelium in the organism is a mission of protection against toxins, a very important property, especially in regard to the intestines, the liver, the kidneys, the thyroid. On the other hand, as soon as the arterial tissue becomes less elastic, less contractile, the blood flow is imperfectly regulated. For this reason, the arterio-sclerous patient suffers from diminution of function in all his economy, from a kind of organic poverty which has been well defined by Potain with the help of neologism "meiopragia." Lumbar pains, palpitation, muscular fatigue, despondency, abundant urine, poor in chlorides and showing intermittent traces of albumin, hard pulse, transient œdema, laboured dyspnœa, pale and yellowish colour of the face (occasionally vaso-motor disturbances producing a very great instability of the complexion), physical inaptitude for work, apathetic and irritable character, special neurasthenic affections characterised by a laborious condition of mind and of thought—all these constitute the inherent phenomena of confirmed arterio-sclerosis.

Again, we find baring of the teeth, with shrinking of the gums, heavy feelings in the legs owing to the local circulation being implicated, trifacial and intercostal neuralgia, with insomnia and tossing about in bed.

Further, presbytia or transitory amaurosis (caused by spasm of the arteria centralis retinæ), disorders of hearing, tinnitus, and a blowing sound in the ears, cataract—in short, a general diminution of organic resistance may be observed. The slightest infraction of ordinary diet brings about nocturnal or toxi-alimentary dyspnœa (Huchard). Moreover, rest in bed at night increases the toxæmic phenomena by diminishing elimination, so constituting a cause of weakness for the arterio-sclerous patient, who asserts that he gets up in the morning more tired than when he went to bed.

To a more advanced period belong the deep visceral lesions, and notably the impermeability of the kidneys with its attendant uræmic oppression, mechano-toxic dyspnœa, vertigo, nocturnal polyuria, gallop rhythm of the heart with metallic bellows murmur in the second intercostal space (Huchard), resonant diastolic bruit, showing dilatation of the aorta. The pulse is small, tense, and frequent, the cephalalgic pulsation is seen on the temples and on the forehead; amnesia and transitory aphasia, incomplete paraplegia, epileptiform fits, also are seen, whilst death takes place frequently either through sudden cardiac spasm or accompanied by cerebral symptoms. Sometimes cancer appears in the last stages of the disease. At this advanced period the most eminent medical man can only treat symptoms. Even if it be supposed that iodides or high-frequency currents can arrest and turn back the anatomical processes of sclerosis, what miracle could replace the important elements which have been suppressed and which have disappeared? It is as much as we can do to endeavour to restore to some of the already degenerating epithelial tissues their functional activity which is being lost. But we must act quickly. We must also mistrust those renitent and painful œdemata which have been qualified in too euphemistic a way as *neuro-arthritic*, and likewise those nodosities (Heberden's or others) which are supposed to be toxi-infectious arthropathies; they are characteristic symptoms of arterio-sclerosis.

Amongst drugs, the iodides, their strength moderated by alkalies, especially by benzoate of lithium, will render valuable aid. These medicines must always be preceded or accompanied by laxatives that favour their toleration by contending with the concomitant zymotic processes. When, as it frequently happens, the iodides are badly tolerated by the patient (even when combined with such bases as calcium, sodium, or strontium), I have prescribed with great success Lauder Brunton's matutinal powder: Take every morning, in a large glassful of water, 2 grammes of bicarbonate of potassium, 1.20 grammes of nitrate of potassium, and 30 centigrammes of nitrite of sodium. We thus obtain much less hypotension than that brought about by trinitrin, by nitrite of amyl, or by Trunecek's serum; this fact is easily proved.

More powerful, however, than pharmacotherapy against the functional premonitory symptoms of sclerosis is physicotherapy, which attacks the permanent symptoms of the nutritive changes, modifies deeply the most intimate exchanges, completes imperfect elimination, improves oxydation, and brings into equilibrium the dynamicity and the physiological chemiotaxis of the living human being. We all know that the action of physicotherapy, which consists in the scientific application of air, of water, of motion, of temperature, of light, and of electricity, is in absolute antagonism to bradytrophy. Now it is precisely this diathesis of slow progression that ends in an excess of incompletely elaborated material, and even in the hardening by incrustation of the arterioles, in hepato-renal insufficiency, in interstitial nephritis. By stimulating nutrition, by exercising a toni-sedative influence of the highest order on the nervous system, by favouring the peripheral circulation, and by stimulating the uniformity of cellular movement, physical agents have a beneficial power of resistance over the inevitable transformation of the functional premonitory sclerosis into sclerosis with anatomical characteristics.

Methodical gymnastics and kinesis, vibratory massage, thermo-luminous baths, carbonic acid baths, are all excellent agents against auto-intoxication. With the help of lacto-vegetarian diet, all these methods, whether combined or alternating with one another, slacken the vascular tension, diminish the plethora of the blood vessels, secure progressive hypotension and vaso-dilatation, sustain the heart in its often unequal battle, and relieve the functional insufficiency of the sympathetic.

When the arterial pressure is considerable, auto-conduction by means of the large solenoid (Darsonvalisation) sometimes lowers the tension in a few minutes. The same may be said, however, of the carbo-gaseous baths, of the hydro-electric sinusoidal applications, and of the blue light, with this difference—that these methods not only lower the hypertension, but suppress also the symptomatic albuminuria of interstitial nephritis and bring to the patients a much more complete general euphoria. Under these conditions there is certainly diminished reflex spasm in the intra-renal vessels, and a rise in the entire cardio-vascular tonus. Subaqueous massage, which it is important not to neglect, ameliorates still more the diuresis, and puts a stop to the cylindruria by regulating the pressure in the tubes and pelves of the kidneys.

In certain cases of arterio-sclerosis, generalised faradisation is of great service; the same may be said of electro-static baths and douches, whose *rôle* is evidently to forward the euphoria and to battle with the weakening of the nervous centres.

The hypertension, in my opinion, is much less alarming than the intoxication. These two conditions are not always correlative, but it must be admitted that the intoxication is a pathological syndrome, whilst the hypertension is but a symptom. Therefore the question is much less simple than certain authors seem to think when they imagine, and, moreover, quite honestly, Darsonvalisation to be the heroic and specific remedy for arterio-sclerosis. The truth of the matter is always the same. It is what Darsonval himself in 1898, and Charrin in 1899, recognised after numerous experiments: The high-frequency current possesses with regard to blood-pressure a regulating action. Applied to a person showing premonitory signs of sclerosis, the current progressively lowers tension in proportion to the acceleration of its organic exchanges, and to the operation of the lavage of the blood being carried out by stimulation of the liver and the kidneys. The action, often rapid, of high-frequency currents should, in order for it not to go beyond the object in view, always be closely followed by the specialist; it should be supported by severe dietetic measures, and aided by other medical and physical methods that favour elimination. In reality the Darsonval current throws into the circulation residual products of which the organism must be freed at any price; therefore, calomel, castor oil, diuretic drinks, heat, etc., are indispensable adjuncts.

In my opinion no physical agent acts directly on the lesional disorder, but, though indirect, the action none the less reaches the circulation, and affects also nutrition and innervation to the extent of the production of most excellent and useful results. Nevertheless, we must not lose sight of the permanent struggle against constipation, cholemia, and renal insufficiency, which are causes of grave symptoms and real dangers in arterio-sclerosis. In this manner (and only in this manner) can we anticipate apoplexy and angina pectoris. In cases of confirmed aortic dilatation, aneurysm, or coronaritis, the condensation couch is excellent to strengthen the arterial floodgates and to stimulate the nervous apparatus which controls myocardiac energy. If we persevere with this treatment ever so little, we see a cessation of the attacks, and a notable mitigation of the angina and of the dyspnœa.

For topalgia and localised neuralgia, the constant current progressively carried out as far as the patient can bear it constitutes the best treatment for choice. In characteristic gout we must endeavour to obtain uric reduction by the method of pharmaco-electric modification of the blood; ionisation with salicylate of lithium gives the most conclusive results in such cases.

Darsonvalisation, which is but a unit in physicotherapy, remains a very appreciable unit of treatment, not so much by its distinct influence on the walls of the vessels as specially (of this Apostoli had a presentiment) because it improves nutrition, and so attenuates the progressive evolution of the generalised sclerous processus.

It is but just to give a place in the treatment to actinotherapy, which is often employed with success. The violet rays have a sedative action on spasm, whilst the white and red rays improve the trophic affections. This action too is long dated, for the organism seems to have the faculty of accumulating the potential energy of the rays so as to utilise them when it is no longer directly under their influence. Thus we check the initial symptoms after having reinforced the energy of the defensive line. In relaxing a too tight vascular constriction, in suppressing arterio-spasm and vaso-constrictive nephritic meiopragia, do we not prevent formidable complications (aneurysm, sternalgia, glaucoma, visceral hæmorrhage, etc.).

Sinusoidal undulatory hydro-electric baths I think also improve to a considerable extent certain disorders of the cerebral circulation, and increase at the same time hepato-renal permeability. In this manner they constitute a method which is always efficacious in placing the endovasal pressure of the viscera in a durable condition of hypotonia. Besides, is there not invariably correlation between decompression and depuration. This is not surprising when we admit the probable *rôle* of urates, phosphates, and chlorides in the usual genesis of arterio-sclerosis, this affection being the great disease of those patients who suffer from chronic intoxication through waste of nutrition.

To sum up: I consider that we must understand in the following manner the physicotherapeutical cure of arterio-sclerosis.

1. We have to fulfil two principal indications: fortify the enfeebled myocardium and lower tension so as to diminish the work of the heart. At the same time our therapeutical duty is to push remedies as far as possible with the object of removing the intoxication of the blood and of restoring the tone of the nervous system.

2. To fortify the myocardium we advise: the high frequency or the interrupted current; thermotherapy; massotherapy applied to the thorax and to the abdomen; vibratory massage of the cardiac region. It is certain that the greatest cause of arterial hypertension is paresis of the heart. If we raise the myocardiac energy, if we diminish the constriction and frequency of the pulse we increase the expanding power of the lungs, thereby ensuring a more perfect hæmatosis. A marked sensation of relief proves this physiological amelioration, and at the same time the zone of dulness becomes more limited. Vibratory massage and monopolar effluves are also very useful against a tendency to syncope joined to tachycardia, to intermittency of the pulse, and to failure of the circulation, this last being signalised by irregularities of the beat felt at the wrist.

3. To lessen arterial tension: respiratory gymnastics or exercises as carried out with our perfected apparatus of the Zander system, carbonic acid and hydro-electric baths notably diminish peripheric resistance, and possess a remarkable vaso-dilatory action even when there is nephritis and hypertrophy of the heart. We alternate this method (20 minutes *séance* on an average) with Darsonvalisation. However, we always proceed prudently with reference to thermic degree, ampérage, duration of application, etc. In fine, when the patient cannot live in the open air, we endeavour to stimulate his pulmonary circulation, and to improve his nutritive hæmatosis by means of ozonisation. This method has a singularly good effect on renal debility, and to it we owe the cure of several cases of intermittent albuminuria.

4. If we wish to retain for physicotherapy the primordial place that it occupies in the cure of arteriosclerosis our aim must be directed more especially to the pathogenic causes of the malady, and we must not allow ourselves to be arrested by the consideration of any one symptom. It is only by combining all our resources that we can attain, without straining any of our therapeutical measures, a really brilliant synergy of defence. I will even add (by virtue of experiments that give me a right to speak) that the neuro-vascular system shows itself much more tolerant when face to face with our combined treatment than when brought in contact with univocal methods.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Cholecystostomy.—Mr. **Joseph Cunning** operated on a woman, æt. 30, who had been admitted on account of three attacks of pain in the upper part of the right side of the abdomen, accompanied by vomiting and constipation. During the last attack she was seen by Dr. Laurence, of Catford, who said she was rigid over the painful area, and that there was a distinct lump extending directly downwards from the liver in the line of the tip of the tenth costal cartilage to the level of the umbilicus. During this attack her temperature was raised for two or three days. There was no history of colic or jaundice. On admission there were no symptoms, nor could any lump be felt. Mr. Cunning remarked that the symptoms of pain, vomiting and constipation, with rigidity and fever, clearly pointed to an attack of localised peritonitis. The presence of a lump in the region of the gall suggested that this was the diseased area from which the peritoneum had been infected. It was possible, of course, that a diseased appendix situated higher than normally might be the cause. He was of opinion that gall-stones were present, and were causing attacks of pericystitis, with surrounding local peritonitis. The absence of colic or jaundice was of little importance, for he was coming more and more to the conclusion that although these last were very typical signs of gall-stones, they were met with only in the minority of cases. At the operation the abdomen was opened through the upper part of the right rectus, and the gall-bladder was exposed after a mass of adherent omentum had been removed. It was found to contain gall-stones, but, before opening it, the cystic and common duct were felt carefully with the fingers, but no stones were detected in them. After careful packing round with gauze to prevent the passage of bile into the peritoneal cavity, the gall-bladder was opened, and three large stones were removed. It was clearly seen from the shape of these stones that no more were present, for the centre one had two facets, the terminal ones had each but one facet and a rounded extremity, the whole mass being about the size and shape of a thick bent thumb. A purse-string stitch of catgut was inserted round the incision, and a drainage tube was thus fixed in the gall-bladder. The gall-bladder was further fixed to the peritoneum and posterior sheath of the rectus at the upper part of the abdominal incision, the rest of which was sutured in three layers. Mr. Cunning pointed out that it was extremely important to explore both the cystic and common ducts before opening the gall-bladder, for it was impossible to tell from the symptoms and course of the case the absence of stones in these situations. A point to be guarded against was mistaking an enlarged gland alongside the cystic duct for a stone inside the duct. The way to avoid such a mistake was to differentiate the elastic feel of a gland from the unyielding resistance of a stone; and also it can be determined by careful palpation of the cystic duct that a gland is only lying adjacent to it, whereas a stone would be, of course, within it. He thought cholecystectomy should be reserved for those cases in which the gall-bladder was much diseased, instead of its being regarded as a routine operation. Cholecystostomy is a safer operation, but recurrence of stones may take place, although cases of this are rare. With regard to the sutures used in gall-bladder cases, he preferred catgut, for there was always the possibility of some infection from the gall-bladder when it was drained, and if silk were used, sinuses would remain until the silk had been extruded.

The patient left the hospital at the end of three weeks, feeling perfectly well, but still with a tiny sinus from which a little bile was occasionally discharged.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Clinical Section.

Meeting held Friday, March 13th, 1908.

The President, Sir **Thomas Barlow**, in the Chair.

Mr. **T. H. Kellock** read a paper on a case of

HERMAPHRODISM.

The patient, a man, æt. 25, had had a left inguinal hernia since childhood. On that side the testicle seemed normal; on the right it could not be felt. The penis was incurved, and marked hypospadias was present. At the operation for hernia two sacs were found. The upper communicated with the peritoneal cavity, and at the upper end a uterus was found, the size of a horse-chestnut. Both the broad and the round ligaments were present. A small ovary was found on the right side, the size of a haricot bean.

In reply to a query from Mr. Pearce Gould, Mr. Kellock stated that he had not been able to feel the prostate per rectum.

Dr. **Parkes Weber** read a paper on a case of

ANGINA PECTORIS COMBINED WITH AORTITIS.

The patient, a woman, æt. 42, had been healthy except for recurring attacks of angina. These gradually increased in severity, and she was brought to hospital in one which ended in death within a few hours. During life coarse râles were heard over the back and front of the upper part of the left lung. At the autopsy no lesions were found except in the ascending aorta and coronary arteries. The patient had almost certainly had syphilis, and Dr. Weber attributed the aortitis to this cause. He discussed the case in its relation to Allbutt's aortitis hypothesis of angina pectoris.

Dr. **James Mackenzie** inquired as to the effect of amyl nitrite in the case. In his experience this drug often succeeded in low tension cases and not in the high tension ones. He drew an analogy between this case and the one of intermittent claudication recently shown by Dr. Weber, which illustrated the importance of the cutting off of the blood supply from healthy muscles.

Dr. **De Havilland Hall** thought the case one of syphilitic origin. In his opinion true angina never occurred apart from aortic disease.

Sir **Dyce Duckworth** also agreed with the syphilis view of the case. He considered that true angina was due to distension of the heart, and that it occurred only in men.

Dr. **A. E. Garrod** related a case that had been published by Sir William Church. The patient died during convalescence from pneumonia, and at the autopsy he had found an acute pneumococcic endocarditis implicating the aortic valves. A fragment of vegetation had become detached, and had lodged in the mouth of one coronary artery.

In reply to a query of the President's, Dr. **Weber** said that he had not found any spirochætes in the sections. He referred to the acute nature of the coronary obstruction in Dr. Garrod's case.

Dr. S. W. **Carruthers** read a paper on a case of

CEREBRAL HÆMORRHAGE DUE TO PURPURA.

The patient, a woman, came for slight ecchymoses of the lower limbs. These recurred in spite of calcium treatment. No bleeding from the mucous membranes took place except, on one occasion, epistaxis. Shortly after the patient suddenly became comatose, and died from apoplexy in four hours. The case was afebrile throughout.

The **President** said that he had seen several such cases, but usually in severe forms of febrile purpura hæmorrhagica. As a rule the bleeding was into the arachnoid sac.

Dr. **Porter Parkinson** had recently seen a similar case. In 1906 Dr. Soltau Fenwick and he had read notes of two cases before the Royal Medico-Chirurgical Society. He had obtained good results from the administration per rectum of polyvalent antistreptococcic serum, and recommended its being employed in similar cases.

Dr. **Porter Parkinson** and Mr. J. S. **Hosford** read a paper on a case of

TUMOR CEREBRI WITH PROPTOSIS.

The patient came on account of failing sight. She had double proptosis, intense double neuro-retinitis more marked on the right side, nystagmus, absent knee-jerks, weakness of the right arm, and staggering gait. No signs of Graves' disease were present. After being four months in the hospital she died. No operation was performed. At the autopsy a firm tumour, the size of a pigeon's egg, was found attached to the under surface of the cerebellum on the right side and pressing on the restiform body. It proved to be a fibro-psammoma. There were three similar cases in the literature, and in all a tumour had been found in or attached to the cerebellum.

The **President** thought that the proptosis may have been due to the hydrocephalus, for in this condition the symptom was not very rare.

Sir **Dyce Duckworth** considered that proptosis might arise from several conditions other than Graves' disease, notably a central neurosis of the medulla.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

Meeting held Friday, February 21st, 1908.

The President, Dr. A. R. **Parsons**, in the Chair.

AN EXCEPTIONAL CASE OF TUBERCULOSIS.

Dr. **James Little** said the patient, a man about 42, was admitted to hospital in November last looking very emaciated. He had only a cough, with a little pain in the right side of his chest. A few days after admission a student noticed a friction sound low down on the right side of the chest. His sputum did not give any tubercle bacilli. He complained of abdominal pain; he was always constipated, and his temperature was hectic, though not highly so, up to his death on February 8th. About a fortnight after admission it became plain that there was fluid in the right thoracic cavity, and on passing a needle it was found to be bloody. From the character of the fluid he became certain that it was due to tuberculous mischief in the thorax, but as the fluid did not cause any inconvenience he did not draw it off. Later, however, the patient got very ill, and 20 oz. of exceedingly bloody fluid were drawn off. The symptoms improved, and the patient lived for two months, ultimately dying from inability to take food, for which he had a total dislike from the date of admission. The specimens exhibited showed an immense blood clot in the right pleural sac. The lung itself did not appear to be affected by any tuberculous formation; it only appeared to have existed in the sac. The upper surface of the liver and lower surface of the diaphragm were affected by tuberculous disease, and the peritoneum was also the seat of diffuse tuberculous trouble. The case showed the certainty almost of a bloody pleural fluid depending on tuberculous pleurisy; it showed also that tuberculous peritonitis might affect the peritoneum without tuberculous disease of the inner surface of the intestine.

Dr. **Kirkpatrick** thought that the dictum about bloodstained pleural effusion being tubercular required modification; although the effusion might frequently be tubercular, certain tubercular effusions were not always hæmorrhagic. The case would suggest that in cases of primary tuberculosis of the pleura the hæmorrhagic effusion might be of considerable diagnostic value.

The **President** asked if there was any examination made of the patient's brain?

Dr. **Little**, in reply, said there were no symptoms that pointed to the brain, and no examination was made.

TWO CASES OF GANGRENE OF LUNG.

Dr. **Little** exhibited a specimen showing gangrene of the lung from a man 45 years of age, who died four days after admission to hospital. His own statement was that he was perfectly temperate, but that had to be accepted with some reservation. He had been at home for a fortnight with what he called a cold. His temperature was not at all elevated on admission. The only striking thing about him was his cough, which was incessant. On the third day the nurse noticed extreme fœtor of his breath. His expectoration was always that of pneumonia. The specimen showed excavations in the lower lobe of the right lung, differing from the ordinary cavities by having no wall of circumvallation. The whole lung was in a condition of solidification.

The **Secretary** exhibited a second specimen obtained about six years ago. The patient was a child suffering from diphtheria. The gangrenous mass was in the right lung; the destruction was quite localised, and there was a considerable amount of fibrinous pleurisy. Corresponding to the centre of the gangrenous area, and directly facing it, was a puncture, and outside, between two ribs, the puncture mark was seen surrounded by a dark blue zone. The child had apparently been inoculated with antitoxin at that point directly into the lung, and this seemed to be the cause of the gangrene. The gangrenous area was found, on examination, to contain diphtheria bacilli, amongst other organisms, and efforts to cultivate the organism from other parts of the lung failed. Pure cultures of diphtheria bacilli were also got from the spleen. It was possible, though improbable, that the diphtheria bacilli got there by means of the serum. It was more likely that the practitioner used a dirty needle, which caused a necrosis, and probably the bacilli were aspirated, and grew in the necrosed part, while they would not grow in the more healthy parts of the lung.

Dr. **Day** said the case was that of a boy of five, who came into hospital in January, 1902. He had ordinary diphtheria, and was injected with 4,000 units before admission. About two days after admission he got symptoms of pneumonia, which, however, disappeared. He then developed great fœtor of the breath, and the case was diagnosed as gangrene.

Dr. **Kirkpatrick** asked Dr. Little if he had formed any opinion as to the cause of the condition in his case. That primary gangrene of the lungs should start in a healthy man seemed a very unusual occurrence. They saw it occasionally following aspiration in pneumonia, and especially in patients who were anæsthetised.

Dr. **Little**, in reply, said they found no evident cause of the gangrene. The only lesion the patient had was diseased kidneys, and during life he had albuminous urine. Their knowledge of the condition was not at all precise.

DIVERTICULA OF THE URINARY BLADDER.

Mr. L. G. **Gunn** exhibited five specimens of above. The specimens were, he said, of acquired diverticula. Congenital diverticula might occur in a very young bladder, but he had never seen a congenital case. Acquired diverticula commonly occurred in the aged, and were due either to (*a*) increased pressure; (*b*) chronic inflammation of the bladder wall; or (*c*) diminished blood supply occurring from arterial sclerosis. As to how diverticula occurred, they went through three stages; some obstruction took place, and the bladder hypertrophied in order to drive the urine out. With the increase in the thickness of the muscle covering the bladder wall, fasciculation in the inner wall occurs, followed by a certain amount of atrophy of the muscle. The bladder then commenced to dilate and to thin out in places. Then a bulging occurred between the inner muscular fibres, and the mucous membrane protrudes, and so a diverticulum is formed. He did not know if it was possible to diagnose the condition in any other way than by cystoscopic examination. It had been suggested that it might be suspected if, when on washing out a bladder, a sudden gush of foul urine and some matter followed the clear return flow along the catheter. Were diverticula of much importance clinically? He did not think they were. They might conceal a stone, they certainly prevented efficient washing out, and they were a source of danger of rupture in flushing a bladder. It had, however, been a matter for wonder to him that they did not rupture spontaneously. In three cases of bladder rupture which he had seen, there were no diverticula.

Dr. **Stokes** said he had seen a case where a man had a hernia which emptied when he micturated, and swelled up when he did not. The case was easily diagnosed as diverticulum. The only hope of curing such a condition was to excise it.

Dr. **Gunn**, in reply, agreed to Dr. Stokes' opinion as to the cure of diverticula, but the operation was an exceedingly dangerous one, as they were dealing with a bladder which probably had a poor blood supply and a septic inside.

THE SOCIETY FOR THE STUDY OF DISEASES IN CHILDREN.

Meeting held Friday, February 21st, 1908.

Dr. Edmund Cautley in the Chair.

A paper was read by Mr. H. S. Clogg on a case of

ACUTE INTESTINAL OBSTRUCTION

produced by a band, the latter being in part a diverticulum bearing an accessory pancreas; resection of a foot of gangrenous intestine; recovery. A boy, æt. 12, immediately following a blow on the abdomen, developed signs of acute intestinal obstruction. When seen about 44 hours after the onset of symptoms, he was very ill, and evidently suffering from some form of intestinal obstruction. The presence of a rounded and resonant swelling in the right iliac and hypogastric regions suggested a volvulus as the cause. Operation was performed about 46 hours after the commencement of the illness. About one foot of small intestine was snared under a band of this loop, and the gut was also twisted on its mesenteric axis. The intestine appeared gangrenous, and was excised. The ends were anastomosed by Murphy's button. The band and diverticulum were removed. The boy's condition was precarious for several days, but he ultimately made an excellent recovery. The interest of the case lay in the nature of the band. It was composed of an intestinal diverticulum some ¾ in. in length, with more or less perfectly formed intestinal walls. Attached to the distal extremity was a flattened glandular body ¾ in. in diameter, which showed the structure of the pancreas on microscopical examination. Leading from the extremity of the diverticulum at its junction with the accessory pancreas was a definite rounded cord consisting of fatty and fibrous elements. The diverticulum was regarded as a true congenital one.

Mr. **Hugh Lett** agreed that the specimen was a diverticulum, and thought that the strongest argument in favour of this was the thick round cord which was connected with the diverticulum. The prognosis in cases of acute intestinal obstruction due to Meckel's diverticulum was very grave, for, of 21 cases mentioned, no fewer than 16 died; that was a mortality of 76.2 per cent., compared with a mortality of 53 per cent. for all cases of acute intestinal obstruction. One reason which had been given for this high mortality was the frequency with which the diverticulum itself became gangrenous in consequence of its being rotated on its own axis, and so strangulated by the coil of intestine which it obstructed.

Two Specimens of Congenital Morbus Cordis were shown by Dr. **George Carpenter**. The first was from a female, aged 10 weeks. When admitted to hospital she was anæmic, ill-nourished, and ill-developed. Her tongue was large, and protruded from her mouth, and she did not close the lips over it. The cartilages of the last four ribs were absent. She was not cyanosed. The area of cardiac dulness was increased to the right, and there was a loud systolic bruit best heard over the pulmonary orifice; it was audible over the back and front of the chest, louder on the left side than on the right. Ten days after admission she was convulsed, and some hours afterwards died, collapsed. The aorta rose from both ventricles, four-fifths of its lumen being over the left. The pulmonary artery was small, and but half the size of the aorta; it had two semi-lunar valves. The ductus arteriosus was patent and of the size of a small probe. The foramen ovale admitted an ordinary lead pencil. The auricles were of equal size and thickness. The heart was inclined to be bun-shaped, and the left ventricle was twice the thickness of the right. The tongue was examined microscopically, but nothing abnormal was seen.

The second specimen was from a female, aged nine months. When admitted to hospital she was very pale and thin, and suffering from pneumonia. She died on the following day. There was a loud systolic murmur best heard over the third left interspace, audible back and front, better on the left side than on the right, and also to be heard in the great vessels of the neck. The pulmonary artery was larger than the aorta. It divided right and left into branches for the lungs, and ended in a third vessel which practically continued the thoracic aorta. The aorta having given off the usual vessels, was contracted at its junction with the ductus arteriosus, being at this point a trifle larger than the innominate artery. Beyond the union the artery was smaller than the branches to the lungs being 3-16 in. in diameter. The right and left auricles practically formed one chamber, though its right side was twice as thick as, and larger than the left The auricular septum was represented by a translucent membranous partition of semi-lunar outline hanging from the roof of the auricle and attached back and front. It measured a trifle more than a ½ in. in depth, and about ⅜ in. from before backwards. Posteriorly it was somewhat fenestrated. The heart was inclined to be rounded on the right side. The left ventricle, though apparently more muscular than the right, did not bear the usual relationship in regard to thickness. The cavity of the left ventricle was smaller than that of the right. Dr. Carpenter said that although the malformations were so dissimilar, the physical signs were practically identical. Further, the bruits that were heard were the same as those audible in stenosis and atresia of the pulmonary artery and the perforate septum ventriculorum. They well illustrated how deceptive the auscultatory phenomena are as a means of determining the nature of cardiac malformations.

Dr. **Poynton** said that cases of patent ductus arteriosus were described as having a long bruit heard to the left of the sternum, which occupied the whole systole and diastole as a sort of continuous humming murmur. But it had also been recorded by the late Sir William Broadbent and others that the same continuous murmur was associated with a patent septum ventriculorum. He asked whether Dr. Carpenter thought that the murmur in a patent ductus arteriosus was exactly like the murmur in his first case, or whether it struck him that it occupied the whole systole and diastole. He would also like to hear if any member had an autopsy on a case where there was a continuous humming murmur over the pulmonary region. Cases of the kind which he had seen had done remarkably well. He had three which were still alive without any cyanosis, though with some shortness of breath.

Dr. **William Ewart** said that Dr. Poynton did not refer to the possibility that some cases might be intrathoracic venous murmurs.

Dr. **Charles W. Chapman** said that such cases met with in children did not seem to die, yet the murmur did not seem to be met with at a later age. He did not know what became of them. Some of the patients in whom there was a continuous murmur went about quite well, and there were no symptoms.

Dr. **Carpenter**, in reply, said that the murmur in the second case was exactly similar to that which was audible in stenosis of the pulmonary artery. He thought an identical murmur was produced in stenosis of the pulmonary artery with a patent septum ventriculorum and without a patent septum ventriculorum.

In the second case there were two factors in the foramen ovale and a patent ductus arteriosus where the ductus arteriosus and the aorta joined, there was stenosis, and a murmur might have been produced at that point. He did not think the murmur was caused at the foramen ovale, as it was systolic in point of time.

Specimens from a case of frontal *Meningocele and Spinal Myelo-Meningocele* were shown by the **Chairman**:—

(*a*) The skull cap showing—(1) a circular orifice in left frontal bone through which a meningocele projected during life; (2) the remains of a cephalhæmatoma in the left posterior parietal region, with some subdural hæmorrhage under both parietals; (3) isolated patches of cranio-tabes.

(*b*) A myelo-cystocele from the lumbo-sacral region showing that the arches of five vertebræ were defective, and that the spinal cord could be traced from the canal to the lower end of the tumour. The specimens were from a male child, aged 18 days. Labour was instrumental. He was the seventh child, and the mother had had no miscarriages.

A case of *Cerebral Ataxia and Imbecility* was also shown by the **Chairman**. She was a girl, æt. 2, and only weighed 14 lbs. 14 ozs. She had been deserted by her mother. She was unable to stand, walk, or talk; she could sit up, use her hands, and feed herself with bread or biscuit, but would not use a spoon. There was coarse tremor of the hands, and the knee-jerks were exaggerated. The head was 17½ in. in circumference, she had 12 teeth, and the fontanelle was still unclosed. The mother had had two miscarriages, two still-born children, and had one other child, æt. 3.

Dr. H. T. **Thompson** thought it a case of imperfect development of the brain in which the convolutions were small.

The **Chairman**, in reply, thought that the condition was due to either meningeal hæmorrhage or encephalitis, or else that it was one of backward development, the so-called agenesis corticalis. The main incidence of the disease was on the prefrontal convolutions, the motor area being very little affected, but that it was affected was shown by the ataxia in the hands, and perhaps also by the delay in learning to walk. He thought the child would always be more or less backward, though the amount of imbecility was difficult to estimate at present. She would be able to walk as there was no muscular defect, and as she was now bright, her mental condition might become clear.

(1) A case of *Angioma of the Right Auricle and Meatus* was shown by Mr. P. **Macleod Yearsley**.

(2) A specimen from a fatal case of *Labyrinthine Suppuration*, and

(3) A case of *Suppuration of the Right Labyrinth* which recovered under operation.

A case of *Bronchiectasis and Pulmonary Tuberculosis* in a boy, æt. 16, was shown by Dr. T. R. **Whipham**. The former condition having apparently supervened on an attack of pneumonia when the patient was 14 months old. X-rays showed a marked opacity of the left side of the chest and scattered patches on the right. There was no polycythæmia.

Dr. H. T. **Thompson** did not regard it as an ordinary straightforward case of bronchiectasis because of the greater incidence of the disease on one side. The history of the case, and the fact that the heart was displaced towards one side seemed to suggest as a primary lesion pneumonia of the left side which had been followed by some dilatation of the bronchi. There must have been a secondary infection with tubercle as the bacilli of that disease had been found. He thought that the lung was fibroid.

Dr. **Whipham** said that the prognosis was a bad one. The boy had been fairly well. He last year showed a child before the Society with signs on one side of the chest and slight signs also on the other. Post-mortem there was multiple bronchiectasis in one lung, and the other was emphysematous.

A case of *Incomplete Congenital Ophthalmoplegia Externa* was shown by Mr. **Sydney Stephenson**. The boy was 8 years old, well nourished, with adenoid facies. No syphilitic stigmata could be found in the face or teeth. Pupils responded to light and accommodation. There were no corneal opacities and no Hirschberg's vessels; there was incomplete but bilateral ptosis. The movements of both eyes were deficient in all directions. The greatest range was downwards, while the excursions inwards, outwards and upwards were less than 2 mm. in range. There was no evidence of paralysis of the seventh cranial nerve. The knee-jerks were absent, though the ankle-jerks were present.

The **Chairman** asked whether Mr. Stephenson had seen cases occurring after birth affecting either the external muscles only, or only the internal vessels, and, if so, what explanation was offered.

Mr. **Stephenson** said, in reply, that he could not answer the question except by saying that after diphtheria the internal musculature of the eye might suffer, or sometimes, as in cases published by Dr. Parkinson, the external musculature.

(2) A case of *Persistent Capsulo-Pupillary Membrani and Hyaloid Artery with Atypical Development of the Vitreous* was also shown by Mr. **Sydney Stephenson**.

A girl with *Inherited Syphilis* was shown by Dr. **Porter Parkinson**. The case showed the following features: infantilism with want of development of breasts and uterus with absent catamenia, periostitis chiefly of tibiæ and ulnæ, synovitis of knee and elbow-joints, nephritis, and a marked *café-au-lait* complexion.

Dr. **Poynton** said he had attempted in one of his cases to obtain the spirochæte from the fluid drawn off from the joint, but without success. He had recently had a case of Charcot joint in an adult in which several people were able to demonstrate micrococci in the fluid.

Dr. **Carpenter** asked whether Dr. Parkinson could say what the condition of the ovaries was. Infantilism occurred in diseases of the testicle and in testicles which were immature, but he did not think a case had been recorded in which disease of the ovaries had brought about infantilism.

Mr. **Stephenson** asked whether the fundus oculi had been examined, and, if so, what was found? The remains of interstitial keratitis never wholly disappeared, and probably one could always find in people who had suffered from interstitial keratitis at any time of their life very fine vessels in the depths of the corneæ.

Dr. **Parkes Weber** alluded to the enlargement and curving of the tibiæ, and thought that cases such as these led some authorities to consider the osteitis deformans of Paget a syphilitic disease.

Dr. **Porter Parkinson**, in reply, said examination of the fundus of the eyes revealed nothing abnormal, and said he would have the fluid in the knee examined for micro-organisms. The amount of albumin in the urine had not decreased while he was using mercury.

Dr. **Carpenter** said he had given mercury in cases of syphilitic nephritis without curing them, but they were none the worse for the treatment.

A case of *Enlargement of the Upper Jaw* in a boy, æt. 9 years and 10 months, was shown by Mr. **Philip Turner**. He had no pain, but the swelling which had been noticed three months previously was increasing in size; it extended upwards to the margin of the orbit, bulging forwards so as to obliterate the canine and incisive fossæ. The alveolar process was larger than on the right side, and the palate was slightly depressed. There was no exophthalmos, and no obstruction to the passage of air through the left nasal fossæ. Egg-shell crackling could be obtained by pressure on the anterior surface. Six teeth were present on each side of the middle line in the upper jaw. On the right side the first permanent molar was present with two permanent incisors, the two temporary molars and temporary canine. On the left side there were two temporary incisors, the temporary canine, two temporary molars, and the first permanent molar. The second dentition was thus considerably delayed. The skiagram showed the two retained permanent incisors on the left side, the lateral incisors had a well-formed root, but that of the central incisor was short and abrupt, while from it a definite shadow was continued in an upright direction. The existence of the swelling, with egg-shell crackling, suggested the presence of either a growth, probably a sarcoma, or a follicular odontome, frequently known as a dentigerous cyst. The short history suggested the former, but the non-eruption of the incisor teeth, together with the appearance of the central incisors in the skiagram, pointed to the latter as the correct diagnosis.

Mr. **Russell Howard** thought another possibility was myxomatous tumour of the upper jaw.

Mr. **Clogg** said that, in addition to the outer wall of the alveolus being protruded, there was bulging of the inner wall also. That seemed to him to favour its being a neoplasm of a sarcomatous nature, especially as it had grown somewhat rapidly.

Mr. **Lockhart Mummery** suggested that transillumination should be tried before going further.

Mr. **Turner**, in reply, thought there must be something more than retained teeth, as there was definite swelling, and the bone could be felt to give way.

A case of *Multiple Arthritis* in a girl, æt. 10, was also shown by Mr. **Turner**. Six months ago there was painless swelling of the right knee-joint; this was followed by a similar trouble in the left knee-joint, both wrist-joints and the first inter-phalangeal joints of both hands. There had been no constitutional disturbance and no pain in the affected joints. Both knee-joints were markedly distended, and the ends of the bones appeared to be enlarged. Thickened synovial fringes could be rolled under the fingers, and grating could be felt on flexion of the knees. The spleen could not be felt, and there was no general enlargement of the lymphatic glands. No history of any previous disease could be obtained, and there were no signs of congenital syphilis. No local source of septic infection was present.

Mr. **Turner** considered the diagnosis lay between congenital syphilis and osteo-arthritis. He favoured the latter diagnosis.

Dr. **Whipham** thought the case was one of osteo-arthritis in children; they occurred rapidly, painlessly, and without temperature.

A case of *Hæmophilia with Adhesions in the Knee-Joint* was shown by Dr. **Kenneth Kellie**. When three years of age, the boy cut his finger, and the resultant bleeding was difficult to stop. Since then he had suffered from bruises which appeared without any cause, and the right elbow and knee-joint frequently swelled and became painful. The right knee-joint was in a condition of semi-flexion. He brought the case before the Society in order to hear any opinions as to the treatment of the knee.

Mr. **L. Mummery** advised that an anæsthetic should be given, and an attempt made to break down the adhesions, though there was the risk by so doing of re-starting hæmorrhage into the joint.

Dr. **Poynton** thought that if the adhesions were broken down now, there would be no danger of bleeding into the joint, and that the limb could be got into position. Calcium chloride had been in his hands very disappointing.

Dr. **Porter Parkinson** agreed with Dr. Poynton as to calcium chloride. He had used fibrolysin in the case of a boy with a large scar in the neck made by a burn with satisfactory results.

Army Medical Service.

The following have been officially gazetted:—Surgeon-General J. D. Edge, C.B., M.D., is placed on retired pay; Colonel G. D. Bourke, C.B., to be Surgeon-General, vice J. D. Edge C.B., M.D.; Lieut.-Colonel H. W. Murray, M.B., from the Royal Army Medical Corps, to be Colonel, vice G. D. Bourke, C.B.

Royal Army Medical Corps.—Lieut.-Colonel S. F. Lougheed, M.D., C.M.G., retires on retired pay.

CORRESPONDENCE

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 15th, 1908.

The Prognosis of Cancer.

Prof. **Reclus** chose, a few days ago, for his clinical lecture the subject of cancer as regards its prognosis, which was published in the *Journal des Practiciens.*

For the last fifteen or twenty years, he said, new treatments have seen the light almost every day, amongst which may be mentioned: Radium-therapy, radiotherapy, currents of high frequency, salts of soda, potash, quinine, and numerous analogous preparations, as well as an infinite number of serums. Strange to say, everyone of these methods appeared at the beginning at least to produce, if not always a cure, at least considerable improvement.

Surgeons of all countries rushed to these vaunted remedies, but less than a decade sufficed to undeceive the most sanguine.

At first it seems difficult to explain how men of science could have allowed themselves to be enticed by these deceptive discoveries, and to publish some ephemeral successes. But it must not be forgotten that those affected with cancer are patients treated without much conviction, and frequently abandoned to morphia. Suddenly a saviour appears and communicates his confidence; hope revives with the desire to live, sleep returns, appetite and strength increases, and both patient and surgeon are carried away by enthusiasm, and end by proclaiming as incontestible, imaginary cures.

But the true source of our errors lies in our ignorance of the progress and development of cancer. As soon as the histological examination, with or without clinical aid, permits us to diagnose a malignant tumour, the patient is condemned without any possible appeal. We conclude that the same structure will have a similar end, and since the anatomical elements are the same, and grouped in an identical tissue in each of the tumours, the patient suffering from one kind will have the same lot as one suffering from the other. We forget that there exists besides a series of unknown conditions which constitute that which, in our ignorance, we call "malignity," certain neoplasms progress very rapidly, and kill in a few months, while others require years.

Text-books on general pathology teach us that cancer terminates fatally always, and that in a very short time. The first point is but only too true, and one could count on the fingers the authentic cases of cancer cured spontaneously.

But if the termination is always fatal, at least it is not always rapidly so. There are certain cancers which develop very slowly.

Certain cancroids of the skin, for instance, frequently, especially of the jaw, forehead, nose, and those that can also be met on the limbs over old ulcers or cicatrices, persist years and years without affecting the general condition of the patient. The same might be said of certain epitheliomas of the mucous membrane of leucoplasic surface.

A third variety of cancer of slow development is constituted by a curious variety scirrhus.

Prof. Reclus treated an old lady for ten years whose breasts were covered with, so to speak, a coat of mail of rough and hard skin, and who was finally carried off by some pulmonary complication.

Certain visceral causes are not incompatible with prolonged life. Neoplasm of the bladder can remain dormant for years, while cancer of the kidney is not always rapidly fatal. M. Guyon cites a case of a magistrate who would not accept an operation in spite of frequent hematuria, and who lived for nineteen years afterwards.

We have only spoken up to now of cancers left to themselves, but I have no intention of forgetting the prognosis of cancers submitted to operation. If all surgeons are agreed in affirming that the knife is still the best treatment of malignant tumours, many sustain, and, no doubt, with reason, that medical treatment following the operation is capable of preventing relapse, and some propose the employment of certain serums, whilst others have recourse to radio-therapy, either over the open wound or under the skin covering the seat of operation, to obtain immediate cicatrisation.

Here, again, we are confronted with some of the complex nature of cancers; the same paradoxical developments, sometimes rapid, other times slow, and contrary to the usual clinical rules.

What do we know, for instance, of epithelioma of the tongue? Outside surface epithelioma of leucoplasic mucous membrane we declare this cancer to be the worst of all cancers, and Denonvilliers used to say that every ulcerated cancer of the tongue killed within a year. Yet there are cases of cancer of the tongue which do not return after extirpation. Twenty-two years ago M. Reclus removed a cancer from the tongue of a jeweller, and he is still living!

Cancers of the breast are so frequent, and operations so numerous, that statistics bear on hundreds of cases of non-recurrent cancer.

Cancer of the uterus was considered 20 years ago as almost rapidly fatal, and the prolongation of life after extirpation was insignificant. But since then we have altered our sombre prognosis, and numerous gynæcologists publish encouraging statistics, amounting in some cases to 30 per cent.

Cancer of the rectum remains always grave, prolongation of life after operation being the least marked.

If you have followed my ideas, concluded Prof. Reclus, you will have found that I tried to show you that development of cancer before operation is not always progressive, that it may remain dormant for several years, and that after operation a definite cure is obtained in about one-third of the cases.

But as I have already said, we have yet to learn the reasons why two identical structures can, in the same organ, at the same age, in persons of the same sex, have in one case a slow development, or can be cured by operation, and in another assume rapid strides and carry off the patient in spite of the earliest and most complete extirpation. Consequently, in each case our prognosis must be reserved. The fact is we know, up to the present, nothing of the origin and nature of cancer.

Gold in Therapeutics.

Prof. Grassel employs chloride of gold and sodium in chronic rheumatism.

Chloride of gold and sodium, 2 gr.
Water, 10 oz.

A tablespoonful at each meal (2) during 20 days a month.

Dr. Bué injects a solution of 1—90 into tuberculous ganglions, while Prof. Lemoine prescribes bromide of gold in epilepsy.

Bromide of gold, 2 gr.
Water, 8 oz.

One or two teaspoonsful at evening.

Prof. Robin prescribes the same bromide in the treatment of cancer of the stomach and in that of cancer in general.

Bromide of gold, 1 gr.
Water, 10 oz.

A tablespoonful at each meal (2).

GERMANY.

Berlin, March 15th, 1908.

At the Medical Society, Hr. W. Körte spoke on

Resection of the Lung for Bronchiectic Cavities.

He described the differences between bronchiectic cavities and those produced by abscesses and gangrene. In the latter case there was generally one large cavity that could be easily laid open and drained; in bronchiectasis a large tract of lung was the seat of a system of cavities, the extent of which it was difficult to make out thoroughly. Neither was it always easy to differentiate between them and abscess or gangrene cavities. He had performed pneumonotomy for abscess or gangrene 28 times. Of these, 20 recovered; on the other hand, of those who had been operated on for bronchiectasis, only 4 recovered. In the 11 that died, the autopsy showed that recovery could not have been brought about by pneumonotomy.

If anyone would operate in these cases, it was necessary to make a large window in the thorax, for which at least two ribs must be resected. According to whether the pleura was adherent or not, it must be first sutured and the lung then opened. A cylindrical cavity was then reached, into which, as a rule, neighbouring cavities opened on all sides. These cavities were opened gradually one after another, usually at several sittings, in which the separating tissues were cut through and the bleeding vessels ligatured or stitched round. This operation could be performed under either local or general anæsthesia. The individual cavities were tamponaded with iodoform gauze, soaked in Peruvian balsam. If recovery was not brought about in this way, then contraction could be advanced by extensive resection and thoracic plastique. If this was not successful, nothing remained but removal of the whole of the affected part of the lung.

In connection with the remarks he had been making, he showed a boy, æt. 8, who was admitted into hospital in August, 1906, on whom during the course of the year he had performed all the operations described, with the result finally that he was now quite sound. He came with purulent expectoration and an exudation at first serous, but which soon became purulent.

The empyæma was first emptied by resection of ribs, and in a few weeks the boy was discharged improved. He soon returned, however, with offensive sputum. Pneumonotomy was performed in December, and gradually a whole system of cavities was opened; but even after this there was no improvement. In March, 1907, extensive thoraco-plastique was performed, after which the suppuration continued unchanged. In April the whole right lower lobe was divided and adjusted, after which the expectoration ceased, but the suppuration from the lung continued. On May 26th the whole of the right lower lobe was again opened up as far as the hilus, and a portion of the middle lobe resected. After cleansing the wound, the large flaps of the soft parts formed in the thoraco-plastique, which had shrunk in the meantime, were straightened out, and sutured so that the stump of the afferent bronchus was covered. The wound healed without the formation of a bronchial fistula, the boy recovered, and he was now quite well.

The chief dangers of operations on the lungs were hæmorrhage and sudden collapse at the moment of incising the lung. Both the speaker and others had witnessed sudden death at this point, probably through reflex in the vagus, against which we were powerless. The danger of pneumothorax was not so great here if the lung was grasped quickly and drawn out. He had not made use of the Sauerbruch chamber; it could be dispensed with, and from the moment when the lung was opened it was useless.

Hr. Krause reported on a case that had remained well since 1899. It was that of a man, æt. 34, in whom a pulmonary fistula remained in consequence of an operation performed elsewhere; it secreted one litre of pus daily. He resected the ribs from the sixth to the tenth extensively, separated the partition wall between the various cavities without hæmorrhage, and, lastly, resected the whole lower lobe.

For the prevention of pneumothorax he recommended the introduction of a large piece of gauze into the pleural cavity as soon as the lung sank back.

Hr. Baginsky related a case of

Septic Arteritis and Aneurysm

in a child. A child of 7 was admitted into hospital in a state of high fever. Nothing was found beyond a slight murmur at the apex of the heart. Some days later a rigor occurred, and from that time for some weeks there was continuous septic fever. One day a tumour was felt below the umbilicus, but it did not pulsate. A short time afterwards the radial pulse suddenly ceased. Two months later pulsation was felt in the tumour. A diagnosis was now made of aneurysm of the abdominal aorta. Shortly afterwards cerebral symptoms appeared, soon followed by a fatal termination.

No sign of syphilis appeared either in the history or at the autopsy. There was an abdominal aneurysm with infarcts in the kidneys and spleen. The disease in the aorta appeared to have started in the media. Pure cultivations of streptococci were present in the thrombi, filling the vessels, and even in the diseased walls. It was a case of septic arteritis, a very rare affection in children. (The preparations were shown.)

AUSTRIA.

Vienna, March 15th, 1908.

Myxœdema.

At the Gesellschaft, Moszkowicz exhibited a six-year child who suffered from myxœdema when an infant through thyreoaplasia. When 3 months old he inserted a piece of thyroid gland 3 or 4 cubic centimetres in size, which had been taken from a patient that had been operated on for goître in the tibia. After this implantation the child rapidly improved in general appearance and psychic movements, the cranium having increased 2 centimetres, = .79 in. This improvement he assigned to the absorption of the gland, and as the improvement has continued, it is fair to assume that the function has been supplanted by the insertion of the gland portion.

His reason for selecting the medullary substance of the tibia was owing to the frequency of metastasis that occurs here in adenomatous carcinoma, resembling thyroid, which he surmised had some affinity to the gland. He was not alone in this opinion, as Payr supported this view that the circulation in the marrow of the bone was more favourable to this operation than the spleen.

Eiselsberg said he had selected a position between the fascia and peritoneum, thus following the example of animal experiments which always do well. He thinks the tibia a much better place to implant than the spleen, no matter how much may be urged theoretically in favour of the latter; but the reason given by Moszkowicz for implanting in the tibia is not a rational one, and he would pause to consider the results before giving an authoritative opinion on the subject.

Biedl said he was in favour of the transplantation method of Moszkowicz, because he found in his experiments on animals that the transplanted sections were better nourished, owing to the better blood supply and firmer support than they had in the spleen or peritoneum. It is certainly much better than the subfacial implantation, and more vascular.

Mongol Habitus.

Knöpfelmacher next exhibited an interesting case of erythrodermia desquamativa in a child 3 months old. It had a blue mark, resembling a cross, on the sacrum and ischial surfaces, which was typical of the Mongolian race. In European children this mark is a very rare thing, though sometimes to be met with beside the Mongolian and Malayan races. The prognosis in this case, he thought, was hopeless.

Ankylosis and Contractions.

Jerusalem gave a report of his experiments with the Bier-Klapp apparatus, which is worked as an air-pump by extracting the air and correcting the contraction. He had applied it in 35 cases during the year, 10 of whom were perfectly cured, while the others were more or less improved. Röntgen photographs were produced. His experience led him to the conclusion that the knee and elbow-joints were the hardest to move when ankylosed. The pressure of air in these cases was often so great as to cause paralysis of the limb, which he obviated by bandaging the extremity well before operating, and then firmly fixing the limb in the apparatus before the air is extracted. To guide the operator he has devised an arthrometer to measure the excursion of the joint towards the normal position.

Bum said he preferred the mobilising of the syndesmosis with the hand, as you could better judge of the straining and injury that could be done by such a powerful machine as that shown. He always found these ankyloses yield better by associating Bier's congestive treatment with the stretching which greatly reduces the pain and supplies more nutrition to the stiffened joint. When the adhesions are too strong, it is then necessary to resort to stronger measures, but, as a rule, he could manage with the hand.

Jerusalem said he had as delicate a control with Bier's apparatus as with the hand, as the instrument is fitted with glass fenestra for observing the hyperæmia and pressure exerted on the limb. The force can be more regularly and gradually applied than with the hand.

Genital Malformation.

Lichtenstern exhibited a young man, æt. 25, with a double scrotum, one at each of the annulus inguinalis externus overhanging a hypoplastic penis. The seminal cords issued from the inguinal canals, with a curve towards the symphysis, and suddenly turned outwards to enter the scrota, under which lay a penis 5 to 6 centimetres, or 1.9 to 2.3 in., and directed outwards according to the patient's own story.

Perforation of Nasal Septum.

Goldreich showed a six-months child with hereditary syphilis and perforation of the nasal septum, which is a rare condition in a child so young. It did not appear to be the result of a single gumma, but rather an inflammatory hyperplastic process in the mucosa, which subsequently acted on the perichondrium and cartilage.

HUNGARY.

Budapest, March 15th, 1908.

At the last meeting of the Society of Physicians, Dr. Rosenberg reported on some

Sequelæ Resulting from the Use of Adrenalin.

The patient, a young woman in good physical condition, presented what appeared to be symptoms of an accessory nasal sinusitis. A small swab saturated with suprarenal extract was applied to the swollen inferior turbinate. It brought on an unpleasant disturbance of smell, and within a few hours was followed by a diffuse urticaria extending over the trunk and arms. This disappeared after a short time, but about a week later, when the treatment was repeated, the same trouble reappeared. Swabs saturated with water or cocaine failed to produce the same effect. Dr. Rosenberg believes that this urticaria was caused either by absorption of the drug or was a reflex disturbance brought about by an irritation of the olfactory nerve, the patient complaining of an unpleasant sensation of smell at the time when the adrenalin was applied.

Dr. Kryte read a paper on

The Pathological Anatomy of Epilepsy.

In a case where epilepsy had proved fatal, he found the cortex of the brain the seat of a number of cavernous angiomata, the largest of which were surrounded by calcified connective tissue. They were probably congenital, since the epileptic seizures began in earliest youth. Their relation to epilepsy can hardly be explained by variations in intracerebral blood pressure, since experimental venous stasis, even in epileptics, never brings about an attack, and since compression of the carotids in animals is never followed by convulsions. It is more probable that they irritate the cortex by their constant growth. Angiomata of the brain are rather rare, but have been found in several previously reported cases of epilepsy.

Dr. Hollos read a paper on

The Influence of the Alcoholism of Parents on their Children.

It is a well-recognised factor in pathology that the habitual parental inebriety has a pernicious influence on the offspring, and statistics seem to show that this cause is vastly more operative when, of the two parents, the mother is the drunkard. This, indeed, is only what one would anticipate, seeing that for nine months the fœtus remains exposed to the perilous influence of the alcohol taken persistently. Sobriety on the part of the father has but little effect so far as the health and vitality of the child is concerned, and, in presence of maternal drunkenness, may at most be discarded, although, no doubt, the result of the two bad strains would intensify the consequent mischief. The influence of chronic parental inebriety in this connection bears mainly on the higher department of the nervous system, producing more or less marked intellectual inferiority and a functional incapacity on the part of what may be described generally as the moral functions of the brain. For instance, the children of drunken mothers have but an imperfect conception of the moral obligation of honesty, truth, etc., in spite of careful training, which, by the way, they do not usually get. Their emotions and passions cannot be brought under adequate control; consequently, they furnish a large contingent to the criminal and to the so-called irresponsible classes. Looked at from this point of view, it becomes obvious that criminal tendencies are of the nature of a constitutional disease, to be dealt with preventively and therapeutically.

The Presence of Koplik's Spot in Measles.

Dr. Roth has looked for the spots on the buccal mucous membrane, first described by Koplik, as preceding by some days the general eruption of measles, and has found them in 22 cases. In 1 case they preceded the eruption by six hours, in 11 cases by one day, in 5 by two days, in 3 by 1½ days, and in 2 by four days. The spots were generally situated on the mucous membrane of the cheeks opposite the molar teeth, but occasionally on the lips, beginning as slightly raised, bluish-white, circular, sharply defined points, in size less than a pin's head, and surrounded by a narrow red areola. In a few days they generally increase slightly, and become more prominent, and the areola enlarges and becomes more irregular in outline. Their number varied between 6 and 20, and the time during which they persisted from two to six days. They were not marked just before, or at the time of the general eruption. They were not present in 14 cases. Since they were never seen in other conditions not accompanied by fever, they are of the greatest importance for the early diagnosis of measles. Roth claims that the buccal eruption in measles was first mentioned by Gerhardt, and that their importance was recognised by Filutow in 1895, a year before their independent discovery by Koplik.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Extra-Mural Teaching in Glasgow.—Since Mr. Andrew Carnegie provided a fund for the payment of students' fees, the prosperity of some of the Extra-Mural Schools of Medicine in Glasgow has decreased. St. Mungo's College, especially, which is the teaching school in connection with the Glasgow Royal Infirmary, appears to have suffered greatly. And, as it is desirable that the Royal Infirmary be in close contact with a medical school, a deputation consisting of some of the governors of the Royal Infirmary and of St. Mungo's College approached the Glasgow University Court last Thursday, for the purpose of laying the claims of both of those institutions before the University authorities, with the desire that the University may see their way to take advantage of the rich clinical material in the Royal Infirmary for the clinical instruction of the students. It is an admitted fact, that the classes in the Western Infirmary are congested, and this congestion might be relieved by utilising the wards of the Royal Infirmary. Thereafter, a committee, consisting of Principal McAllister, Sir Hector Cameron, and others was appointed to look into the matter and report to the Council.

Vacant Professorial Chairs.—The chair of the Practice of Medicine in the University has not yet been filled up, and the profession are keenly awaiting the news of the appointment. We understand Dr. Gibson, of Edinburgh, has retired from the contest, so that there is reason to believe a Glasgow man may be appointed.

The chair of Medical Jurisprudence in Anderson's College has been recently advertised. Dr. Carstairs Douglas recently taught there both forensic medicine and public health. He desires to confine his attention to public health, and an attempt is being made to have a teacher for Forensic Medicine pure and simple.

The Ruchill Hospital Inquiry.—The Commissioners' report on Ruchill Fever Hospital was the subject of a long debate in Glasgow Town Council on Thursday last. After a fruitless discussion, the whole matter has been referred back to the Hospitals' Committee. One gentleman proposed an amendment that the dismissed doctors be reinstated, but he was induced to withdraw his amendment. The redoubtable Mr. Andrew Scott Gibson wished to probe the whole matter to the bottom, but we must wait on the Committee's next report to the Council.

Medical Justices of the Peace.—Among names lately added to the Commission of the Peace for the County of Aberdeen upon the recommendation of the Lord Lieutenant, the following members of the medical profession occur:—Dr. Robert Bruce, Cults; Dr. John Findlay, Lonmay; Dr. Edward Oliphant, Buckburn; Sir James Reid, Bart., Ellon; Dr. Alex. Trail, Fraserburgh; Dr. E. R. Turner, Kintore.

County of Fife Medical Officership.—Dr. Naismith's place has been filled by the election of Dr. T. F. Dewar, Medical Officer for the County of Forfar. Dr. Dewar is an Aberdeen graduate; he is a medical officer to the Fife Imperial Yeomanry, and served with distinction during the late campaign in South Africa.

Administration of Falkirk Fever Hospital.—The Commissioners, who some time ago held a public inquiry into the affairs of this hospital, have now issued their conclusions and recommendations. In homologating there the Local Government Board express their satisfaction with the efficiency of the hospital as now reorganised. The Commissioners found that prior to May, 1907, the administration was unsatisfactory in respect of the failure to provide the nursing asked by the Medical Officer, the insufficient checking of the use of alcohol, the laxness and inefficiency of the matron, and the preservation of discipline and admission of visitors. They recommend that the Medical Officer should be the responsible head, and responsible only to a committee of the Town Council; that visiting should be restricted to the members of the committee. The charges brought by Mr. Miskimmin, beyond the above, have not been substantiated, and there is no evidence bearing out the statements made concerning one of the city officials and a medical man in the town.

BELFAST.

The Serum Treatment of Cerebro-Spinal Meningitis.—At a meeting of the Public Health Committee held last week, Dr. Gardner Robb reported the results obtained up to date by the use of Flexner's serum. Since September 1st last year, all cases of cerebrospinal meningitis admitted to Purdysburn fever hospital have been treated with this serum. The total number of cases is now over 70. In the first 50 of these which have been treated to a conclusion, 13 died and 37 recovered, giving a case mortality of 26 per cent. Before using the serum the number of cases in hospital was 275, and the death-rate in these was 72 per cent. So far as Dr. Robb could judge, he thought there was no improvement in the type of the disease.

The Irish University Question.—A debate on the Irish University question was held last week at the Presbyterian Theological College in Belfast, and was specially interesting as showing the views of the rising generation of the Presbyterian clergy. The opener of the debate advocated the scheme generally looked upon as Mr. Birrell's, a new University controlled by the Roman Catholic authorities, but open to all, in Dublin, and a new Northern University in Belfast, while Dublin University should be left untouched. The leader of the opposition advocated the formation of one National University for all Ireland. No vote was taken, but it was evident that there was a considerable body of opinion in favour of an Ulster University, and a growing faith in its possibility. There was also a noteworthy disposition to recognise the fact that the Roman Catholic Church's objection to mixed education must be allowed, and University affairs arranged accordingly. This is a decided advance on the attitude generally adopted in the Presbyterian Church a year or two ago.

Nature Study.—The Lion and Jackal.—At the meeting of the Ulster Medical Society, held on Thursday last, the evening opened with a short paper by Mr. R. J. Johnstone on "The Lion and the Jackal: A Nature Study." In the form of a thinly-veiled allegory he dealt with the burning question of the relations between the consultant and general practitioner, and displayed an amount of wit, wisdom and common sense that delighted his audience. He divided the genus Leo into two species, Leo sectator and Leo scrutator, and described the habits of each, and the manner in which the jackals helped them in the capture of their prey. The fat old lions, who never attended the meetings of the jungle folk, and the hungry young lions who did most of the roaring at the meetings, were in turn described, and the question of hospital abuse was discussed under the guise of an account of the sanctuaries into which the natural prey of the lion was admitted when too thin and mangy to afford a decent meal, though, as it was remarked, the jackals often thought they might have been allowed another bite before the lions passed the prey into the sanctuary!

LETTERS TO THE EDITOR.

WORKMEN'S COMPENSATION ACTS.

To the Editor of The Medical Press and Circular.

Sir,—I notice in your Notes and Comments you raise the question "Where a workman should attend for examination?" Under the Workmen's Compensation Acts (Sec. 60 and 61 Vict., cap. 37, Schedule I., Section 11) a workman must attend at the consulting room of the medical practitioner selected by the employer, unless in the opinion of his own medical attendant he is unable to travel.

I am, Sir, yours truly,
Robert Saundby.

140b, Great Charles Street, Birmingham.
March 12th, 1908.

[We are obliged to Dr. Saundby for his letter, but may we remind him that the Workmen's Compensation Act, 1906, 6 Edw. 7, consolidated the previous Law on the subject, as well as amended it. The obligation does not appear in the new Act nor in any of its Schedules. At the moment of going to press we are not able to state if it occurs in any of the rules under the Act, but our memory is that it does not.—Ed.]

THE STUDY OF TWINS AND "DOUBLES."

To the Editor of The Medical Press and Circular.

Sir,—May I trouble you to insert a further letter of inquiry on a point I raised a few months ago in your columns in reference to diseases of twins?

Many of your readers were obliging enough to reply to my inquiries, and I have now a considerable quantity of evidence on this subject, though I should be very glad of additional material.

A further question I would wish to have medical experience upon is that of similarity of diseases in persons not brothers nor sisters, and yet greatly resembling each other.

From time to time popular magazines have published photographic reproductions of these resemblances, and instances of odd mistakes are now and again commented on in daily newspapers and elsewhere. The popular saying that "every person has his double" records the general recognition of this fact.

The evidence which I now possess makes it probable that twins suffer similarly from disease, and that constitution is a much more important factor than has lately been assumed, the older medical men being largely justified in their insistence upon this.

Before, however, giving facts to support such a conclusion, I am anxious to obtain an independent source of study to compare with my twin researches, and the possibility of the availability of "doubles" has been brought into my mind by a case in my own experience, which was as follows:—

A colleague of mine and myself both mistook a new patient we had not previously seen for an old one suffering from diabetes, so alike were they in appearance; and at our request she brought up a sample of urine to be examined, and it was diabetic. The woman herself had no suspicion at the time of this disease, nor had she any noticeable symptoms, and, but for the chance likeness to the other patient, the disorder might very possibly have been overlooked.

If any other medical men have similar experiences I should be glad if they would kindly communicate with the writer at the address appended below, or through your hospitable columns.

I am, Sir, yours truly,
J. Lionel Tayler.

8, Adys Lawn, St. Paul's Avenue,
Willesden Green, N.W.

CHRISTIAN SCIENCE.

To the Editor of The Medical Press and Circular.

Sir,—On unquestionable authority, I learn that Mr. Dixon's letters in your pages have attracted attention widely, and have done much to discredit his teaching; and I have been informed of at least one case in which they have prevented a patient afflicted with a disease easily curable by surgery from putting his trust in miracle-mongers, and have induced him to undergo the simple operation certain at once to give relief to his sufferings and put an end to an otherwise fatal malady. If you could only induce Mr. Dixon to continue, and could bring his writings before those of the public able to appraise their value, a great deal might be done to dispel illusions which are undoubtedly giving rise to much suffering and misery. Nothing could be more harmful to Mr. Dixon than his unfounded charge that he is abused by those who expose his fallacies—a charge which he repeats to-day. If you will allow me, I will recapitulate some of my chief statements, and with this I shall be glad to end my contributions to the debate.

I pointed out, first, that the conception of the Deity put forth by Christian Science is necessarily blasphemous in the estimation of every enlightened religion, in that it degrades Divine Providence to the level of an African fetish—a household god which bestows its favours on those alone who know how to propitiate it by the prayers and ceremonies which it loves. Although the knowledge of the merest tyro is not needed to expose the sophistries of Mr. Dixon's theology, it has not been necessary for my purpose to examine into it at length. It has sufficed to point out that out of his theology arises the claim to cure all diseases by miracle. This claim is supported by a newly-invented tissue of transcendental pseudo-metaphysics, a grotesque travesty of legitimate philosophical speculations on the ultimate nature of matter and force. To deal with these utterances seriously is impossible—it is more futile than beating the air; they are fit only for ridicule. In so far as they bear upon the cure of disease they could be listened to only by those entirely ignorant of physiology—the structure and functions of the body in health—and of pathology—the changes which take place in the organism during disease. Whatever be the ultimate nature of matter and force, we cannot by prayer without human agency provide food and convey it into the stomach of a starving man, however devout he be. It would be miraculous; but not more miraculous than the expulsion by the same means of a group of hydatids from the liver, a mass of tapeworm from the intestines, or a colony of itch insects from the dermal tissues. Mr. Dixon seems to know little about such comparatively simple maladies, and less about "consumption, cancer and epilepsy," which, he says, are being "destroyed" daily by Christian Science He looks upon these diseases as distinct entities, to be exorcised and driven out of the body by the methods of mediæval thaumaturgy. By consumption he no doubt means pulmonary tuberculosis. Does he pretend that the cavities caused by the destruction of lung substance can be repaired and filled with new tissue by means of prayer and the pious emotion of the patient?

Then, again, many distinct varieties of malignant growth are classed as cancer; the phenomena presented during the invasion of different organs and tissues are extremely complex, so that no one with a rudimentary knowledge of the subject can fail to realise the miracle which "destruction" of these products by Christian Science would imply. Then, for another illustration, epilepsy presents several totally distinct varieties. If any one kind is purely psychic, perhaps Christian Science may influence it; but it is inconceivable that epileptic fits due to a gumma in the brain, or to the pressure of a depressed fracture, with perhaps a spiculum of bone penetrating the cerebral substance, should be curable by such methods—it would be a miracle. Imagine the misery that may result if patients, relying upon Christian Science in such cases as the last, refuse anti-syphilitic treatment or the surgical operation which so often provide the means of relief and cure. Then, as a last example, we may consider the vast range of diseases due to degeneration. To restore the tissues of a kidney in advanced chronic nephritis, or of a spinal cord in advanced sclerosis, to restore these obliterated tissues to functional activity would surely constitute a miracle hardly less stupendous than to raise to life a putrefying corpse. If Christian Science can do the one, it can surely do the other. Lastly, when Mr. Dixon speaks of the rapid spread of Christian Science, he forgets Joe Smith the Mormon Prophet, Dowie of Zion City, and the whole army of smaller and bigger inspired preachers of the same sort, whose progress for a time was much more wonderful than that of which the new cult can boast. The former bubbles have been pricked, and have collapsed; *magna est veritas et prævalebit.*

I am, Sir, yours truly,
Henry Sewill.

March 11th, 1908.

[Correspondence on this subject must now cease.—Ed.]

VACCINATION AND THE MEDICAL PROFESSION.

To the Editor of The Medical Press and Circular.

Sir,—The question raised by Mr. Swan in your issue of the 4th inst. really has no bearing on the matter under discussion. We are concerned with facts, not theories, and explanations can be dispensed with in view of the unquestionable fact that vaccination *does* protect against small-pox, as Mr. Swan concedes in his second paragraph. I can no more explain why it does so than why quinine arrests malaria, mercury syphilis, and so on.

As a matter of fact, vaccination does in some measure protect against itself in that a large proportion of re-vaccinations at an early date prove negative, and, when successful, the resulting serum is comparatively inert—but all this is beside the mark.

The duration of the protection afforded by vaccination no doubt varies in different individuals, just as does the immunity created by an attack of typhoid or scarlet fever to these diseases respectively; but the evidence at our disposal justifies the belief that it is much longer than the period so confidently stated by your correspondent.

I am, Sir, yours truly,
Alfred S. Gubb, M.D.

Algiers, March 12th, 1908.

OBITUARY.

HALLIDAY DOUGAS, M.D., ED., F.R.C.P.

The death occurred on the 10th inst., at his residence, Park Crescent, Edinburgh, of Dr. Andrew Halliday Douglas, Senior Fellow on the roll of the Royal College of Physicians, Edinburgh, as a practitioner. A son of Mr. William Douglas, W.S., Edinburgh, he was born in 1819, and was thus in his eighty-ninth year. He was educated at the High School of Edinburgh. In 1835 he entered the University of Edinburgh, and graduated in medicine in 1840. Three years later he became a Fellow of the Royal College of Physicians, and in the same year, 1843, at the age of 24, he was appointed ordinary physician to the Edinburgh Royal Infirmary. During the tenure of his office in the infirmary, and for some years subsequently, he had a considerable practice as a consultant, and among other posts filled by him was that of Physician to the Chalmers Hospital and Medical Officer to the General Post Office. He held the latter appointment from its inception for a period of about 40 years, and resigned it in October, 1897. For many years Dr. Douglas was Treasurer of the Royal College of Physicians, and in 1870 held the office of President of the College. Dr. Douglas was specially interested in the pathology and treatment of heart disease, and wrote one or two monographs on that subject. He also made a special study of relapsing fever, which was epidemic in Edinburgh in 1843. In 1890 Dr. Douglas retired from active work, and since that time resided partly in the country. His eldest son, Dr. Kenneth M. Douglas, succeeded him in practice in Edinburgh. His second surviving son is Mr. Charles M. Douglas, of Auchlochan, formerly M.P. for North-West Lanarkshire. His second son, the Rev. Professor Halliday Douglas, of Knox College, Toronto, predeceased him in 1902.

THOMAS DEAN, M.D.St.And., M.R.C.S.

We regret to learn that Burnley has lost one of its most familiar figures by the death of Dr. Thomas Dean, who died at his residence on March 11th, after a brief illness. He had been in failing health for some months past, but a week last Monday he was attending to his duties as Medical Inspector of Factories. The deceased gentleman was one of the oldest medical men in East Lancashire, and he was certainly the oldest in the Burnley district. Born at Slaithwaite, Yorkshire, in 1833, he came to Burnley over half a century ago. For over 30 years he acted as Medical Officer for the borough, retiring some few years ago, and for over 20 years he had been the Certifying Surgeon to the Factories. In years gone by the Liberal cause found in him a zealous worker, and he was a Vice-President of the Burnley Liberal Association. He took a great interest in the Burnley Literary and Scientific Society, and he has lectured before the society on the "Place Names of Burnley," on which subject he was the recognised authority. He was a genial and most highly respected gentleman.

EDWARD ROBERT BICKERSTETH, F.R.C.S.Eng. and Ed.

It is with much regret we record the death of Mr. Edward Robert Bickersteth, which took place on March 7th at his Liverpool residence, at the ripe age of eighty. The family to which Mr. Bickersteth belonged was well known for many generations in South Lancashire. His grandfather, a medical gentleman, had four sons. Of these, one was the Rev. Edward Bickersteth, vicar of Walton, Herts, whose son became Bishop of Exeter. Another, who went to the Bar, became the famous Lord Langdale, Master of the Rolls; a third, the Rev. John Bickersteth, vicar of Sepcott, Leeds, was father of the late Dean of Lichfield, and of the late Bishop of Ripon. A son of the Bishop of Exeter, just named, became Bishop of Japan. His fourth son, Mr. Robert Bickersteth, father of Mr. E. R. Bickersteth, was surgeon, and afterwards consulting surgeon of the Liverpool Royal Infirmary. Mr. E. R. Bickersteth's medical studies, commencing in the Liverpool School of Medicine in 1845, were afterwards pursued in Edinburgh, London, Dublin, and Paris. After obtaining his diploma as member of the Royal College of Surgeons, England, he returned to Edinburgh, and he had the honour of being elected by Professor Syme as his house surgeon. In 1852 he began general practice in Liverpool, according to the almost invariable provincial custom of that time; but his predilection for surgery was so strong that in 1857, finding no surgical appointment vacant, he established a private hospital, which attracted considerable attention from the public and the profession, and led to his appointment, at the age of twenty-eight, as surgeon to the Royal Infirmary. For many years also he conducted a course of lectures on systematic surgery in connection with the Liverpool School of Medicine. Although the responsibilities of a large consulting practice, extending over a very wide district, had curtailed the time at his own private disposal, he found opportunity during his earlier career, extending to the early seventies, to contribute upwards of twenty papers recording his experiences. From that time onwards his services were so much in demand that his opportunities for adding to these enrichments were practically nil. The Liverpool Royal Infirmary may be said to have enjoyed the services of the Bickersteths, father and son, for almost a century, Mr. Robert Bickersteth having served it as operating surgeon from 1811 to 1853, and Mr. E. R. Bickersteth from 1856 to 1888. At the close of his career as surgeon to the institution named, the subject of this memoir was appointed consulting surgeon, a position he held till his death. A remarkable indefatigable worker while on duty, he annually enjoyed a summer holiday, which he generally spent in yachting, and to that was largely attributable the excellent health he so long enjoyed.

WILLIAM CLARKSON, L.R.C.P.ED., L.F.P.S.GLAS.

WE regret to record the death of Dr. W. Clarkson, who was buried at Morpeth on March 10th, and who, in addition to having a large private practice, had held many public medical appointments, and was an ex-Mayor of the town. He was 78 years of age, and obtained his first qualification, the L.F.P.S. of Glasgow, as long ago as 1856. The funeral was attended by the Mayor and members of the Town Council, in addition to representatives of numerous other private bodies.

REVIEWS OF BOOKS.

HYPNOTISM AND SUGGESTION.

IT is more than seven years since (August 1st, 1900) we reviewed the fourth edition of Dr. Lloyd Tuckey's book on "Treatment by Hypnotism and Suggestion." In the time that has since elapsed there has been curiously little added to our knowledge of the subject, but that little has not escaped Dr. Tuckey's notice, and consequently the fifth edition (*a*) of his book, recently published, will be found to contain the most recent information. In commenting on the previous edition, we said that "hypnotism has established its right of therapeutic tenure." Of this there is, of course, no doubt, but, at the same time, it is not to the credit of the medical profession that the exercise of hypnotism as a therapeutic agency has been left so much to the quack and the enthusiast. While the medical use of hypnotism and suggestion has grown but little during the past half-dozen years, the various sects of faith-healers and Christian Scientists whose methods depend on suggestion have flourished greatly.

In the present volume Dr. Tuckey claims for suggestive treatment its proper place, not as an exclusive method, but as an important weapon in the physician's armamentarium. He makes clear, by reference to actual cases in his own practice, and in the practice of others, the classes of disease which are likely to be benefited by this method of treatment. In particular he shows that various drug-habits, and other evil habits, may be cured by hypnotic suggestion when all other treatment has proved ineffective. At the same time he is laudably frank in admitting his failures, and he writes in the cautious spirit of a man of experience as well as of a man of science.

His directions as to the methods he himself finds most useful are clear and precise, while he does not attempt to tie individual physicians within a definite set of rules. Individual cases will require individual treatment, and the physician must use his discretion as to the methods he will employ.

Dr. Tuckey writes in pleasant, chatty narrative style, and his book is one which a reader will find convenient to take up at any moment. His knowledge of his subject is thorough, and his own views are constantly supported by references to the literature as well as to the records of his own extensive practice.

It is unnecessary to recommend a book already in its fifth edition.

PRECIOUS STONES FOR CURATIVE WEAR. (*a*)

FROM time immemorial gems and precious stones have exercised a fascination for men and women which cannot be adequately explained by their intrinsic value or even by their beauty. The book before us purports to offer as an explanation for this fact that such precious stones when worn as jewellery can, and do, exercise a direct physical influence over the life and health of the lucky possessor. Such teaching was, of course, almost universally accepted in the Middle Ages, and it would seem that the discovery of the therapeutic action of radio-active substances in recent years is tending to cause its readoption. The great advances of physical sciences has in no way killed the superstitious beliefs of the majority of the people, and even the most slender basis of physical science is gladly welcomed by them as a justification for the practices which result from such beliefs. With such a subject our author has ample material for a most interesting book, and we can only regret that he has not made better use of it. Where he confines himself to the description of the gems or the history of their uses in medicine in the past he is interesting, but the numerous repetitions and the long extracts from the novels of Dickens and other authors make the extraction of the interesting paragraphs not a little tedious. Much, however, we suppose must be forgiven to a medical author who believes that the wearing of a diamond ring is a preventive "against a disposition to acid, flatulent indigestion," and that the suspension of a disc of copper against the skin of the abdomen will prevent infection by the cholera vibrio.

CARDIAC AFFECTIONS. (*b*)

AMONG the new volumes constituting the series of "Oxford Medical Manuals," Dr. Poynton's work is one of the best. It is an excellent example of concise yet comprehensive presentation of a peculiarly difficult and almost unlimited subject. By judicious grouping, clear exposition, and a real knowledge of the needs of the young practitioner, the author has been enabled to gather into this pocket manual a serviceable description of the more important forms of cardiac lesion, with indications as to the best means for their clinical investigation and effective treatment. As would be expected from such an investigator as Dr. Poynton, special attention is devoted to what are considered the "rheumatic" affections of the heart; but throughout there is a fair and broad-minded presentation of points, and personal views and predilections are not unduly urged. The work is primarily intended for the inexperienced practitioner, and for such it will be invaluable, but it contains much which will be of suggestive value even to the cardiac "specialist." The former will welcome the numerous prescriptions and notes on diet, Schott movements and preparation of Nauheim baths, and the latter will be particularly interested in the well-executed series of illustrations dealing with pathological conditions. Dr. Poynton has accomplished a difficult task with conspicuous success.

AT the joint half-yearly conference of representatives of societies and institutions engaged in social service held in the Onward Buildings, Manchester, Principal J. W. Graham in the chair, a resolution was passed unanimously trusting "that the Notification of Births Act will shortly be adopted in Manchester; subject to such changes in administration as may be agreed on," and suggesting that the notice might go to the Registrar, the Registrar communicating frequently with the Medical Officer of Health.

FORTY new cases of bubonic plague have occurred at Antofagasta during the last few days.

(a) "Treatment by Hypnotism and Suggestion, or Psycho-Therapeutics." By C. Lloyd Tuckey, M.D.Aberd.; Membre Fondateur de la Société d'Hypnologie; President of the Medical Society for the Study of Therapeutic Suggestions, &c. Fifth Edition, revised and enlarged, with an introductory chapter by Sir Francis R. Cruise, M.D., D.L., K.S.G., Honorary Physician to the King in Ireland. Pp. xxviii and 418. London: Bailliere, Tindall and Cox. 1907.

(*a*) "Precious Stones for Curative Wear: and other Remedial Uses; likewise the Nobler Metals." By W. T. Fernie, M.D. 8vo. Pp. xviii. and 486. Bristol: John Wright and Co. 1907.

(*b*) "Heart Disease and Thoracic Aneurysm." By F. J. Poynton, M.D., F.R.C.P., Assistant Physician to University College Hospital. Pp. 310, with xvii plates and 20 figures. London: Henry Frowde and Hodder and Stoughton. 1907. Price 5s. net.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Adrenalytic and Thymolytic Sera.—Ritchie has endeavoured to produce specific antisera from the adrenal and thymus glands, working principally with ducks and guinea-pigs (*Journal of Pathology*, January, 1908, p. 140), and has partially succeeded. He summarises his results as follows:—(1) The serum obtained from ducks which have been treated with guinea-pigs' adrenals contains an adrenaphilic immune body, which in the presence of guinea-pigs' complement becomes fixed to guinea-pigs' adrenals. (2) The serum is not strictly specific, but there is no evidence of it being hæmolytic. (3) The serum, although adrenaphilic, was not adrenalytic. (4) The adrenaphilic immune body was thermostabile at 51° C., but not at 57° C. With the thymus gland Ritchie was enabled to obtain a leucolytic serum, of which he gives the following account:—(1) The serum obtained from ducks which had been treated with the thymus gland of guinea-pigs contained a leucophilic immune body. (2) In the presence of this immune body, guinea-pigs' complement became fixed to guinea-pigs' thymus, lymphatic gland, bone-marrow and spleen. (3) The serum was not hæmolytic. (4) The structural changes in the thymus of the guinea-pig following injection of the serum were due to its leucolytic action, and are not specific.

M.

Leucocytosis in Diphtheria.—Dean has carried out some interesting investigations on the leucocytosis of diphtheria, and the modifications observed in the blood after the injection of antitoxin. He has worked both with patients suffering from diphtheria, and also experimentally with rabbits (*Journal of Pathology*, January, 1908, p. 154). He gives the following main conclusions:—(1) After the experimental injection of diphtheria toxin there is a great increase in the total number of leucocytes; this increase is due to the appearance in the blood of enormous numbers of polynuclear cells. (2) After the injection of diphtheria toxin, degenerative changes can be demonstrated in both the white and the red cells. In the latter polychromatophilia is well shown. The eosinophile cells usually completely disappear. No myelocytes are seen. (3) The changes following experimental injection of toxin are similar to those seen in cases of diphtheria occurring in the human subject. (4) A dose of antitoxin, which, when given simultaneously with the toxin, completely protects the animal under observation, prevents the appearance of a leucocytosis. Similarly, when a sufficient dose of antitoxin is given shortly after the injection of the toxin, the number of leucocytes rapidly falls to normal. (5) When a considerable interval is allowed to elapse between the injection of toxin and the injection of antitoxin, no reduction in the leucocytes occurs. (6) In two clinical cases the interval between the onset of the disease and the employment of antitoxin was relatively short, and in these cases a considerable reduction in the leucocytosis appeared to follow the use of antitoxin. (7) No reduction was observed in four other cases in which a relatively longer time had elapsed between the onset of symptoms and the use of antitoxin. (8) A marked reduction in the leucocytosis occurring within the first 24 hours after the injection of antitoxin probably indicates a good prognosis. (9) A sufficient dose of antitoxin completely protects the blood cells from degenerative change.

M.

New Growths of the Testicle.—Nicholson presents an elaborate study of new growths of the testis, based on an examination of 65 cases (*Guy's Hosp. Reports*, Vol. LXI., p. 249). His conclusions are as follows:—(1) The only form of carcinoma met with was spheroidal-celled. This was in almost every case encephaloid in character, and was both alveolar and non-alveolar. It is frequently mistaken for sarcoma, and may be met with at an early age. It is clinically malignant, and is the second most common variety of tumour met with. (2) The sarcomata met with are usually round-celled. They are more malignant than the cancers, and are met with at an earlier age. They are occasionally bilateral, and appear to disseminate by the blood-vessels, as distinguished from carcinomata, which spread by the lymphatics. (3) Endotheliomata arise from the endothelium of the blood-vessels or lymphatics. They occur most often in young adults, and usually run a benign course. They may, however, produce metastatic growths in lymph glands. (4) Embryomata are the commonest form of new growth in the testis. They contain structures from the three blastodermic layers of the embryo. Although not necessarily malignant, they may produce metastasis of all the tissues of the primary growth, or one tissue may become actively malignant, in which case the deposits will be formed from that tissue alone. (5) Some embryomata contain trophoblast derived from the epiblast of the primary growth. In these cases the trophoblast assumes malignant characters and forms secondary growths. The trophoblast may assume a form resembling carcinoma, sarcoma, or endothelioma.

M.

Typhoid Carriers.—The term "typhoid carrier" has been applied during the past few years to people who, having once suffered from typhoid fever, retain the typhoid bacilli in their bodies after their return to health, and may, therefore, act as distributing agents of the infection. This condition may last for several years. A. and J. C. G. Ledingham report (*British Medical Journal*, January 4th, 1908) an investigation into the cause of typhoid in an asylum in Scotland, in the course of which they discovered three "typhoid carriers." Ever since 1893 the asylum in question, a small one, with a population of about 150, had been subject to outbreaks of typhoid fever. Thirty-one cases had occurred, 24 of the patients being females. The water and milk supplies were shown to be pure, and the drainage system excellent. Examination of the blood and fæces of all the female patients, some 90 in number, was made. It was discovered that three not only gave a positive Widal reaction, but exhibited large numbers of typhoid bacilli in the stools. The typhoid bacilli had grown almost to the exclusion of other germs, and were more plentiful than *b. coli*. One of the patients had certainly not had typhoid fever since 1896, another had it in 1895, and the third in 1904. Dean publishes (*British Medical Journal*, Maroh 7th, 1908) a remarkable case of a "typhoid carrier," where infection apparently persisted for 29 years. The patient, a medical man, had, at that distant period, suffered from typhoid fever. Ever since, though as a rule his health was good, he had been subject to occasional attacks of biliary colic, sometimes accompanied by jaundice. The Widal test with his blood was doubtful, but typhoid bacilli were present in the fæces in enormous numbers, being more plentiful even than *b. coli*. The importance of such cases from the public health point of view is great, as "typhoid carriers," especially those employed in certain occupations, may disseminate infection far and wide. It is supposed that in the "typhoid carrier" the germs are present and multiply in the gall-bladder, making their way into the intestine with the bile.

R.

Experimental Bone Formation.—The formation of bone in abnormal situations has long been a familiar phenomenon in certain pathological processes. It is only recently, however, that bone has been produced as the result of experiment. Harvey publishes (*Journal of Medical Research*, October, 1907) a description of certain experiments which demonstrate that the process can be carried on without difficulty. He exposed the aortas of rabbits to the action of a strong irritant—silver nitrate or copper sulphate—and in five out of ten experiments bone was produced in the middle coat of the vessel. In three others bone-like tissue, but not calcified, was found. The bone formation took place in the tissue previously necrosed, and was a sequel of extreme calcareous degeneration. In some of the cases not only bone, but bone-marrow, was found. Harvey believes that the process is one of ossification of previously formed connective tissue. R.

The Giant Cell of Tubercle.—There are two current theories as to the histogenesis of the giant cell so frequently found in tubercular lesions: (1) Origin from a single cell by multiplication of nuclei and enlargement of protoplasm; (2) formation by fusion of several cells. Laura Forster (*Journal of Pathology and Bacteriology*, October, 1907) puts forward a new theory. She holds that the so-called "giant cell" is not a cell at all, and has no function as a cell. It arises, she believes, from the coalescence of the cytoplasm of several epithelioid cells, the margins of which have merged and disappeared. As reasons for this view, she points out that the typical shape of the giant cell is really the result of shrinkage, and that with careful preparation the cell appears merely as a protoplasmic mass, filling the space between the epithelioid cells. Its form is moulded by the groin space. When considerable shrinkage has taken place the typical processes are seen, which, according to the author and others, are connections with the reticulum of the part. She believes she has observed a reticulum present in some giant cells. Mitotes figures were not observtd in the giant cells, nor was any evidence found of increase in the number of nuclei. The number of nuclei seemed to correspond with what would be found if a like space were occupied by epithelioid cells. She concludes, therefore, that the giant cell of chronic tuberculosis is a retrogressive metamorphosis, and one, if not the only, stage towards the process of caseation. R.

Phagocytic Action of the Alveolar Cells of the Lung.—Briscoe publishes (*Journal of Pathology and Bacteriology*, October, 1907) an account of a series of experiments undertaken to discover what cells undertake phagocytic duties in the lungs. His experiments were performed by introduction of foreign particles through a tube inserted into the trachea and carried down to the lung, the animal being killed a definite time after the inoculation. In different experiments, pigeons' blood corpuscles, staphylococci, and other organisms were employed, and the tests varied by the presence or absence of opsonins and minimum sera. The following are among the conclusions arrived at: (1) The mononucleal cells, whether containing pigmtnt granules or not, which are present in the alveoli, when of sufficient size, are powerful phagocytes. (2) Their phagocytic action depends on the presence of an opsonin. (3) With a mild injection, by the help of on opsonin and without the intervention of leucocytes, the alveola cells can free the lungs of the organisms. (4) If the injection is more virulent, but not fatal, the polymorphs give active assistance. (5) Phagocytosis by the alveolar cells is more rapid when the injected bodies have been treated with minimum serum than when untreated organisms are injected with a previously immunised animal. (6) Phagocytosis is more rapid when the animal injected has been previously immunised than when a normal animal is employed. (7) During the first hour and a half nearly all the phagocytosis is performed by the alveolar cells. (8) The bronchioles, not being lined with phagocytic cells or mucous glands, are at a disadvantage as compared with the alveoli during the early part of an infection spreading down the trachea. R.

Morbid Anatomy and Histology of Myelocythæmia.—Gulland and Goodall report (*Journal of Pathology and Bacteriology*, January, 1908) the results of their examination of seven cases of myelocythæmia. The following are the principal findings, classified under the various organs:—*Liver.*—The portal spaces and hepatic capillaries were invaded by leucocytes, myelocytes predominating. Hæmoblasts were numerous in three cases. Large phagocytes, ingesting red and white cells, were found. Pigment was present in every case. *Spleen.*—The Malpighian corpuscles were small. The pulp was packed with leucocytes; nucleated red cells were frequent; giant-cells were numerous in two cases; phagocytes injecting red cells were found. Pigment was present in every case. *Kidneys.*—Catarrhal changes were present in four cases; leucocytic infiltration was frequent; pigment was found in the epithelial cells in two cases. *Bone Marrow.*—In every case the bone marrow was myelocytic. *Blood.*—The total counts of leucocytes varied between 200,000 and 500,000. The differential percentages varied greatly, not only in the different cases, but in the same case at different times. Thus, in different cases, the polymorphs varied from 10 to 77 per cent., and the myelocytes from 2 to 65 per cent. In one case the polymorphs were found to vary from 7 to 31 per cent., and the myelocytes from 44 to 68 per cent. Nucleated red cells, and especially myaloblasts, were numerous. R.

MEDICAL NEWS IN BRIEF

Royal College of Surgeons of England.

At a meeting of the Council, held last Thursday, Mr. Henry Morris, President, in the chair, the Secretary reported the deaths of Mr. Reginald Harrison, Vice-President, and Sir Alfred Cooper, Vice-President. Votes of condolence were unanimously passed expressing the deep regret of the Council at the death of their distinguished colleagues, and their sincere sympathy with Mrs. Harrison, Lady Agnes Cooper, and their families in the loss which they have sustained.

Mr. David Ranken, of Durham University, and Mr. B. A. Lloyd, of Birmingham University, having passed the required examinations and conformed to the by-laws, were admitted members of the college. Mr. W. A. Maggs, dental surgeon to Guy's Hospital, was re-elected a member of the Board of Examiners in Dental Surgery, and Mr. Rickman J. Godlee was elected the representative of the college upon the council of University College, Bristol in the vacancy occasioned by the resignation of Mr. Thomas Bryant.

A letter was received from the University of Liverpool asking the Council to accept two summer sessions and the second winter's attendance at general hospital practice for the L.D.S.Eng., instead of two winter sessions as required by the present regulations. The letter was referred to the Board of Examiners in Dental Surgery to consider and report thereon.

The Admission of Women as Members.—The President stated that he had fixed July 1st as the date for closing the poll of Fellows and Members on the subject of admitting women to the diplomas of the College. With regard to the question the following notice is to be circulated to the Fellows and Members: "The Council, although they have decided that it is desirable to admit women to examination to the diploma of member, and although they have power to act upon this opinion, are anxious, in accordance with a resolution passed at a meeting of the Council on May 9th, 1907, to obtain the views of Fellows and Members on the matter. In regard to the corporate position of women, if the diplomas of the College be granted to them, the council have taken legal opinion, and are advised that while under the Medical Act of 1876, women can be admitted as members or as Fellows, no woman so admitted would thereby be entitled to take any part in the government, management, or proceedings of the college. (a) In your opinion, is it desirable that women should be admitted by examination as members of the College? (b) In your opinion, is it desirable that women, after admission to the Membership, should be admitted by examination as Fellows of the College?"

Dublin Sanitary Association.

The annual meeting of the Dublin Sanitary Association was held last week in the Theatre of Leinster House, Major D. C. Courtney in the chair. The Secretary (Dr. P. C. Kirkpatrick) read the annual report, which stated that there were 131 members on the books of the Association, being 3 more than last year. For some years past the chief work which had occupied the attention of the Council was to endeavour to put some check on the high rate of infant mortality that obtains in all large cities. In that respect Dublin is more favourably situated than many of the large manufacturing towns in England, but still the waste of infant life, which to a large extent is the result of preventible causes is one of the most serious blots on the sanitary administration of the city. They earnestly appealed for funds to push forward the work successfully. The Council was impressed with the necessity of the strictest control being exercised over the milk supply. The report went on to observe that since the State had adopted the principle of compulsory school attendance it was only right that it should protect children from disabilities arising from such attendance. Such protection could only be secured by systematic and efficient medical supervision. On the subject of private slaughter-houses, which formed a serious blot on the sanitary administration of the city, the report stated that since the City Abattoir was opened in 1882, a considerable amount of public money had been spent on it, and that expenditure had been made on the understanding that the Abattoir was to replace the private slaughter-houses. The Council believed that the matter merited the most careful consideration of the city authorities, and that while steps should be taken immediately to put the city in possession of a thoroughly efficient abbattoir, it was almost useless to embark in that expense unless steps were at the same time taken to ensure that when ready it would not only replace some, but all, of the private slaughter houses The report referred to the recent wakening up throughout the country to stay the ravages of tuberculosis.

Consumption in the Army.

The preliminary report of the War Office Committee on the treatment of soldiers invalided for tuberculosis has been issued. The Committee is of opinion that the practicable methods of treatment resolves itself into three alternatives as follows: (1) To continue the present method, viz., to discharge at once from the Army any man who is diagnosed as suffering from tubercle of the lung, to discharge him from hospital as soon as he is fit to travel, and afterwards to disown all responsibility for him; (2) to provide a special central military sanatorium for tuberculous patients, to which all soldiers suffering from the disease should be sent for treatment; and (3) to make use of existing civil sanatoria, in all parts of the country, by reserving in each a number of beds at the expense of the Army funds, and by transferring soldiers who are suspected of having the disease to the available institution nearest to their own homes. The last method (3) is the one recommended by the Committee. Under existing arrangements no provision whatever is made by regulation for soldiers invalided for tubercle. The cost of this proposal cannot be ascertained in detail until the sanatoria have been consulted, but a rough idea of the amount involved can be given. About 200 beds would, it is computed, require to be maintained. The cost of these, at 30s. a week, would be £15,600 per annum. It may therefore be said that the total cost of the scheme will not exceed £20,000.

Male Nurses.

An appeal for £2,000 is made by the Army and Navy Male Nurses' Co-operation, recently founded under the patronage of her Majesty the Queen. Once started, it is hoped that it will be self-supporting. The object in view is to afford the public the opportunity of engaging well-trained male nurses and sick attendants of assured good character. The men supplied by the Co-operation are retired non-commissioned officers and men of the nursing section of the Royal Army Medical Corps and members of the Sick Berth Staff of the Royal Navy. The funds are needed to defray the initial cost of providing and equipping a suitable office, to be available day and night, of advertisements, and of obtaining a small house, where the men can lodge when waiting to be despatched to their cases. This latter requirement is essential in the interests of the patients served and for securing prompt response to all applications. The public, by supporting the movement, will be giving employment to a deserving class of men, and without such an organisation as the present find it difficult to obtain employment in their profession after leaving the Army or Navy

Scholarships for Students of Midwifery.

We are asked by the Executive Committee of the London County Council to announce that six Scholarships of £25 each to Students in Midwifery will be awarded in July next to candidates who must furnish satisfactory evidence as to character, must be not less than 25, and not more than 40 years of age. Candidates must also be prepared to satisfy the Council as to their need for pecuniary assistance for the purpose of training as midwives, and to enter into a bond with sureties that they intend to practice as midwives for two years among the poor within the area of the Administrative County of London. They must be resident within the area of Council, and will be required to pass a qualifying examination on May 15th in writing from dictation and elementary arithmetic, the standard being substantially equivalent to that set out in the Board of Education Code of Regulations for Public Elementary Schools, 1907. Candidates will be supplied with forms and additional information on application to the Executive Officer, Education Offices, Victoria Embankment, W.C.

King Edward's Hospital Fund.

We are asked to state that hospitals in the County of London, or within nine miles of Charing Cross, desiring to participate in the grants made by this fund for the year 1908 must make application before the 25th inst. to the honorary secretaries, 7 Walbrook, E.C. Applications will also be considered from convalescent homes and sanatoria for consumption which are situated within the above boundaries or which, being situated outside, take a large proportion of patients from London.

It will be seen that the scope of the operations of the fund has been extended by the enlargement of the radius from seven to nine miles from Charing Cross, as well as by the admission to consideration of the claims of consumption sanatoria situated in the country in those cases in which it can be shown that a large number of London patients are treated.

Another X-ray Victim.

Mr. T. J. Oliver, the X-ray operator at Leeds General Infirmary, has had an arm so badly affected by dermatitis that amputation was found to be necessary. Mr. Oliver's health has broken down and the Infirmary Board have granted him a pension of £1 5s. per week.

Trinity College, Dublin.

The following candidates passed the Final Medica Examination—Part I., at Hilary term, 1908:—Phibbsl John L., Frederick A. Anderson, Desmond Drew, Wellesley R. Allen.

Dr. George F. Blacker, F.R.C.P., Physician to University College Hospital and the Great Northern Central Hospital, has been appointed a Director of the Clerical and Medical Life Assurance Society, in the place of Sir William H. Broadbent, M.D., Bart., deceased.

Owing to a serious outbreak of whooping-cough, it has been decided to close the elementary schools in Northenden for a period of three weeks. Already five or six fatal cases have been reported.

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

DR. JAMES A. S.—Steel instruments should not be steamed with the object of sterilising them. They should be boiled in water containing an alkali. In practice a heaped-up tablespoonful of washing soda to the gallon of water is used. The soda should never be omitted. It should also be remembered that no soda is contained in the steam from soda and water.

DR. BRILL.—The letter of Dr. Schweiger has been addressed to the gentleman referred to.

MR. GREATREX.—We have made inquiries, and have found that the work is out of print. A new edition, however, is in preparation, and will, we understand, be issued about October next.

DR. C. H.—Our correspondent has undoubtedly been misinformed. The present holder of the title is the grandson of the distinguished surgeon, who died in 1893.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 18TH.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m.: Mr. C. F. Rousselet: Exhibition of Mounted Specimens. Right Hon. Lord Avebury: On Seeds, with Special Reference to British Plants.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Mr. M. Greenwood: The Physiological and Pathological Effects which follow Exposure to Compressed Air. (Arris and Gale Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. R. H. J. Swan: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. H. Thursfield: Post-Basal Meningitis.

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Surgical In-patients (Mr. Stabb); Medical Out-patients (Dr. Horder); Gynæcological (Dr. Lockyer); Skin (Dr. Whitfield); Teeth (Mr. Baly); Operations (Mr. Stabb).

THURSDAY, MARCH 19TH.

ROYAL SOCIETY OF MEDICINE (DERMATOLOGICAL SECTION) (20, Hanover Square, W.).—5 p.m.: Clinical Cases will be shown by Dr. J. H. Sequeira and others.

CHILD STUDY SOCIETY, LONDON (Parkes Museum, Margaret Street, W.).—8 p.m.: Dr. F. C. Shrubsall: Anthropometry and Physical Development (illustrated by lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. L. Guthrie: Precocious Development.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture-Demonstration:—Mr. H. Evans: Congenital Dislocation of the Hip-Joint.

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—2.30 p.m.: Medical In-patients (Dr. Morison).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Lecture:—Dr. M. Dockrell: On the Treatment of Skin Diseases.

HOSPITAL FOR SICK CHILDREN (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Poynton: Rheumatism in Children under Five Years.

FRIDAY, MARCH 20TH.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11, Chandos Street, Cavendish Square, W.).—5 p.m.: Dr. F. Langmead, Dr. P. Weber, Dr. C. Chapman, Dr. G. Carpenter, Dr. P. Parkinson, Mr. S. Stephenson, and others: Cases and Specimens.

SOCIETY OF TROPICAL MEDICINE AND HYGIENE (20, Hanover Square, W.).—8.30 p.m.: Mr. A. E. Shipley: The Relation of Entozoa to the Mucous Lining of the Alimentary Canal. Dr. W. T. Prout: (1) The Role of Filaria in the Production of Disease; (2) Note on an Unusual Cause of Dysenteric Diarrhœa in the Tropics; (3) exhibit of the Sword of a Sword Fish removed from a man who had been transfixed by it.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m.: Mr. M. Greenwood: The Physiological and Pathological Effects which follow Exposure to Compressed Air. (Arris and Gale Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. R. Lake: Clinique. (Ear.)

GREAT NORTHERN CENTRAL HOSPITAL (Holloway Road, N.).—3.30 p.m.: Lecture:—Dr. A. Morison: On Cardio-pulmonary Murmurs, their Diagnosis and Signification.

Appointments.

BRISCOE, J. CHARLTON, M.D.Lond., Assistant Physician to King's College Hospital.

CROSS, F. G., F.R.C.S.Eng., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Kingston District of the county of Surrey.

EAGER, RICHARD, M.B.Aberd., Senior Assistant Medical Officer at the Devon County Asylum, Exminster.

HUDSON, BERNARD, M.D.Cantab., M.R.C.P.Lond., Assistant Physician to the Royal Hospital for Diseases of the Chest, City Road, E.C.

JEWESBURY, REGINALD C., M.B.Oxon., M.R.C.P.Lond., Assistant Physician to Charing Cross Hospital.

MONTESOLE, M. HERSCHEL, L.R.C.P.Lond., M.R.C.S., Junior House Surgeon at the Western General Dispensary, Marylebone Road, N.W.

RIGGALL, ROBERT MARMADUKE, M.R.C.S., L.R.C.P., Second Assistant Medical Officer at the Devon County Asylum, Exminster.

SILVER, CLIFFORD MARKING, L.D.S.Eng., Dental Surgeon to the Exeter Dental Hospital.

WATKINS, JOHN G., L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Taunton Board of Guardians.

Vacancies.

The Royal National Orthopædic Hospital, 234, Gt. Portland Street, W.—House Surgeon. Salary, £250 per annum. Applications to the Secretary.

Jaffray Branch of the General Hospital, Gravelly Hill, near Birmingham.—Resident Medical and Surgical Officer. Salary, £150 per annum, with board, residence, and washing. Applications to the House Governor, General Hospital, Birmingham.

Borough of Ipswich.—Assistant Medical Officer of Health. Salary, £150 per annum. Applications to Will. Bantoft, Town Clerk, Town Hall, Ipswich.

University of Manchester.—Senior Demonstrator in Physiology. Salary, £150 per annum. Applications to the Registrar.

Urban District of Finchley.—Medical Officer of Health. Salary, £300 per annum. Applications to E. H. Lister, Clerk to the Council, Council Offices. Church End, Finchley.

Devon County Asylum, Exminster.—Third Assistant Medical Officer. Salary, £140 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Asylum, Exminster.

Kent County Council.—Medical Officer of Health. Salary, £800 per annum, with all travelling expenses. Applications to W. B. Prosser, Clerk of the Kent County Council, Sessions House, Maidstone.

Women's National Health Association (Carlow Branch).—Qualified Nurse. Salary, £70. Applications to Hon. Sec. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer for eight months. Salary, £20, washing allowance £2 10s, with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician for eight months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

Births.

BARENT.—On March 14th, at 65, Rodney Street, Liverpool, the wife of Frank H. Barent, M.D. Lond., F.R.C.S., of a daughter.

CLARK.—On March 13th, at 88, Chamberlayne Wood Road, Kensal-rise, Kathleen, the wife of Reginald Clark, M.R.C.S., L.R.C.P., of a son.

MAXWELL.—On Feb. 3rd, at Yung-chun, Fuhkien Province, China, the wife of J. Preston Maxwell, M.B., F.R.C.S., of a daughter.

MORTON PALMER.—On March 9th, at 13, Orchard Gardens, Teignmouth, S. Devon, the wife of F. W. Morton Palmer, M.A., M.B., B.C.Cantab., of a son.

OXLEY.—On March 10th, at Osborne Road, Buckhurst Hill, Essex, the wife of F. J. Oxley, M.R.C.S., L.R.C.P., of a son.

Marriages.

BRUCE-LOW—BERGEN.—On March 12th, at the Cathedral, at Singapore, Robert Bruce-Low, jun., M.R.C.S., L.R.C.P.Lond., of Kuching, Assistant Government Medical Officer to the State of Sarawak, youngest son of Robert Bruce-Low, Esq., M.D., Helmsley House, 92, Christchurch Road, Tulse Hill, London, to Eva Charlotte Louise, only daughter of Henry Bergen, of Balham.

Deaths.

MAYNARD.—On March 15th, at Erith, Kent, J. Martin Maynard M.R.C.P., M.R.C.S., J.P., aged 72 years.

GOOLDEN.—On March 11th, at 4, Clifton Place, London, W., of heart failure, Richard Edward Goolden, of Horton Grange, Maidenhead, eldest son of the late Richard Henry Goolden, M.D., F.R.C.P.

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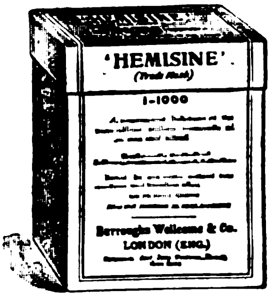

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MARCH 25, 1908. No. 13.

NOTES AND COMMENTS.

Nauheim in London.

SOME six months or so ago medical men were offended to see in the columns of the *Times* and other papers a series of blatant advertisements of an institute professing to give the "Nauheim Kur" in London, and very properly advised such patients as consulted them on the point to have nothing to do with the concern. It seems that the company, which had undoubtedly sunk a large amount of money in the enterprise, thought it possible to run with the hare and hunt with the hounds, that is to say, they did not fully realise the strength of medical sentiment on the question of patients with serious diseases being in the hands of lay persons for treatment. Disillusionment, however, on that point was brought home in the most practical way by medical opposition, and the refusal of the medical journals to take advertisements from the institute. We have good reason to believe that the proprietors have now repented of the error of their ways, and wish to run their business on ethical lines. They have given up advertising in the lay press, and three months ago engaged two medical men, Dr. Bain and Dr. Hill, to take charge of patients sent to them, and to prescribe and direct treatment in all cases. They assert their willingness for medical practitioners to supervise the treatment of their patients, if so desired, and, whenever possible by the circumstances of the case, they are prepared to refuse treatment to patients unless the family attendant is agreeable, or, at any rate, has had the opportunity of expressing his own views.

On Right Lines.

FROM a personal inspection of the institute, we can say that the arrangements and fitting up of the installations are very good. On the ground floor are baths and cubicles for men, and on the top floor similar appliances for women, whilst the two intermediate floors are occupied by separate gymnasia and exercise rooms for the two sexes. The baths and general system of treatment differ in some minor points from that carried out at Nauheim, but practically the same plan prevails at both, and medical men wishing their patients to undergo the treatment, have, therefore, a favourable opportunity of recommending them to undertake it in London, instead of after the fatiguing journey to Nauheim itself. The benedictions of others than ourselves have, before this, been passed on the new institute, and there are already cases under treatment sent by some of the leading hospital physicians. Its aim seems to us to be much the same as a hydropathic institution, namely, for a private company to conduct the business part, and to provide the regular staff, and for medical men, on their part, to undertake the direction of the treatment, and full responsibility for it. It is fair then to say that the ban previously, and very properly, placed on the institute should now be withdrawn, on the ground that the desire is to cater for a want in a legitimate and ethical way. We think it would certainly conduce to the establishment of confidence, if the proprietors had a board of highly-placed physicians to advise them on matters from time to time.

Indecent Advertisements.

QUITE the most objectionable type of quack advertiser is he who mingles with his ordinary trade, or makes his ordinary trade a cloak for, the purveying of sexual stimulants and similar filth. It is fair to say that there has been a great improvement in the lay Press of late years with regard to advertisements of this type, but there are still several journals which, under one disguise and another, publish announcements whose real character cannot be mistaken. With the extra vigilance of the police as to bills pasted up in urinals and similar delectable places, the gentry who live on this disgusting trade have considerably fewer opportunities of purveying their wares, and consequently fresh avenues for business have to be sought. The most offensive way which these dealers take to dispose of their "goods" is to send the descriptive pamphlets of them to recently-confined ladies, whose names and addresses are taken from the births column of the newspapers. The practice appears to be a very common one, and it is hardly possible to imagine a greater insult than for young mothers to be made the recipients of printed matter of this kind, especially when, as is usually the case, the covering envelopes are marked "Private." The suggestion in such cases is that the wife should conceal the receipt from the husband, and perhaps there is a certain fear of physical violence if the advertisements reached the husband direct.

How to Stop Them.

WE are therefore very glad to see the matter was taken up in the most practical manner by a medical man last week. A firm trading as the Cardinal Manufacturing Company, Wilson Street, Finsbury, having sent some of these indecent advertisements to his wife, who had given birth to a child a few days before, the doctor in question communicated with the police at Scotland Yard, and as a result of his action a summons was taken out under Section 4 of the Post Office Protection Act, 1884, which makes it an offence to send indecent matter through the post. The summons was heard at Bow Street, and it is perhaps hardly necessary to say that the company, which seems to be doing a large business, did not put forward any witnesses. A feeble attempt was made by the solicitor who defended to make out that the advertisements were not indecent because the words used were to be found in the dictionary, and because good-class firms advertised in their catalogues drugs like nux vomica, which have an aphrodisiac effect. This sort of stuff did not go down with the magistrate, who considered the offence proved, and to have been aggravated by the circumstances, and the full fine, £10, together with £5 5s. costs, was imposed. This case should therefore act as a precedent and an incentive. It is quite worth a man's while to give up an hour or two of his time to put a stop to this obnoxious practice, and if the trade of the Cardinal Manufacturing Company, or any other similar indecent firm, were broken up by such proceedings, we fancy it would not be much loss to anyone.

Compulsory Operations. The important question whether a workman drawing compensation under the new Act can be compelled to undergo a reasonably safe operation for the relief of the condition he is suffering from, came up again last week at the City of London Court. The question as regards Scotland was recently settled by a judge reducing the claimant's compensation to a shilling a week till the operation had been performed, but it has yet to be decided definitely in England. In the case under notice the workman had had an injury to the knee which had displaced the internal semilunar cartilage, and the plaintiff rather than undergo an operation for the relief of the condition preferred to continue indefinitely on half wages. Medical evidence on both sides was to the effect that the risk was practically confined to the risk of the anæsthetic, and that the result would almost certainly be a complete cure. Judge Rentoul, before whom the case was tried, held that in face of the evidence the workman, as a reasonable being, ought to submit to the operation. However, having regard to the importance of the point, His Honour would not take the responsibility of saying the man was bound to, or of ordering the stoppage of his compensation, until the matter had been submitted to the Court of Appeal. We think the learned judge's conclusion a sound one, and we hope the matter will now be definitely settled. There is a class of man who prefers to make the most of a disablement of this type till the employers can be induced to part with a lump sum in settlement. Then he undergoes the operation and starts on full wages again.

Hard Cases under the Act. Beneficent in the main as the Act is to the working classes, it operates with cruel injustice in some instances. Last week a case was reported from Manchester of a cycle fitter who has been lame since 1888 as the result of an accident to his knee, but who, owing to his skill and diligence, never had any difficulty in obtaining employment till the Act came into force. His masters at that time directed all their employees to undergo a medical examination on behalf of the insurance company which was to indemnify them, and the doctor's report was to the effect that if any further accident happened to the man the limb might have to be amputated. The insurance company thereupon refused the risk, and the man was compelled to leave his employment, and has not since been able to obtain work because of his defect. Once or twice, indeed, when he has been taken on by firms when they were busy, he has been dismissed when his lameness was noticed. It is pleasing to note that the man says that his warmest sympathisers are the medical men who have examined him; but, grateful as such sympathy may be, it is a poor substitute for board and lodging. We certainly may reckon ourselves among the sympathisers of such patients, but we do not see how their case is to be remedied by legislation or any other means.

LEADING ARTICLES.

THE LECTURE SYSTEM IN MEDICAL EDUCATION.

The art of teaching, like other human institutions, is governed by processes of evolution which will doubtless, sooner or later, lead to the best system attainable under existing conditions. So far as medical education is concerned, the whole field is constantly undergoing such rapid extension and change that frequent revision of methods is especially desirable. One of the old-standing questions that has vexed the minds of teachers for generations past is the desirability or otherwise of compulsory lectures. Long ago, when fewer books were available, it became necessary for the teacher to deliver his message orally. Now it is difficult to realise the experience which induced the further disciplinary step of rendering attendance upon such lectures compulsory. Human nature is much the same all the world over, and among a number of medical students a certain number will always shirk the burden of systematic study wherever possible. But the career of the student has changed of recent years in a manner hardly less remarkable than the revolution which has overtaken many principles of medical and surgical practice. The standards of examination are greatly raised, and it is impossible nowadays for the ignorant and careless student to attain the goal of medical qualification. Under modern conditions, then, it seems clear that some at least of the former arguments in favour of compulsory lectures have disappeared, while in other directions a new order of things has arisen. So far as the lecturer was concerned, it was natural enough that, after the first effort of preparing up his course of systematic lectures, he should be content to deliver them session after session in stereotyped form, bringing them up to date from time to time in the light of fresh discoveries. In some instances the lecturer publishes his lectures in book form, while in the majority of schools where stereotyped lectures of the kind were delivered it is possible to obtain note-books covering the whole of the ground. Under these circumstances the question arises with redoubled force as to whether the student is not wasting his time in attending lectures, the sub- of which can be more readily acquired from other sources. Possibly the true reading of the problem is, that while the diligent student might dispense with lectures readily enough, on the other hand, his less energetic or dull companion might suffer greatly if deprived of the daily modicum of instruction. Then, again, there are positive advantages in the system of oral delivery whereby the individualism of the lecturer is impressed in many ways. Indeed, perhaps the best test of the competency of any given teacher is the power of filling his classrooms. That test is applied in foreign universities where classes are not, as a rule, compulsory. For that matter, it may be taken for granted that some lecturers would secure a good attendance whether obligatory or otherwise. In one famous Scottish university it was the custom of more than one of the professors to call the roll on certain fixed days, but their class-rooms were always full, regardless of the fact that names would or would not be registered on any given occasion. But all lecturers are not competent any more than all medical students are capable and studious. It is not impossible that the system of compulsory lectures has outgrown its original sphere of usefulness. At any rate, there seems to be some indication from various professional quarters that it would be well to revise the situation with regard to a time-honoured method which has proved a potent weapon in the hands of past generations of medical teachers.

CURRENT TOPICS.

The Physiological Age for Smoking.

AT what age can smoking be countenanced by the physiologist and the physician? Like most apparently simple medical questions, that modest-looking query takes a good deal of answering. One thing may be said off-hand without a moment's hesitation, namely, that juvenile smoking is a bad thing from every point of view. Then, again, excessive smoking is injurious at any age, but that is implied in the condition of excess. A great deal depends on the individual himself with regard to the effects of tobacco upon his constitution. If he be vigorous, well-fed, and under good conditions of general environment, he can withstand quantities of tobacco poison that would wreck a weaker vessel. As regards the latter end of life, it is interesting to note how many veterans gradually curtail or altogether discontinue the habit of smoking. That is most likely an unconscious surrender to hidden physiological promptings, which show that the pipe or cigar is no longer smoothly tolerated by the nervous system as in days of yore. Not long ago a speaker at a Northern university conference moved that physiology be included amongst the list of subjects for a degree in Arts. One of his arguments was that divinity students thus educated would become sounder advocates of such social problems as that of temperance. Probably, he added, they would acquire much light on the heinous practice of smoking. The heart of that assembly of learned men was sorely vexed by this frontal attack, and so great was the subsequent confusion that the speaker hurriedly qualified his statement by the assurance that he meant smoking by boys under fourteen. Possibly a further conference of Scottish universities might settle the exact age at which a man might be permitted to begin smoking, and the hardly less important point as to when he should leave off that altogether unnecessary indulgence.

Soothing Syrups for Children.

AMONGST the causes of excessive infantile mortality may be reckoned the various soothing syrups and carminatives sold under various names. In nine cases out of ten they contain some preparation of opium, and in the tenth some deadly drug, such as acetanilide or chloral. The number of deaths of infants due to the use of these nostrums must be enormous, although there is, of course, no means of securing precise information upon the point. While newspapers share in the profits of this nefarious traffic it seems hopeless to anticipate any serious lessening of the evil. For all that, the resources of modern civilisation are by no means exhausted. The police have the power in many instances to institute prosecutions. One way in which they might do good is by prosecuting in all cases where a scheduled poison is contained in the preparation sold, but where the word "poison" is not attached to the label. Many mothers would hesitate before giving a baby an openly declared poison. The other method whereby the police might deal a deadly blow upon the patent medicine trade is by proceeding against those who make obviously impossible promises to cure various maladies. The police, however, are slow to take action in such matters. Indeed, it seems that the higher authorities will have to be carefully educated as to the meaning and the extent of the evil before any efficient action will be taken by the administrative arm of the State. The general education of the public may probably be best attained by the publicity attached to the proceedings of a much-needed Royal Commission upon secret remedies and cures of all kinds.

The King Edward's Fund and Hospital Out-patients.

THE annual meeting of the President and General Council of the King Edward's Hospital Fund was held on Friday last at Marlborough House. The Prince of Wales, in moving the adoption of the report, made an important announcement with regard to the out-patient system as follows:—"Since our Council meeting in December, acting on the advice of the Executive Committee, and in acordance with the powers given under the Act, I have decided to appoint a committee to inquire into the system prevailing in the London voluntary hospitals regarding the admission of out-patients. It is to be hoped that the labour involved in the holding of such an inquiry may perhaps to some extent be lightened by the results of the work of the Royal Commission on Poor Laws." The need of some such investigation will be universally endorsed by general practitioners, upon whose shoulders the brunt of hospital competition falls. If the Fund be judicial enough to lay bare the facts of the case, and sufficiently courageous to enforce an adequate remedy, they will most assuredly earn the gratitude of the medical profession. It seems hardly likely, however, that the King Edward's Fund will ever attain the goal of absolute justice under its present irresponsible constitution. The day of pure autocracy is dead, and no non-representative body with great public duties to perform can hope to retain a hold upon the confidence of the people. One result of this autocratic policy is the destruction of the small hospitals which are being slowly crushed out of existence by the Metropolitan Sunday and King Edward's Funds, regardless of their past or present careers of usefulness, or of the former support which has been diverted to the Funds. With every admiration for the spirit which has animated the creation of so magnificent a charitable agency as the King Edward's Fund, we fear it will never attain the full measure of achievement to which it is entitled until its Council is elected upon a broad representative basis.

Cerebro-Spinal Fever in Dublin.

SOME anxiety has been occasioned in Dublin by the news that there has been recently a marked increase in the number of cases of cerebro-spinal fever in the city. It is just twelve months since the first cases occurred, and though a considerable number were recorded during the summer months, during the winter season the disease dwindled down. The city, however, has never got entirely free from it, and deaths from cerebro-spinal fever have been registered at frequent intervals. It is, therefore, natural that some uneasiness should prevail lest the recent increase in the number of cases should be the first sign of a serious outbreak, such as that from which Belfast suffered last year. Dublin has barely escaped so far, and the danger of an epidemic has not passed. There seems, too, to be a policy of silence on the part of the health authorities, which does not tend to allay uneasiness. They are so much in the habit of calling "Peace" when there is no peace, that when they say "Peace," one at once suspects something wrong. It would appear, however, that up to the present the number of cases of cerebro-spinal fever is not such as should cause undue alarm, and we hope that Dublin may soon be free of the disease.

Proposed Legislation for Dublin.

We cannot pretend to regret that the Dublin (Various Powers) Bill, on which we commented some weeks ago (Medical Press and Circular, February 12, 1908), is dead. Before proceeding further in Parliament it was necessary to hold a plebiscite for or against the Bill, and, by a large majority, the burgesses of the city have scouted it. As we pointed out, the promoters of the Bill, in deference to the opposition of interested parties, notably dairymen and butchers, gutted the Bill of its public health clauses. In spite of this it came before the public with the many-columned blessings of certain medical men, who, apparently, had not noticed the omission of the clauses which might have merited their praise. We do not claim that the burgesses of Dublin rejected the Bill promoted by their elected representatives from any interest in the public health. There is no reason to suppose that the opinion of the public in Dublin is any more instructed than the opinion of those who are primarily responsible for the present disastrous conditions. The Bill was probably rejected purely from motives of economy. It is of interest, nevertheless, and it is of good omen, to find the citizens exercising their power to control the vagaries of the Corporation. It impresses on the members of the latter some sense of their responsibility, and it suggests the possibility of the citizens being awakened to a sense of their own duty, as well as of their power.

The Danger of the Hot-water Bottle.

In certain depressed states of the circulation the hot-water bottle is a valuable aid to the therapeutics of the sick room. That there are various risks attached to the use of this homely appliance should be known to every good nurse. The chief dangers arise when sensibility is impaired in any way or when the circulation is sluggish and the vitality of tissues impaired, as in the case of spinal palsies. In a recent case investigated by a coroner's jury in Manchester death was indirectly due to burns caused by a hot-water bottle. The deceased had suffered from diabetes and locomotor ataxy, and underwent an amputation of one of his legs for gangrene. The nurse noticed some burns on the remaining foot, but failed to call the attention of the medical attendant to them. She dressed the wounds with boracic ointment, and they all healed with the exception of one on the heel. The jury returned a verdict of death from natural causes, and added the extraordinary opinion that "the nurse should have told the doctor of the burns at once, and placed the responsibility upon him." This suggestion of making a scapegoat of the medical attendant for the carelessness and neglect of an obvious duty by a nurse is somewhat curious. We venture to believe there are few modern-trained nurses who would fail to report wounds or inflammations in a patient suffering from locomotor ataxy.

Death under Chloroform.

An inquest held recently in the country revealed a death under somewhat unusual circumstances. A tradesman of the town, having fractured his fibula, an operation was subsequently found necessary, and this was undertaken at the General Hospital. The operation was performed, and the patient appeared to be doing well, when he was left with a sister and a nurse by the house surgeon. A few minutes later the latter was called back hurriedly by the nurse, and found the patient dead. A post-mortem examination showed that there had been vomiting of solid food, some of which had regurgitated into the windpipe and caused suffocation. The jury found that the cause of death was heart failure, and that the chloroform was properly administered. It certainly seems from the foregoing account of the case, which we take from the *Western Daily Press* of March 19th, that the patient should not have been left by the administrator when recovering from anæsthesia. Presumably there was no time to prepare the patient, whose stomach was full at the time of the accident. Under such circumstances the administrator should obviously be more than ever on his guard against the risks of post-anæsthetic vomiting. This case shows the necessity of detailed reports of every fatal case under an anæsthetic. If this death were returned under the heading of chloroform, it would be, of course, fallacious, as vomiting might have caused a similar fatal result in the case of any other drug.

The British Medical Association Referendum.

A correspondent has drawn attention to the apathy of the 20,673 members of the British Medical Association, inasmuch as only 1,978 took the trouble to vote on the highly important matters submitted to them by Referendum. That aspect of the voting is not without its significance, as showing the difficulty of arousing medical men to look after their own affairs. Another aspect of the matter of hardly less significance is the revolt of the Association against the government of the Council. The Council considered the resolution passed by the Special Representative Meeting held in London in May, 1907, did not properly represent the wishes of the Association. The Council put various principles to the Referendum, with the result that the decisions of the representatives have been endorsed by two to one of those who voted in the United Kingdom. Medical men are so accustomed to have their institutions governed by councils that it is refreshing to see a great Association insisting upon having its own say on matters vital to its independence and self-government.

Infantile Mortality.

The excessive death-rate amongst infants has at length awakened the conscience of the world at large, and it is to be hoped that with the progress of scientific medical knowledge this waste of human life may be prevented so far as it is preventible. The International Congress, recently held at Brussels, has re-awakened public attention to the facts of the case. The death-rate per 1,000 in various European countries among children below one year of age is stated to be approximately as follows:—Norway 79, Sweden 93, Denmark 112, England 132, France 137, Belgium 155, Italy 172, Germany 204. In Japan the mortality is 152 per thousand. Startling as these figures are, they become dwarfed by the returns from some parts of Russia. According to the last available Russian statistics, the death-rate among children in the Chernigoff, Kharkoff, and Poltava Governments is 217; in the Smolensk, Tamboff, and Vilna Governments 310; and in the Nijni-Vovogorod, Perm, and Viatka Governments, 440. The only diminution shown is in the frontier provinces. Esthonia and Courland have a death-rate of 163, and Finland of 127. A Reuter's telegram states that the annual mortality in European Russia among children under twelve months reaches the enormous figure of over 1,200,000. There are many factors at work in this deplorable waste of human life, but none of them should be beyond the ultimate understanding of scientific medicine.

Commercial Logic,

Clearly, the proper enforcement of the Dangerous Trades Regulations of the Factory Acts is highly desirable in the interests of the working classes. From an economic point of view it acts as a kind of insurance premium, and in the long run saves the pocket of the ratepayer, who has to support the disabled victims of trade diseases. That there are many offences on the part of employers is doubtless true, but for all that the lot of the labourer is now immensely lightened. In a recent prosecution of the British Rubber Manufacturing Company for breaches of the Factory Act, it was proved by the Home Office Inspector, Dr. Legg, that in one process the worker was exposed to the fumes of naphtha, and in another to those of bisulphide of carbon. The manager of the works said that the work required by the Inspector had not been hitherto carried out, owing to technical difficulties. As a matter of fact, he stated that only two girls were engaged in the work where the fumes were. The fallacy of that line was ruthlessly exposed by the magistrate, who pointed out that two girls had just as much right to be protected as 2,000. This illustration of commercial logic throws an interesting sidelight upon the intellectual methods of employers when put on their defence for injuries caused to workpeople by the neglect of statutory obligations. On similar lines the Government of Hayti might now plead that they had murdered only five citizens without trial, and therefore nothing more need be said about the matter.

PERSONAL.

On Friday last, the 20th inst., the Queen, accompanied by her sister the Dowager Empress of Russia and Princess Victoria, paid an unexpected visit to the Royal Military Hospital at Millbank.

Later the royal party visited the Army Medical College, in the pathological laboratory of which Sir Frederick Treves presented Colonel Bruce, the discoverer of the organism of Malta fever.

It is announced that H.M. the Queen has given permission for the North-Eastern Hospital for Children, Hackney Road, to be known in future as "The Queen's Hospital for Children." A special meeting of the governors of the institution will be held on April 2nd, at 4 p.m., to receive this information formally.

Dr. D. T. Rocyn-Jones has been appointed Medical Officer of Health for Monmouthshire.

Surgeon-General John D. Edge, C.B., of the Army Medical Service, has been placed on the retired list.

Dr. C. Theodore Williams, M.V.O., is to preside at the annual general meeting of the Medical Graduates' College and Polyclinic on Friday next, at 22 Chenies Street, W.C.

Dr. Arthur Mechan has been elected first President of the newly-formed Western Medical Society at Glasgow, and Drs. William Snodgrass and Gibson Graham vice-presidents.

Her Excellency the Countess of Aberdeen opened the Tuberculosis Exhibition at the Guildhall, Londonderry, on Wednesday last, in the presence of a large assembly.

Prof. G. Sims Woodhead inaugurated the Northern Counties' Branch of the Incorporated Institute of Hygiene at the Armstrong College, Newcastle, on Monday evening last.

Principal Donald MacAlister, President of the General Medical Council, has been appointed representative of the University of Glasgow on that body in the stead of the late Sir Thomas McCall Anderson.

Mr. Rickman J. Godlee has been elected representative of the Royal College of Surgeons of England on the Council of University College, Bristol, in the room of Mr. Thomas Bryant, resigned.

We are much pleased to announce that the First Lord of the Treasury has granted a Civil List Pension of £120 to Dr. Hall-Edwards in recognition of his services to medical science and the misfortune his pertinacity has brought upon him.

Sir Henry Swanzy, President of the Royal College of Physicians of Ireland, has been selected as President of the Section of Ophthalmology at the forthcoming annual meeting of the British Medical Associaton, and Dr. James Craig, as Vice-President of the Medical Section.

Dr. R. H. Scanes Spicer, on retiring from the position of Surgeon for Diseases of the Throat to St. Mary's Hospital, which post he has filled with distinction during the last twenty years, has been unanimously elected Honorary Consulting Surgeon for Diseases of the Throat to that institution.

Colonel J. Lane Notter, R.A.M.C., will take the chair at a provincial sessional meeting of the Royal Sanitary Institute at the Town Hall, Hull, on Saturday, April 4th. Dr. Wright Mason will open a discussion on "Diphtheria in Elementary Schools and its Prevention."

Sir Henry Littlejohn last week sent in his resignation of the post of Medical Officer of Health for Edinburgh, after nearly fifty years' service. Sir Henry is in his eightieth year, and all who have had the pleasure of his acquaintance will ungrudgingly hope for him the same vigorous health in his well-deserved retirement that he has possessed for so many years.

Dr. J. F. Dwyer, of Beaufort, was, on March 14th, appointed Principal Medical Officer of the Beaufort district under the Workmen's Doctors Fund Committee, at a salary of £500 a year. There were 55 applicants.

A CLINICAL LECTURE

ON

THE VALUE OF LABORATORY METHODS IN THE DIAGNOSIS OF TYPHOID FEVER.

By PROFESSOR LEON BLUM, M.D.,

Chief of the Laboratory of the Medical Clinique at the Medical School of Strasburg.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

EASY enough to diagnose in typical well-marked cases, it is quite otherwise when we are dealing with typhoid fever in which one, or several, or most of the characteristic signs are wanting. In many of these cases clinical observation alone may leave us in doubt even after the disease has run its complete course. On the one hand, we may mistake for enteric fever a disease which happens to present one or several of its symptoms, and which thus becomes impossible to distinguish therefrom. We are specially liable to be misled by the very signs to which we are accustomed to attach most importance—such, for instance, as a spotty, rose-coloured eruption, the ulcerated typhoid throat, etc. It may be objected that such cases are of their nature exceptional, and, though this may be conceded, they are nevertheless frequent enough to be interesting. On the other hand, the absence of certain symptoms to which we look to suggest typhoid fever may leave us in doubt or lead us astray. It is unnecessary to insist on the possibly grave consequences of error in either direction.

Modern bacteriological research, which has achieved more in respect of typhoid fever than of any other disease, has materially altered the aspect of things. We may indeed ask whether it has not now become possible to establish our diagnosis with certainty by basing it on objective signs free from all suspicion of subjective influences. Then, too, several other accessory methods of investigation have now become part of the routine clinical investigation, which, though less important, have the advantage of being easy of execution.

In future the term typhoid fever ought to be restricted to diseases demonstrated to be due to infection by Eberth's bacillus, cases in which it is absent being eliminated. In this way we may ultimately succeed in differentiating the numerous diseases commonly described *en bloc* as cases of typhoid fever, though due to different micro-organisms. The question arises whether traditional clinical methods will have to abdicate before these measures, or whether the latter should only be subservient and accessory to clinical diagnosis.

Daily practice provides an immediate reply to this question. Our conclusions are based on the observation of cases of typhoid fever treated at the Strasburg Medical Clinique, the para-typhoid cases having been intentionally put aside, although most of our conclusions apply as well to these as to typhoid fever proper. I propose to discuss procedures which have either enabled us to confirm the diagnosis or else to reject it, so that I shall not deal with the methods *per se*, but only with their diagnostic and practical value.

The bacteriological methods employed by us comprise the search for bacilli in the organism or the excreta of the patient, and the specific reactions that make their appearance in the organism under the influence of typhoid infection—agglutination and the bactericidal power of the serum. To these measures we may add the diazo-reaction and the leucocyte count.

Of all the clinical and bacteriological methods, the most important is unquestionably the search for the bacillus in the blood. Its presence is an irrefutable proof of the nature of the infection, whatever course the disease may run. This has never once failed us, and we know of no fact in opposition thereto.

In view of the absolute value attaching to the discovery of the bacillus in the blood, the examination must be conducted under conditions so strict that every possible source of error shall have been discarded. Our conclusions, therefore, are based exclusively on blood withdrawn under antiseptic precautions from a vein, and collected in duly sterilised recipients. The search for the bacillus is merely a matter of bacteriological technique. We know for certain that the bacillus is always, or almost always, present at the onset of the infection. The proportion varies according to the procedure employed from 80 to 100 per cent. The procedure adopted by us has been that of Kayser-Conradi, which is based on the property possessed by bile of favouring almost exclusively the multiplication of the typhoid bacillus. It entails very small quantities of culture medium, 5 c.c., which is inoculated with 2 or 3 c.c. of blood, so that it can easily be carried or sent by post.

The results obtained have been scheduled according to the gravity of the infection and the period at which the examination was made. Of 36 typhoid patients examined during the first week, hæmoculture was practised in 32. The bacillus was present in every instance of grave infection, in three-quarters of the medium cases, and in half of the mild cases. At a later period blood inoculation gave a positive result in 81 per cent. of the grave cases, while in the average and mild cases a negative result became more and more frequent the later the examination after the onset of the disease. This diminution was specially marked in respect of the mild cases in which, after the second week, the bacillus could only be discovered in about 6 per cent., and at a still later period it was uniformly negative.

The proportion of positive results obtained by us, especially during the first week, differs somewhat from that obtained by others, but this is not the fault of the method, but is to be explained by the fact that our statistics comprise a larger number of cases than all the others put together, so far, and this particularly in respect of average and mild cases, and it is precisely in these cases that the results have most influence on the statistics. In slight cases of the disease, which run a very rapid course, sero-diagnosis alone will enable us to recognise their nature.

It may be stated, therefore, that the chances of our finding the bacillus are greater the more pronounced the gravity of the case and the nearer to the onset the examination is made. Still, even under the most favourable conditions, it will not invariably be found when the examinations bear on a sufficiently large number of patients and extends to all forms of the disease.

Sero-diagnosis is one of the best-known bacteriological methods of research. It is much simpler than blood cultures, it only requires a few drops of blood, and can be carried out in a short time away from any laboratory. It possesses considerable diagnostic importance, enough in most instances for all practical purposes. Still, it is not absolute, and, as with every other symptom, its results must be accepted with reserve.

From a numerical point of view, our figures show that the result was negative in 50 per cent. of the cases during the first week, so that at this stage it is obviously inferior to hæmoculture in respect of grave and average cases, while in slight cases, on the contrary, we are more likely to recognise the disease by sero-diagnosis. At later stages the two procedures are of about equal value in respect of grave cases, while in average and slight cases agglutination has much the advantage of the other method.

In addition to being absent in half the cases at the onset, agglutination may fail in some instances for a long time, even until convalescence. We have witnessed a certain number of such cases, but we have never found bacilli in the blood in cases where the sero-reaction proved negative at all stages of the disease.

This is, indeed, a specific reaction, but its specificalness is not absolute. The agglutinating power does not depend upon only the particular organism, but extends to others of the same family. For instance, the serum of a typhoid patient may agglutinate not only the typhoid bacillus, but also its neighbour, the para-typhoid bacillus, and *vice versâ*. This lack of specificalness is of little practical importance, since both diseases are infectious, and the treatment of both is purely symptomatic.

But there is another aspect of the agglutination phenomenon which deserves attention—viz., that although agglutination indicates typhoid infection, it does not justify the conclusion that the subject is actually under its empire, for, as we know, this may persist for months, and even years, after an attack. I will relate two instances which show the importance of this fact.

A young man was seized with abdominal pain, without any special localisation. He walked to hospital, where he related that he had had no previous illness. On examination, the belly was rather more swollen on the right than the left side, with some muscular resistance, but not enough to prevent free palpation of the iliac fossa. Temperature, 99.5° F.; pulse, 100; leucocytes, 11,000, with pronounced polynucleosis; diazo-reaction negative. The temperature went up next day to 104° F.; belly wall soft; leucocytes, 13,300. In the evening some blood was taken for examination. Next morning the general state was decidedly unsatisfactory, with marked gurgling in the right iliac fossa, but no tumefaction in that situation. It was decided to operate, and we found a gangrenous appendix; yet sero-diagnosis had given a frankly positive reaction at 1—100. At the operation there were no traces of typhoid lesions, nor was the bacillus found in the stools. This patient's mother had been under our care in the previous year with appendicitis, and the diagnosis between it and typhoid remained uncertain for some time. She was 53 years of age, and had had typhoid fever when 18, followed seven years later by hepatic colic with jaundice. For twelve days before admission she had suffered from great pain in the right side of the abdomen, with liquid stools and vomiting. There was marked thickening in the right iliac fossa, with muscular resistance and tenderness. We diagnosed appendicitis; the temperature was about 103° F.; no diazo-reaction, but the urine contained a trace of albumin; sero-diagnosis gave a positive result, 1—50 macroscopically, and 1—100 microscopically. The temperature chart of the subsequent course very closely resembled that of typhoid fever. Throughout, the leucocytosis remained between 15,000 and 19,000, with marked polynucleosis. The bacteriological examination of the blood, fæcal matter, and urine, gave negative results. It remained a moot question whether the case was one of appendicitis in a former typhoid patient, or of typhoid fever with appendicitis.

These two cases suffice to exemplify the hesitation with which the results of sero-diagnosis must be accepted in doubtful cases.

We may formulate the following conclusions with regard to sero-diagnosis. The agglutination test, though the one to be preferred in practice, must always be accepted with caution. A negative result does not eliminate the possibility of its being a case of typhoid infection, especially when made early in the case, when the proportion of negative results is one in two. If we get a positive reaction, we are not justified in affirming forthwith the existence of actual typhoid infection. Doubtless it is a symptom of great value, but it requires to be scrutinised, like every other symptom, and it may thus serve to complete or diminish the sheaf of evidence which in the aggregate establishes a diagnosis. It is especially in doubtful, irregular cases that caution is required.

The research of the bacillus in the fæces has comparatively little diagnostic value, compared with blood culture and sero-diagnosis. Apart from the difficulties inherent to the search, the presence of so many other bacilli is very apt to lead to confusion. Nevertheless, we had recourse to repeated examination of the fæces and urine whenever the blood cultures proved negative in presence of clinical symptoms clearly pointing to typhoid infection. In three cases the discovery of the bacillus in the fæces settled the diagnosis, which was confirmed by the subsequent course. On the other hand, in doubtful cases running an irregular course, the presence of typhoid bacilli in the fæces would not constitute a decisive argument, and might even lead us astray.

In spite of repeated examinations for the bacillus in the blood and excrement, and the sero-diagnosis, there were several cases in which clinical observation led us to conclude in favour of typhoid fever. These were six in all. In four the absence of post-mortem examination or other certain indication left the diagnosis open. The bactericidal power was, unfortunately, not resorted to except in two instances, in which it confirmed the clinical diagnosis of typhoid. In these patients all the other methods of investigation proved negative, though carried out repeatedly at different stages of the disease. The bactericidal power of the serum appears, therefore, to be of great importance in cases of this kind, but in others the difficulty and the tediousness of the method render it impracticable in general practice.

Ehrlich's diazo-reaction did not appear to be of much assistance in our observations, and this for two reasons:—In mild and medium cases, especially in the former, in which it might have proved useful, it often failed, so that we are unable to endorse the view that the absence on repeated occasions of the diazo-reaction in the course of a febrile disease negatives the presumption of typhoid fever. Conversely its existence in other diseases than typhoid, such as tuberculosis, deprives it of any value as a means of differential diagnosis.

Although its absence in a grave infection does not plead in favour of typhoid fever, its existence only amounts to a sign which may prove useful along with others; but it requires to be confirmed by more conclusive symptoms. It is rather as an indication suggestive of a possible diagnosis that it alone possesses any value.

We attach much more importance to the leucocyte count and to the leucocytic formula. Typhoid fever belongs to the group of infective diseases which are accompanied by a reduction in the number of leucocytes. Yet during the first few days leucopenia is far from constant. Of 100 cases selected at hazard, Dr. Arnheim found 59 in which the leucocytes were below 5,000, 35 with a normal proportion, and 6 with an increase of over 9,000. Here, again, the same rule applies—the absence of leucopenia does not enable us to discard the possibility of typhoid, since it may be due to several causes. Early in the disease there may be polynuclear hyperleucocytosis, which is often present at this stage. In other instances some complication may explain the absence of any diminution of leucocytes, either in consequence of some pre-existing malady such as tuberculosis, or some secondary infection. Nevertheless, if we discard these two causes, there remains a certain proportion of unquestionably typhoid cases in which there is marked increase of leucocytes without any discoverable complication to explain the fact.

The diminution of leucocytes only possesses importance in doubtful or irregular cases, in which we have to decide the question for or against typhoid infection. Its absence in no wise justifies us in rejecting that contingency.

Then, too, we must remember that the leucocytes are diminished in other conditions, such as septicæmia and granulia, which are easily mistaken for typhoid. The initial polynucleosis is followed by progressive diminution of the number of polynuclear leucocytes, which may fall below that of the mononuclears. A reduction of leucocytes with mononucleosis constitutes the typical hæmatological sign of typhoid fever, and, judging from our experience, is a sign of very great importance.

Other febrile maladies, it is true, present a very similar leucocytic formula—measles, Malta fever, and possibly non-typhoid septicæmia, complicated with grave or pernicious anæmia. We have also met with it in two instances of coli-bacillosis. Still, it is, as a rule, fairly easy to distinguish these cases from typhoid by the other methods at our disposal.

The leucocytic formula has also proved of considerable assistance in cases where, hæmoculture having failed, we had to decide between relapse of typhoid fever or tuberculosis following typhoid.

Conclusions.—Hæmoculture is the procedure of election, the only one which, in the present state of our knowledge, can be regarded as absolutely conclusive of typhoid infection. At the onset it is, moreover, the one that gives the largest proportion of positive results.

Sero-reaction in doubtful cases always calls for careful examination, and is a sign of great value, but is not absolutely decisive. The same remark applies to the discovery of the bacillus in the fæces.

The diazo-reaction appears to be useful only in so far that its presence may suggest the possibility of typhoid fever.

The leucocyte count, in presence of a reduction in the total number, affords a valuable sign in favour of typhoid fever. Associated with mononucleosis, it may have a decisive value, and is of great assistance in differentiating relapses of typhoid fever from secondary complications.

The failure of these methods, or of one, or several, or even of all, does not enable us to discard for good all possibility of typhoid infection, even when they are practised at various stages.

Lastly, when careful clinical observation pleads in favour of typhoid fever, the negative results of laboratory methods are not *per se* a reason for discarding the diagnosis of typhoid. In cases of this kind, which are assuredly very rare, the examination of the bactericidal power of the serum will sometimes enable us to confirm the accuracy of the clinical diagnosis.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Edred M. Corner, M.Ch. Cantab, F.R.C S. Eng., Surgeon to Out-Patients, St. Thomas' Hospital, and to the Hospital for Sick Children. Subject: "Sub-Acute Infective Epiphysitis, with Illustrative Cases." A Post-Graduate Lecture delivered at the Hospital for Sick Children.*

ORIGINAL PAPERS.

THE RELATION OF PATHOLOGY TO MECHANICS AND CHEMISTRY.

By W. R. MACDERMOTT, M.B., T.C.D.,

Medical Officer, Poyntzpass District.

M. POINCARE, a mathematician and statesman, in his book, "Science and Hypothesis," tells us that the ephemeral nature of scientific theories takes by surprise the man of the world. However potent their hold on mind may be for a time, he sees them given up one after another; he sees ruin piled on ruin; he predicts that the theories in fashion to-day will vanish to-morrow, and he concludes that they are vanities. He calls this the bankruptcy of science.

Is medical science bankrupt because its theories answer this description? No, because it keeps and has to keep to experiment; all its theories begin in empiricism, and can never become, like geometry, abstract systems of thought. The practice of venesection grew into a theory, but the theory was never dissociated from the practice; the results of the latter always remained to modify and invalidate whatever theory was framed to justify the practice. Thus medical science is never anything but inductive; both present and new facts ever accumulating do not allow it to stop, except momentarily, and rest on deduction. The theories which M. Poincaré criticises did and do allow long pauses in which, in absence of new facts and inference from them, they almost necessarily become purely abstract and deductive. But the constant reference of our science to the old and new facts in its field, although it saves it as a whole, does not save its theories from the usual fate; the reference, indeed, makes their life a short one. It would be even shorter if the science had a foundation all its own, if there was a science of life as such. We have had theories of life in medicine, and we all know how useless and unsatisfactory they proved; the only thing that can be said is, that not having any theory of life of any value, we can have no real medical science of life. Neither have we as a matter of fact; all our theories have been built up on chemical and mechanical theories which in themselves are as remote from life as astronomy. Our theories are in reality only variants of the theories M. Poincaré discusses. But so far from the latter being ephemeral the pure abstract form they early assumed in many cases give them permanent and unquestioned influence. They entered the sphere of medical science as masters; our facts had to be conformed to them and our theories have a scope and validity not their own.

In any case the position is an illogical one. There can be no science of life as long as the science of inorganic existence is put in its place, as long as the vital case is reduced to the non-vital and subject to its conditions. But there is a science of life, as such medical science, in a true sense if the facts of life reject this reduction. My object here is to show that they do reject it, and ever increasingly as medicine adhering to its ancient inductive basis holds fast to these facts in a perceptual sense, and never abandons them for the concepts of scientific theories which M. Poincaré truly states as ephemeral sooner or later.

As a matter of present experience there is no science of life for medical men just because, under the influence of these ephemeral theories, they allow themselves to drift away from their own proper facts, to misunderstand and even ignore them altogether. My position I conceive is a practical one, as an attempt to emancipate medical science from theories in the first place foreign to it, in the next vague ever changing and ephemeral in themselves.

The following statements express, sufficiently well, at least, for a short paper, the subordination of medical science to these theories, foreign to it and necessarily forbidding it independent status as a science of life.

"The metabolism of living substance upon which all life depends is conditioned by the existence of certain very labile compounds, which stand next to the proteids, and on account of their significance in life are best called biogens." Again, "The simple expression for the problem of all physiology" (and therefore of all pathology) "is—*The life process consists in the metabolism of proteids.*" (a)

In his text-book "On the Cell," O. Hertwig gives Pluger's definition—

"The vital force is the intra-molecular heat. The highly unstable molecules of albumin which are built up in the cell substance, and which become decomposed through a splitting up of the molecules—carbon-dioxide and nitrogenous bodies being chiefly formed—becoming continually regenerated and re-arranged." (b)

The theories of Metchnikoff as modified by himself, of Ehrlich and others, of immunity and assimilation, all rest on a more or less clear conception of chemical metabolism as given in these passages. I need not dwell on the commanding place these theories occupy in modern medicine. It would suit my purpose admirably to take the theory of chemical metabolism, and in general modern chemical theory as safe ground to go on, but as an honest reasoner, I cannot do so. I can only take it by hypothesis as sound. We have the right, however, to demand precision from chemical physiologists and pathologists, and that is enough. A mechanical and a chemical operation has a spontaneous form of its own in disposing matter, which in the general cosmical case is not free, but subject to fortuitous circumstances. Potassium and oxygen interact when free to do so, and the operation is a chemical spontaneity, but when the metal is sealed in a tube the chemical operation is prevented by what is not such an operation. If light acts on a silver salt in a tube a chemical operation ensues, but if the actinic rays are intercepted by non-chemical means, no change occurs. An endless series of examples might be given showing that, even in the inorganic field, mechanical and chemical spontaneity is not free, that, indeed, in the general case it occurs under conditions of constraint varying in degree up to total hindrance.

(a) "General Physiology." Max Vernon. Translated by F. S. Lee. Macmillan. P. 136. Italics in text.

(b) "The Cell." Dr. O. Hertwig. Translated by H. J. Campbell M.D. London. P. 127.

The position that life is dependent on chemical metabolism or that any free chemical operation goes on in the proteids giving either them or derivatives from them, is a singular error, as such precluding the existence of any science of life. The contradictory of the position would be that the constraint on mechanical and chemical spontaneity, which in the general field may be said to be fortuitous is not fortuitous, but specifically determined in the vital field. The grossness of the error made is seen in the actual fact that the products of vital operation are products neither of mechanical and chemical spontaneity nor of the inhibition or hindrance of such spontaneity, but of controlled constraint on both, products exhibiting permission, sufferance, inhibition, hindrance, within certain limits, on every form of physical activity. The human body and every cell component in it considered as cases in such activity are instances of this; no form of the activity either spontaneous or inhibited apart from concurrent control, always in evidence as long as life can be predicated, gives the cases.

One of the theories which is introduced into medical science or the science of life, is that of rigid determinism. But the theory is a foreign one to our science entering it only to destroy it. We are not concerned with any general principle of the kind, but with an imperfect induction giving us a group of facts under particular forms of determination, and our business is with the facts and their particular determinations, avoiding hasty generalisations. In the vital field, and particularly in pathology, our immediate concern, we should not allow chemical metabolism, which, as usually expressed in the text-books, means chemical spontaneity, to run away with us. In pure chemistry, particularly in its modern development, stereochemistry, the chemical spontaneity itself is supposed to be subject to mechanical interference or inhibition and inert or inactive molecules to interpose themselves in the way of molecules relatively active in respect of one another. What is called "steric hindrance" is supposed to occur when a foreign atom intrudes itself into a molecular group, and either drives out a native atom or is driven out by it. "The case is parallel to that of a person trying to force his way into a crowded room." (c) The relation of two active molecules to each other being the fact of chemical spontaneity, the fact of the inter-position of inert material between them preventing their inter-action is another fact of altogether different nature.

Both facts are represented in the proteids and all forms of living substance, the chemical spontaneity and its inhibition, and along with them as the specific vital fact their control and regulation. But the more important physical or non-vital fact is not the spontaneity but its inhibition, since when vital control ceases the proteid tends to take a form representing the spontaneity alone.

It would be far more consonant with our perceptual facts to say that the somatic proteids express not chemical metabolism or chemical inter-action, but inhibition of such inter-action. It is an error to state as chemical compounds what are really products contradicting the defined nature of such compounds. The chemical formula for the hæmoglobin of horses' blood is $C_{712}\ H_{1130}\ N_{214}\ O_{245}\ Fe\ S_2$ (Zinoffsky), but anything—the horse itself—could be put under a similar formula. If in the hæmoglobin the molecules of iron are partitioned off from those of oxygen and sulphur the body would not be a chemical compound, and its instability would not be a case in chemical equilibrium. Living, the body must be an energid, a store of energy; if it was a true chemical compound it would be a sink not a source of energy, and it becomes that and a chemical compound as it comes to express death or necrobiotic form. Energy, in equivalent material terms, means a definite mass actuated by particle velocity constrained by a boundary or something serving functionally as a boundary. A bottle with a pound weight of water in it, as a boundary, prevents the pound of water taking a configuration which it otherwise would as subject to the general environment, and the measure of the hindrance is what is called energy. A cortical nerve cell as a vessel constraining contents is an energid in exactly the same sense whatever other factors may intervene. In this simple concrete case energy is stored, not by allowing, but by disallowing an opposed mechanical spontaneity. In the same way life commands the energy of chemical affinity, not by allowing, but by inhibiting it; what it wants is energy to dispose after its own fashion, use any way biological necessity dictates. The vital unit is not the creature of or determined by anabolism and katabolism any more than a man is alive because he eats, drinks, and moves things about. Anabolism and katabolism in the vital field are not physical correlatives, but determined independently of one another by a specific vital operation, which is an antecedent determinant. The amount of oxygen burnt in a man's lungs in one hour is not the same as the amount in another hour, and the disposition of the oxygen is governed, not as a chemically spontaneous operation, but by varying biological necessity. To answer such necessity the antecedent potentiality in life transforms, as far as can be seen, every kind of energy, chemical into mechanical, *vice versa*, and so on. This has to be admitted, and we are not altogether in the dark as to the means whereby such transformations are effected. In every steam engine the energy of chemical and physical spontaneity must be constrained and inhibited by a boundary system in order to get transformation into the mechanical form. But analysis of the ashes in the furnace would not tell us what the transformation was or how effected; in the general case it could only express the resultants of chemical spontaneity. In physiology and pathology it may do more, but only when the products are taken under the condition of indicating transformation as the result of hindrance of chemical and physical spontaneity.

In biology, the general form of medical science, chemical metabolism, the intra-molecular heat, biogens and so on, have conventional place in text-books—that is all. The biologist, like the medical man, is so rigidly bound down to concrete perceptual facts, that physical and chemical theories only confuse and distract him as far as he allows them to do so. He keeps thus to the antecedent fact in life, to the germ and its environment in the egg-cell, and therefore to the general form of micro-organic existence, the legitimate extension of the subject. He has as a perceptual fact the unicellular organism and its differentiation into soma and vital unit or units. As he proceeds, instead of approaching the theory of chemical construction, he has to recede from it. He has to describe seeds capable of development into multi-cellular organisms as non-metabolic in respect of their environment, and content himself with a hypothesis of intra-molecular metabolism, whatever that may mean. The experiments of Koch and others seem conclusive of the fact that they are not, as long as living, in metabolic relation with the external environment, and it is evident that what restrains or hinders the relation is life; the vital hindrance removed, they interact with the environment and decay. The fact here is not the death of the vital unit itself; that may or may not be the case; all we can affirm is cessation of a specific influence over its somatic environment. But that influence primarily exerts itself on the mechanical structure of the soma; if that is broken down, the influence no longer restrains chemical spontaneity in it. The influence, however, is only functional in the id or vital unit; the existence of that form does not depend on its exerting energy, on its environment, or being energised by it. Of peculiar significance in pathology is the observation that the non-sporing typhoid bacillus, the bacilli coli communis, and staphylococcus pyogenes aureus retain their vitality when immersed for six months in liquid air at a temperature of − 190° C., and would probably at the absolute zero temperature. It would, indeed, be hasty to say that the organisms were frozen, or even that they exerted no energy to accommodate the medium to their condition of existence. In both the inorganic and organic field energy seems to be inversely as magnitude; an atom as an energid is far more powerful than a molecular group; a flea is a far more powerful animal than an elephant; and the muscular energy of a leech or worm far greater than that of a man. The typhoid bacillus in liquid air, even if not able to raise the temperature of a minute couche of air about it, may have the power of maintaining its own temperature; it would only be in higher degree the case of a man keeping at 98.5° in a medium at 40°. The essential point is that the micro-organism is immensely more powerful as an energid than the metazoan and than the soma the metazoan builds about itself. But, as is evident, this store of energy is a fact of its proper constitution; the demand for energy in the typhoid bacillus is a maximum in liquid air, while the energy of chemical association is, if not abolished, reduced to a minimum. The energy of the typhoid bacillus and its congeners under the condition must be directed to maintain their mechanical configuration, and that energy cannot be derived from chemical metabolism or kinesis, which, as far as we can see, does not exist at all.

(c) "Stereo-Chemistry." A. W. Stewart, D.Sc. Longmans. 1907. P. 314.

A fortiori, the conclusion would be stronger for the vital unit that its specific state is adiabatic—that is to say, allowing flow of energy neither into nor from it. That, of course, would be a case at limit, the general case being that there is varying efflux and influx always leaving a fixed quantity adiabatic. That, in material terms, would be an expression for the conservation of mass as the condition of conservation of energy. The drift of biological theory, as long as it keeps to its own facts, is irresistibly in this direction. The theory, leaving chemical and mechanical metabolism behind, goes back to a vital corpuscle or mass having specific determination of state which is intrinsic, and, as far as specific, incapable of change within the ascertained or probable limits of organic existence. What these limits in terms of space and time are we do not know, but do know that they have been very hastily assumed. Von Helmholtz and Lord Kelvin supposed that life may have come to our planet in a meteorite. If, however, the typhoid bacilli can live in a fluid at or near the absolute zero of temperature, and that an order of the organisms are anærobic, it may be that they exist in vacant space and in typical form as adiabatic energids. In liquid air the typhoid bacillus attains relative immortality, and it is possible that the typical state for the rudimentary micro-organism is changeless for an unchanging environment.

That micro-organic existence is not contradicted by the conditions of vacant space, that a vacuum at the absolute zero of temperature does not necessarily destroy every form of life, is, of course, an inference from a few facts; but, even so, it keeps biology to its own province by excluding the agents in chemical metabolism. The case, however, becomes an immediate one for human physiology and pathology if the typical form of the micro-organism is adiabatic, or in the ultimate case that of a self-contained energid. It is often useful to express for the sake of clearness the limit of a state or action, even though it may be given only under the form of approximation in our range of observation. In that range, however, adiabatism, as in the seed, resting spore, and the egg, is as much in evidence as any fact of metabolism, and is the primary vital fact, as metabolism, however defined, is not. But then the latter is the base of current theories which require the former to be ignored. The case illustrates the intrusion of physical theories into the vital field to obscure it by their own incompetence and partial character. The adiabatism of the egg is as plain a thing as that of a tin of preserved salmon or beef, and it is equally plain that it is obtained through life inhibiting chemical spontaneity. It is plain, again, that the typhoid bacillus, and, inferentially, the id or primary vital infinitesimal, exists not only in the human body, but in a much wider range of circumstance in passive or adiabatic form. The metabolic theory, to be logical, must express that as a particular adaptation to environment. The adaptation of the egg to environment, however, is response to chemical spontaneity giving the case of death or necrobiosis. The response of the vital energid to death is anabolism, but then anabolism is not a case of chemical inter-action, but dynamic continuity of inhibition of such inter-action visible in the whole range of the operation which goes on in the living egg and in the farther ontogenetical development. Darwin, Weismann, Hertwig, Roux and all biologists, as long as they keep to their own region of fact, whatever name they give the vital unit, describe it as a perceptual mass under a boundary, and its growth effected by extension and duplication of boundaries giving form as the result. "Die Form erscheint so in mancher Hinsicht als eine Function der Wacksthum der organischen Substanz." (*a*) The fact begins with the bending in of the blastosphere to form its duplicated cup, and ends with the vast area of boundary and boundary strain which the human brain presents, to take one organ alone. But all this only means the inhibition of mechanical spontaneity, and the storing of energy by occluding particles of mass under boundaries. This again necessarily implies breach of chemical spontaneity; bodies which, if free, would inter-act chemically are partitioned off from one another, and so are under constraint which is equivalent to stating as energids what are not such whenever chemical combination occurs.

That, in every case, is a fact and evidence of death, of life ceasing to exert its adiabatic power of retaining energy measured by mass under constraint to be disposed of according to biological necessity. The concurrence of life and death in organic substance will not confuse us when we grasp the fact that life, even in the dynamic case, is always adiabatic. The limiting case is given by the id or by the typhoid bacillus in liquid air. It is sufficient for the bacillus to retain under the condition such a measure of energy as shall preserve its mechanical configuration and therefore its life; it, or its soma, dies if it is triturated in the medium. In the medium it does not undergo fission, and neither is altered by it nor alters it. That, we will assume, is its normal or typical state, and farther that it may retain that state in very different environments, even in the human body. Transferred however to media acting specifically on it; so-called nutrient media, it has to meet the case of death or dissolution of its soma. In some cases, as when it enters the human blood stream it may be supposed to die, its soma being dissolved. On a nutrient medium, however, it does not die all out; its soma keeps on dying, reacting to the chemical spontaneity represented by the medium or its action; but the bacillus reacts by dividing and sub-dividing, since by so doing it preserves adiabatic energy and thereby its mechanical configuration. If the mass is halved, the energy being only in part a function of mass, is not halved; the continuous sub-division of the mass as it proceeds increases the adiabatic fund of energy on the principle that the energy is relatively greater for the smaller mass.

I say this merely to indicate that we are far from a general theory of micro-organic existence, so far, indeed, that it seems to me that no attempt is made to collate the known facts on which it might rest. The theory of chemical metabolism is, however, a positive obstacle in the way of any such theory, and our pathology is now almost entirely reduced to questions in chemical metabolism which hang very ill together. Logicians tell us that a half truth is to be met by denial *in toto*, and I will conclude by saying that the typhoid and tubercle bacilli—two very different types—are both typically non-pathogenic, that they exist in the human system as non-pathogenic, and that the study of them from that point of view would be one of great utility.

LORD HAVERSHAM, formerly Sir Arthur Hayter, is to be Chairman of the Joint Committee of both Houses of Parliament for considering the Government Poisons and Pharmacy Bill.

(*a*) "Zeit. und Streitfragen der Biologie." Von Prof. O. Hertwig. Jena. 1894. P. 98. (The whole chapter bears on the subject.)

DIVERTICULA OF THE ILEUM RESULTING FROM TUBERCULOSIS AND ACCESSORY PANCREAS. (a)

By ALEXIS THOMSON, M.D., F.R.C.S.,
Assistant Surgeon, Royal Infirmary, Edinburgh, &c.

Diverticula may be met with almost throughout the whole length of the alimentary canal, though they are much more common in some regions than others. They are relatively frequent in the gullet, pharynx, ileum, and sigmoid flexure, rare in the stomach and duodenum, and have not been reported as occurring in the cæcum and ascending colon. Formerly they were divided into true and false diverticula, but since cases of acquired diverticula had been reported in which all the coats of the intestine, etc., had taken part, the distinction formerly drawn between the two forms was invalid. Pharyngeal pouches are not very uncommon about the region of the tonsil; these generally arise from some abnormality of development of the second branchial cleft. Next come pouches at the junction of the pharynx and œsophagus, where for anatomical reasons the wall is relatively weak. Pouching is also liable to occur at the level of the bifurcation of the trachea. Diverticulum of the stomach is rare; so also is that of the duodeunm. Sometimes, however they arise in this situation in the neighbourhood of Vater's ampulla; where there are remains of the fœtal pouches which go to form the liver and pancreas. In the jejunum diverticula are rare; in the appendix they arise chiefly in connection with previous appendicitis, with destruction of the muscular coats and weakening of the wall of the viscus. In the descending colon and sigmoid small diverticula not infrequently are met with, these being due to defects in the muscular coat. Acquired diverticula are in general caused by anything which impair the integrity of the muscular coat, or from traction from without. As regards the features of two cases of diverticulum recently met with, it may be said generally that any diverticulum of the ileum is apt to be put down as a Meckel's diverticulum; but probably, if all were carefully examined microscopically, this would turn out to be an error. In the cases in question tubercle was the cause of one, and an accessory pancreas of the other. The first case was that of a woman operated on on account of recurrent attacks of abdominal pain. On opening the abdomen, the appendix was found healthy, but there was a small diverticulum of the ileum, with an adhesion at its apex. The diverticulum was removed, and proved on microscopic examination to owe its existence to weakening of the wall of the bowel at that point from tuberculous deposits. The second case was that of a young man suffering from acute abdominal symptoms—peritonitis—with some features suggestive of acute pancreatitis. On opening the abdomen a diverticulum of the ileum and acute peritonitis were present. The diverticulum was removed, and the patient made a good recovery. In both these cases the operation completely relieved the symptoms. Microscopic preparations of the two diverticula showed, in the first case, well-marked tuberculosis, which had caused weakening of the bowel. In the second case there was an accessory pancreas in the wall of the intestine and outside the muscular coat, but under the peritoneal covering there was a second and larger mass of pancreatic tissue separated from the first by some of the longitudinal muscular fibres. Accessory pancreas is not a very rare lesion; aberrant portions of gland might be found in several parts of the alimentary canal, usually imbedded among the muscular fibres, and often possessed a duct opening into the lumen of the stomach or intestine. The microscopic features of this case are probably unique. The mass of pancreatic tissue lying about the muscular fibres is practically normal in appearance, and had, no doubt, a duct opening into the ileum. The second mass of pancreas, which formed the apex of the diverticulum, is totally different. There is, in the first place, a great increase in the stroma. Then the ducts are much more numerous than in the normal organ, giving much the appearance of a columnar epithelioma. The cells of the acini can here and there be seen undergoing transformation into ducts. In some cases islands of normal pancreatic cells are present, and close to these are masses of cells taking on an unmistakable malignant action. The case is a good example of Cohnheim's theory of the origin of cancer from an embryonic remnant.

(a) Abstract of paper read before the Edinburgh Medico-Chirurgical Society, March 11th, 1908.

OBSERVATION ON THE USE OF
INOCULATIONS OF BACTERIAL SUSPENSION. (a)

By L. C. PEEL RITCHIE, M.D., F.R.C.S. Edin.

Immunity is of two kinds—anti-microbial and anti-toxic, and only the former is considered here. For the production of anti-microbial immunity, injections of suspensions of dead bacilli are employed. Minute doses of poisonous bacteria cause a protective reaction out of all proportion to what is actually required, and the protective substances are therefore available for guarding against future infections of the same nature. Such inoculations are beneficial in the case of an existing disease, because Nature tends to control infectious processes by localising them, and we can produce and increase by inoculation the quality of specific anti-bacterial substance in the circulation. The plasma after inoculation is able to assist the leucocytes, for in cases of abscess, one finds that as a consequence of the inoculation the cells contain more bacteria than before. In chronic infections, such as tubercle, inoculation has little direct effect on bacteria; but, by keeping the blood rich in protective substances, extension of the disease from the local lesion is rendered unlikely. In inoculation treatment it is desirable to increase the circulation of the immunising plasma through the diseased area, as by artificially-induced hyperæmia. From being largely empirical, inoculation has been put on a more exact basis by Wright's researches. After a therapeutic dose of a bacterial suspension, there is in a healthy person a rise in the index. In an infected person this positive phase is preceded by a negative phase, or fall. It is less generally known that both in health and disease there is a very marked rise, reaching its maximum within six hours after inoculation. In giving inoculations of tuberculin, it is not sufficient to avoid the negative phase, but it is advisable to delay giving each successive injection until the effect of the preceding one has passed off. If this be done, the treatment may be continued for months or years without the occurrence of a prolonged negative stage. The author adopts the method of weighing the bacteria used for suspensions, and finds that, while the ordinary dose of staphylococci weighs 1-10 mgr., a dose of 1-1,000 mgr. is quite as satisfactory. The general idea that it is better to prepare the vaccine from the patient's own streptococci, etc., is not borne out by the author's experience; infections respond equally well to the use of a stock suspension. In chronic infections doses of 1-1,000 mgr. should be given at intervals of two, then three, then four weeks, continuing at that rate for six months. The short interval between the first two or three inoculations is to overcome the negative phase due to the obscure feature of immunisation known as hypersusceptibility. In acute conditions doses of 1-4,000 to 1-2,000 mgr. are repeated every eight or ten days. In children under fourteen these doses are halved, and in infants divided by ten. In treating tuberculosis, fever, in the absence of a mixed infection, must be allowed to subside; if a mixed infection be present, the secondarily infecting organism must also be inoculated. Early glands do well; those which are caseating require a long treatment. If infecting joints are got early, they may recover with no loss of mobility. Skin lesions are intractable unless appropriate local measures are conjoined with inoculation of tuberculin. Cases of multiple tubercular infection are especially suitable for treatment, on account of the risk of extension entailed by operation. Staphylococcal inoculation is beneficial in cases of boil, abscess and acne. Contrary to the usual opinion, Dr. Ritchie thought that streptococcal infections were particularly amenable to inoculations with a stock vaccine. The prophylactic use of staphylo- and streptococcal inoculations prior to operation had also been found extremely succesful.

(a) Abstract of paper read before the Edinburgh Medico-Chirurgical Society, March 11th, 1908.

CLINICAL RECORDS.

CASE OF PREGNANCY COMPLICATED WITH LARGE RETROPERITONEAL AND SUBLIGAMENTOUS FIBROMYOMA.

By JOHN H. DAUBER, M.B.Oxon., M.R.C.P.Lond.,
Gynæcologist, Hospital for Women, Soho.

Mrs. C., æt. 31, married three months, was brought to me on December 11th last year by one of her medical advisers. The last catamenial period occurred on September 16th, previously to which she had always been regular, and the flow normal. No abdominal swelling was noticed until the spring of last year. Since then it had rapidly increased, especially latterly.

The patient complained of being so large a size, and as she considered she was only three months pregnant, she feared there was something wrong. She had already consulted two other medical men, who considered she was probably pregnant, but that the pregnancy was abnormal, being complicated by a large tumour which would prevent her going to full term, and that an operation was necessary; so that it was only left to me to confirm or otherwise the diagnosis already made and the treatment suggested. The patient was a small, slightly-made woman; bright and alert, not ill at all. Upon examination it was found that the abdomen was occupied by a large irregular solid tumour rising almost to the ensiform cartilage. It lay mostly to the left of the middle line. Its right border was clearly defined about two inches to the right of the umbilicus. No fœtal movements were detected, no fœtal heart sounds heard, no rhythmical contractions felt, but over the whole of the tumour a loud hæmic bruit was heard. The breasts were enlarged and tender; the areola of pregnancy was marked, but no secretion was obtained. Per vaginam, a hard round mass was felt coming down into the pelvis to within two inches of the vaginal outlet and continuous with the abdominal tumour. It was quite fixed. It pushed the vagina—which was narrowed and greatly elongated—to the right, so that the examining digit passed it with difficulty The right vaginal fornix, together with the cervix, was drawn up completely out of reach. The uterus could not be made out as distinct from the tumour. Where it lay, or to what extent it was involved in the tumour, could not be ascertained.

The condition seemed to be a three months' pregnancy, complicated by a large fibroid. It was quite evident that pregnancy could not go on to full term, as the pelvis was entirely blocked, and the abdomen occupied already by a tumour as large as a uterus nine months pregnant. I agreed with the previous diagnosis, and advised early operation.

Eight days later, on December 20th, in a nursing home, with Dr. Mansell-Moullin, who kindly assisted me, and Mr. Ogle, who gave the anæsthetic, I operated. Dr. Card, the patient's doctor, and another medical man, were also present. A median incision was made from above the pubes to half-way between the umbilicus and the ensiform cartilage. A large irregular solid tumour was exposed, lying to the left and extending from deep in the pelvis to under the arch of the diaphragm. It was fixed and retroperitoneal throughout. Somewhat behind, and overlapped by the tumour, in the right iliac fossa, lay the pregnant uterus adherent to the tumour by its cervix, which was greatly lengthened. The intestines were adherent over the upper part of the tumour by many adhesions. It took some little time to clamp, tie off, and free them. In peeling off a piece of gut, the capsule of the tumour was torn, and as it was obvious that it would shell out of its bed, the rent was enlarged, a hand passed in, and enucleation rapidly proceeded with. In a few seconds it was free, with the exception of its pedicle, which, the size of a small wrist, had a firm attachment to the neck of the uterus. The hæmorrhage from the bed of the tumour was very great. It would be no exaggeration to describe it as appalling except that nothing appals an operator; so profuse was it that we feared the patient would die then and there on the table. Large swabs, gauze packing, forceps, were rapidly applied, the base of the tumour and neck of the uterus grasped, and the aorta compressed, with the result that the hæmorrhage was controlled to some extent. The base of the tumour was then cut through, as it would not shell out, and with it the left uterine artery, which had been previously seized with forceps. An attempt was now made to finish off the operation and save the uterus, but, in spite of underpinning, ligature of many vessels, deep sutures into the cervix, etc., it was found impossible to control the hæmorrhage sufficiently rapidly. There was little time for further deliberation; immediate action was imperative. So, with much regret, I amputated the uterus supravaginally. The cervix had been so lengthened, cut into, and weakened by the removal of the tumour, that the body of the uterus previous to amputation hung much like a cherry on a stalk. The removal of the uterus enabled one to deal successfully with the hæmorrhage.

The uterus was sacrificed for these two reasons:—(1) The difficulty of controlling the hæmorrhage, which had already been excessive; and (2) because to leave the uterus with its elongated and damaged cervix seemed to be adding a risk of the utmost gravity to a case already sufficiently serious. I may say that Dr. Mansell-Moullin fully concurred in this view.

It now merely remained to cut away the superfluous peritoneum which had covered the tumour, and to sew the cut edges together; but upon removing the gauze plugging from the cavity, a great burst of hæmorrhage again occurred. Many large vessels had yet to be tied, and at one time it appeared that gauze plugging would have to be left in. This eventually proved to be unnecessary. The abdominal wound was closed in three layers of continuous sutures. I used "Triolet" catgut throughout the operation.

For the first few days the patient suffered considerably from shock, and any further complication, such as miscarriage or uterine hæmorrhage, would, in my opinion, have been most undesirable, to say the least of it. For the rest, the recovery was uninterrupted and complete. The stitches were removed on the eighth day, and the patient was sitting up in bed towards the end of the second week

Cases of pregnancy complicated by fibroid tumour are always interesting, because there is a double issue at stake, and it was a great regret to me that I was unable to save the uterus in this case. The fact that the tumour was beneath the left broad ligament, and had then burrowed up behind the peritoneum as far as the left kidney created the difficulty. Rapidity of growth and extreme vascularity one expects to find together. Pregnancy was a further stimulus in both these directions, for it is often possible to enucleate large broad ligament fibroids almost bloodlessly.

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(1) Note of a case read before the Royal Society of Medicine, March 12th, 1908.

Although there appears to be a consensus of opinion in the Section that fibro-myomata of the uterus complicating pregnancy should not be submitted to operation except for the most cogent reasons, in this case there was no alternative for the reasons stated. Although the case did remarkably well, it was not entirely satisfactory in that I did not succeed in saving the uterus.

OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Mitral Stenosis.

By Leonard Williams, M.D., M.R.C.P.,

Assistant Physician to the Hospital; Physician to the French Hospital in London.

This woman, æt. 32, presents a very good object lesson. We are frequently told that we ought not to pronounce a heart to be in a satisfactory condition until we have examined it with the patient lying down, as well as standing up. That is a piece of advice which the exigencies of busy work, either in the out-patient room or in general practice causes us too often to neglect. But its value is admirably illustrated by this patient.

She came to us some time ago complaining of bronchitis, which was accompanied by a quite unusual degree of breathlessness Before I examined her I expected to find the lungs emphysematous, and the bronchitis depending thereon. When I did examine her, however, I found the lungs practically free from emphysema, but there was ample evidence of a "bronchitis" at both bases behind. The cardiac condition seemed ambiguous; there was an enlarged right ventricle and an accentuated sound at the pulmonary base, which seemed at first sight to support the suggestion of emphysema. But the emphysema being absent, we had to look for some other cause. Whilst she was standing, that other cause did not reveal itself, but on laying her down she developed a fairly typical presystolic murmur at the apex. Indeed, when I first heard it, so pronounced was it, that I thought I must have missed it in the upright posture from sheer carelessness, but on standing her up again, the murmur once more disappeared. This condition still persists, and any of you can satisfy himself of the fact that in the recumbent posture she has a quite unmistakable presystolic murmur, whereas in the upright posture the characteristic sounds of mitral stenosis altogether disappear.

Now I need hardly remind you that the presystolic, or crescendo murmur as it is sometimes called, is by no means necessary to establish a diagnosis of constriction at the mitral valve. It is indeed only when that constriction has progressed to a certain point that the murmur developes. The first auscultatory phenomenon which announces the presence of a constriction at this point is the double second sound heard in the neighbourhood of the apex. Various explanations are offered as to the meaning of this double second sound. The one which I personally favour is that offered originally by Potain, which is as follows:—The ventricle contracts producing the first sound; the semilunar valves close, causing the second sound. Immediately after the second sound, the auricle contracts, and in contracting forces the blood through the mitral valve. If this valve is stiffened, as in the case of commencing mitral stenosis it invariably is the forcing of the blood from auricle to ventricle through the stiffened valve will give rise to an added sound. The French called it "le claquement de l'ouverture de la mitrale." That is the first step in the evolution of the sound of mitral stenosis. The next step is the typical rough crescendo presystolic murmur which the late Sir William Gairdner used always to call the "auricular systolic murmur," which is present in this woman's case. The third stage, which precedes death for a variable time, is presented by a single sound exceedingly loud and sharp, which is to be heard all over the cardiac area. The murmurs have been suppressed, and the second sound, though it may still be audible at the pulmonary cartilage, is inaudible elsewhere. That these auscultatory phenomena pass through these various stages should help to remind us of a fact which is too often forgotten, and which from the point of view of prognosis is of paramount importance, namely, that mitral stenosis is essentially a progressive disease.

Rheumatic endocarditis occurring, say, at about fifteen years of age, and causing a constriction at the mitral valve, may, under favourable circumstances, give rise to no symptoms for about fifteen years, that is, until the patient has reached thirty. At about this age, however, certain difficulties are sure to arise. The most common, of course, is bronchitis, but long before the bronchitis becomes at all troublesome the patient will have noticed an increasing amount of dyspnœa on unusual exertion. Another not altogether uncommon manifestation of mitral stenosis, even in its earlier stages, is hæmoptysis. A former President of the Royal College of Physicians was fond of asking candidates for the membership the followng question: "A red-headed woman, æt. 30, suddenly has a violent hæmoptysis, what is the matter with her?" A large majority of the candidates would reply, "Tubercle," but that was not the right answer. The right answer was "Mitral stenosis." It is said to be a fact that red-haired people are more subject to rheumatism than those of dark complexion. Whether or not this be the case it is undoubtedly a fact that at the age of thirty, people who have been the subject of mitral stenosis for many years frequently experience their first unmistakable evidences of cardiac embarrassment. For we must remember that, as the French put it, "une lesion d'orifice n'est pas une maladie de cœur." As long as the orificial lesion is adequately compensated, a person cannot truthfully be said to be suffering from disease of the heart; though he has, no doubt, a mechanical disability which renders him more likely to suffer from cardiac disturbance than those whose orifices are perfectly sound. But so long as the compensation is adequately maintained, such a person requires no treatment other than that which is prophylactic, that is to say, he must be advised to put as little strain upon his cardiac vascular system as possible, and to pay particular attention to the ordinary rules of healthy living.

The danger signals, then, in mitral stenosis are to be found primarily in the lungs: breathlessness, bronchitis, hæmoptysis. But there is another organ which should be investigated, and which is capable of giving us a great deal of useful information long before the danger signals in the lungs become obtrusive. This organ is the liver. The liver may be regarded as the overflow reservoir of the right ventricle. When the right ventricle is pumping against an undue amount of obstruction, it will refuse to admit more blood into its cavity than it can conveniently deal with, and the superfluous blood is returned to the reservoir beneath the right costal arch. This being so, it is evident that the enlargement, especially the tender enlargement of the liver in cases of mitral stenosis, is a warning which, if properly heeded, may save all the troubles and anxieties of a period of broken compensation. The way to deal with a position of that kind, or, indeed, with a mitral stenosis in any of its stages, where it is producing symptoms, is to relieve the pressure on the right heart by venesection and purgatives. Venesection is unfortunately a therapeutic measure of which a great number of people are unduly afraid, and where one comes across such a patient, as one not infrequently does, a very good substitute may be found in the application of leeches. Many people who will not hear of venesection still submit cheerfully to the application of any number of leeches. A practical point in connection with the application of leeches is always to place them over some bony substance. The object of this is to facilitate the checking of the hæmorrhage when the leeches are removed. A little pressure, especially when combined with cold will always ensure this, if there is a hard substance underneath; whereas, if they are applied over the more or less flaccid abdominal organs, the bleeding will often give rise to unnecessary alarm on the part of the patient, and decide him to refuse to submit to the application of leeches on some other occasion, where the necessity for them may be even more urgent.

With regard to purgatives, one of the best is the old-fashioned, and unduly despised, sulphate of magnesium. Dessertspoonful doses of a saturated solution of this salt in water, twice or even three times a day, will produce a very active catharsis, which, after bleeding, is one of the surest methods of relieving the hepatic congestion of mitral stenosis.

Digitalis is, of course, the best heart tonic to use in these cases, but it is useless to exhibit the drug until the hepatic congestion has been adequately dealt with by one or other of the above means.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

DOUBLE INGUINAL HERNIA.—OPERATION THROUGH A SINGLE INCISION.—**MR. ARTHUR EDMUNDS** operated on a man, æt. 22, with a small inguinal hernia on the right side, and a bubonocele on the left. The patient was in excellent health, and apart from the herniæ, exhibited nothing abnormal. The incisions for inguinal hernia, Mr. Edmunds said, are of two varieties: in the first the incision is made along the line of the canal over the upper part of the sac, and is kept as far as possible away from the scrotum; in the second a flap, usually with its concavity downwards, is reflected, so as to expose the area of the abdominal wall in the region of the rings. The object of such a flap is to carry the line of the incision in the superficial structures away from the deep stitches, so that if the wound becomes infected after the operation owing to a soiled or displaced dressing, there is a reasonable prospect of the muscles stitches remaining intact. A flap incision, while possessing this undoubtedly great advantage, necessitates more division of the skin than the straight method, and in those cases in which the operation is performed on both sides, it will be found that there is only a bridge of skin about an inch wide between the two incisions. In the present case an incision similar to the one which finds favour with many surgeons for operations on the pelvis was made: it commenced over or just internal to the internal abdominal ring on the right side, and extended in a curve following the line of cleavage of the skin of the abdominal wall until it reached the corresponding point on the opposite side. The line of incision thus made lay almost parallel to Poupart's ligament on each side, and crossed the middle line about an inch above the upper border of the symphysis pubis. The incision was deepened until the deep fascia was exposed, when it was found that most excellent access could be obtained to inguinal rings on both sides. By retracting the incisions first to one side and then to the other, ample room was obtained for the performance of the operation. This was carried out on both sides in the usual manner, and the wound was closed with a continuous suture. Mr. Edmunds remarked that it was evident that this type of incision was a perfectly efficient method over the more orthodox procedure. The incision lay in the line of the cleavage of the skin, and consequently has less tendency to stretch, and heals slightly more rapidly. In consequence of this the scar left by the operation is much less noticeable, indeed, it lies almost completely within the area of the pubic hairs, so that subsequently it would be difficult to find it without a very searching examination. These points were, of course, unimportant, although it must be admitted they would appeal to some types of patients; the main advantage of the incision consisted in the free exposure of the upper part of the sac on its inner aspect, that is to say, where it lies against the symphysis pubis. The disadvantage of the incision is, without doubt, that in the event of sepsis occurring there would be a greater likelihood of serious trouble; there is, however, no special liability to sepsis, as the wound lies well away from the perinæum, and there should be no difficulty in keeping it aseptic.

TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

MEETING HELD THURSDAY, MARCH 12TH, 1908.

The President, Dr. **HERBERT SPENCER**, in the Chair.

DR. **WALTER SWAYNE** read a short communication on

MYOMECTOMY DURING PREGNANCY,

and described two cases operated on by him. CASE I.—A primipara, æt. 40, pregnant five months, had a solid, rapidly increasing painful tumour growing from the fundus uteri. After laparotomy, a pedunculated fibroid the size of an adult head was removed from the fundus. The flattened pedicle was transfixed, and the peritoneum sewn over it. A smaller fibroid, which was sessile, and situated behind and below the first, was also enucleated. Recovery was uninterrupted. Pregnancy had not been interrupted two months later, after which the patient was lost sight of. CASE II.—Multipara, æt. 35; pregnant 4½ months, with abdominal pain and a bilobed tumour rising out of the pelvis, the left lobe hard, the right soft and elastic. Laparotomy showed a fibroid growing from the right cornu of the pregnant uterus, which had undergone axial rotation, so that the fibroid lay on the left. The rotation was untwisted with some difficulty, and the fibroid was then enucleated. Pregnancy was interrupted a month after the patient left the hospital. Dr. Swayne pointed out that fibroids of the pregnant uterus require operation if causing pain, pressure symptoms, axial rotation of the uterus, or symptoms of twisted pedicle. Rapid increase with pain may point to degeneration. Pregnancy is not necessarily interrupted. Accurate apposition of the gap in the uterine wall is of great importance.

Dr. J. H. **DAUBER** communicated a case of pregnancy complicated by a large and fixed

RETROPERITONEAL FIBROMYOMA,

which completely blocked the pelvis, besides filling the abdomen. (This case is fully reported in another column, under the heading of "Clinical Records.")

In the discussion on these communications, the **PRESIDENT** (Dr. Herbert Spencer) said that, while not criticising the three cases reported, in which the operations were done for definite and serious indications, he felt bound to express his strong opinion that operations in the case of fibroids complicating pregnancy were rarely called for, and that myomectomy, which was occasionally urgently demanded in the case of very large, or impacted, or rotated tumours, was in relation to the frequent occurrence of this complication of pregnancy, very rarely required, and, as the cases exhibited that night showed, was attended by considerable risk. When practicable, the operation should be postponed till the child was viable.

Dr. F. H. **CHAMPNEYS** entirely endorsed the remarks made by the President. He had himself had a long experience of pregnancies complicated by fibroids. It was true that in exceptional cases he had been compelled to adopt serious measures, such as Cæsarean section, but he had frequently been consulted in cases in which the presence of a fibroid had caused alarm to the medical practitioner, but, without any interference, the patients had borne, not one child, but a series, with perfect ease and safety. In his experience the cases requiring serious interference were extremely rare.

Dr. G. E. **Herman** agreed with the last speaker that the mortality of myomectomy in pregnancy, as quoted in the statistics mentioned by Dr. Swayne, was much too high. He narrated a case where he had enucleated a fibroid from a pregnant uterus, and the woman was delivered six months later of a full-term child.

Dr. **Amand Routh** agreed with Dr. Swayne's statement that fibroids complicating pregnancy should not be interfered with unless producing urgent symptoms. Unfortunately, Dr. Swayne had quoted statistics, somewhat obsolete in date, tending to show that fibroids were so serious a complication of pregnancy that operations were frequently justifiable. Dr. Routh thought these statistics quite unreliable. He had collected statistics (*British Medical Journal*, Oct. 3rd, 1903) showing that the maternal mortality of such cases under modern methods was only slightly in excess of the normal, and that the danger to life was not so much due to risks during labour, but to sepsis afterwards, for if the endometrium became infected, a sub-mucous or intra-mural fibroid almost always became infected also. He showed that abortion did not more often occur where fibroids were present, though labour often ensued a few weeks before full time, and urged strongly that no operation should be performed till fœtal viability, unless absolutely essential, so as to save the two lives involved. He had only twice had to perform Cæsarean hysterectomy at or near full term, and never at an earlier date, though he had seen many cases of fibroids blocking the pelvis in the early months. The fibroids in such cases almost invariably underwent flattening and softening (*assouplissement*), and were gradually or suddenly displaced out of the pelvis, sometimes as late as the onset of labour itself, and labour spontaneously occurred without assistance.

Dr. T. W. **Eden** agreed with the previous speakers as to the rarity with which serious complications occurred when women with fibroids became pregnant, and deprecated the view sometimes advanced that pregnant women with fibroids necessarily went in peril of their lives.

Dr. **Arthur Giles** said that speaking in generalities would lead to confusion and inaccuracy. To say that the complication of fibroids and pregnancy was generally unimportant was as much beside the mark as to say that it was generally dangerous. The existence of fundal fibroids might make no difference to pregnancy or labour, but cervical fibroids impacted in the pelvis were in a totally different category. He alluded to a case in which he had removed a fibroid from the left broad ligament in a woman 4½ months pregnant. He experienced great difficulty in stopping the bleeding, and though he succeeded at the time, it recurred later, necessitating the removal of the uterus, as in Dr. Dauber's case.

A short communication was read by Dr. **Russell Andrews** and Dr. **Drummond Maxwell** on

A CASE OF DIFFICULT LABOUR,

with remarks on the frozen sections of the uterus. The patient had been in labour for 2½ days before the resident accoucheur was sent for. He found a very large decomposing child presenting by the vertex. Attempts at craniotomy and cephalotripsy resulted in the whole of the head being pulled off, and traction on the arms pulled both of them off. An attempt at version failed, the foot coming away without any alteration of position being effected. The patient was then sent into the London Hospital. When Dr. Andrews saw her, the uterus was in a state of tonic contraction. He cut through both clavicles, perforated the chest, and removed the heart and lungs, perforated the diaphragm, and removed the liver and intestines. In spite of effecting diminution of the size of the child, no form of traction applied by every conceivable variety of hook and forceps was successful, and attempts at version met with no more success. It was impossible to cut through the fœtal spine. At last, after 1½ hours hard work, realising that he could not deliver per vaginam, he removed the uterus with the child *in situ*, preferring hysterectomy to leaving the patient undelivered with the uterus in a state of tonic contraction. The patient died the next day. The child, who had apparently reached the age of 44 weeks, must have weighed not less than 13 lbs. Frozen sections of the uterus, with fœtus *in situ*, were exhibited. A well-marked ridge, projecting into the cavity of the uterus, was the subject of considerable discussion, it being the opinion of the authors of the paper that this represented the retraction ring. Post-maturity of the fœtus was discussed, and the recorded cases criticised. Sections of the placenta were also shown, but did not throw any light on the etiology and pathology of the condition.

Dr. F. H. **Champneys** said he had felt contraction rings round various parts of the uterus, in some cases round one of the uterine cornua. The experiments of Kleinwäechter showed that spontaneous delivery occurred in some of the most unpromising cases of obstructed labour. In such a case as that under discussion, where the patient was already septic, the choice of treatment was one of great difficulty.

Dr. W. S. A. **Griffith** suggested that the probable cause of the difficulty in delivery was not in the uterus, but in the macerated condition of the fœtus. He wished to emphasise the value of version as a means of delivery after craniotomy if the uterus was not in a state of tonic contraction.

Dr. T. W. **Eden** remarked that the term contraction ring used by the authors was inaccurate; it should be called the retraction ring. He could not accept the view advanced by them as to the formation of this ring that it was the result of moulding on a body groove.

Dr. **Andrews** and Dr. **Maxwell** replied.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, February 28th, 1908.

Mr. Seton Pringle, F.R.C.S., in the Chair.

SOME CASES OF GALL-STONES.

Mr. **Kennedy**, in his paper on gall-stones, laid stress on the fact that the only treatment of avail is operative. He illustrated by a case the difficulty of diagnosing gall-stones when the symptoms may be altogether gastric in character. He mentioned three cases of obstruction to the common bile-duct, upon which he had successfully operated, one in which the obstruction was caused by a single calculus weighing 50 grains—the obstruction was present for three and a half years; another in which six calculi were removed from the common bile-duct. This patient had had perforation of the gall-bladder and peritonitis about six months previously, for which Mr. Kennedy had also operated. The third case was an old lady who had apparently obstruction to the common bile-duct produced by chronic inflammatory trouble in the pancreas. A few points were mentioned dealing with the differential diagnosis between common duct obstruction produced by calculi and that produced by pancreatitis. Mr. Kennedy also gave a short account of two cases in which he had performed cholecystectomy. In both cases the cystic duct was obstructed by a calculus, and numbers of calculi were present in the gall-bladder.

The **Secretary** said Mr. Kennedy had well-expressed surgical opinion with regard to the presence of gall-stone when he said it was no more safe to leave a gall-stone in the gall-bladder than to leave a suppurating appendix inside the abdomen. That had been impressed on him by several cases which he briefly recounted. He agreed that the condition was one which should be put under the care of a surgeon, not a physician. Recently he had removed gall-bladders more often than formerly, as he had had experience of a recurrence of gall-stones in some gall-bladders which he had opened and drained. If the gall-bladder was found very much thickened and distended, and a stone was found in the cystic duct, he thought these were indications for the removal of the gall-bladder. There was a danger of malignant disease with the thickening, and there would be considerable doubt as to whether such had not already started. If a stone had been lodged in the cystic duct for some time, even if it could be removed at the operation, the probabilities of a stricture forming and resulting in a permanent mucous fistula were very great, and could be obviated by the removal of the gall-bladder at the time of the operation.

Mr. **Kennedy**, in reply, said it was by no means proved that the removal of the gall-bladder would prevent a recurrence of gall-stones.

THE SURGICAL TREATMENT OF EXOPHTHALMIC GOITRE.

Mr. **William Taylor** read the notes of a case of Graves' disease treated by removal of the right lateral lobe and isthmus of the thyroid gland. The case was that of a young girl, æt. 24, who had been suffering from the phenomena characteristic of Graves' disease for six years. Both eyes were very prominent, the heart's action was rapid, and palpitations were very distressing on the slightest exertion; muscular tremors were well marked, and her nervousness was so bad that she could scarcely speak intelligibly. The thyroid gland was enlarged, but the enlargement was much greater on the right side. Medicinal treatment had been tried for the six years she was affected, but without any beneficial effect. Her condition was steadily becoming worse, and she was compelled to give up her business, which was that of a dressmaker. After admission into the Meath Hospital, under Mr. Taylor's care, she was kept quiet in bed for three weeks prior to operation. During that time her pulse varied from 120 to 136 beats per minute. Under chloroform anæsthesia preceded by a hypodermic injection of morphin 1-6th gr., and atropin 1-100th gr., the right lobe and isthmus of the thyroid gland were removed. The operation presented no unusual feature of interest. There was very little blood lost, and the operation was well borne. The pulse during the subsequent 24 hours varied from 120 to 140 per minute, and the temperature rose to 101.4°. On the second day the temperature fell to normal, and the pulse averaged 120 beats to the minute. The drainage tube was removed on the third day, and the sutures on the sixth day. The pulse gradually fell in frequency till the tenth day, when the record was 78 beats to the minute. On that day she left for the convalescent home. On examination 20 months after operation, the patient's condition was in every respect quite satisfactory. Her nervousness had disappeared, there were no muscular tremors, she never got any attacks of palpitation, her pulse averaged 80 to the minute, and her exophthalmos—though still present—was much less marked. The girl expressed herself as quite well in every respect, save for the slight prominence of her eyes, and she was working daily at her business. Mr. Taylor then discussed the treatment of Graves' disease, characterising the treatment by drugs as empirical, while the method of treatment by feeding patients so affected upon the milk of thyroidectomised goats could only be palliative, and in no sense curative. Similarly, treatment by injection of the serum of sheep whose thyroid glands had been removed, as well as the treatment by giving rodogen, could scarcely be considered more than palliative. Operative treatment showed the best results, and when undertaken in an early stage, before the heart became disorganised and degenerated, the mortality attending it was but little in excess of partial thyroidectomy for simple colloid goître. The operation should be that of the removal of an entire lobe and the isthmus. One thus removed the source of the mischief by removing the organ in which the disease has its localisation. The degree of amelioration of the symptoms was in direct proportion to the amount of hypertrophied gland tissue removed or destroyed by the operation. Operation in an early stage can cure the patient, but operation in severe and advanced cases, provided the heart is not too disorganised to render such a procedure extremely hazardous, can only be expected to ameliorate the symptoms. Thus it is essential that the operation of partial thyroidectomy should be advocated and undertaken in an early stage of the disease.

Mr. L. G. **Gunn** also read a note on the SURGICAL TREATMENT OF EXOPHTHALMIC GOITRE, dealing mainly with the pathology of Graves' disease. He thought that the parathyroids were primarily affected; the enlargement of the thyroid followed. The microscopic appearances of the gland in the early stages of the disease are not distinguishable from those of simple goître; in the later stages of the disease the appearance of the exophthalmic goître under the microscope is unmistakable. Mr. Gunn then briefly related three cases of Graves' disease in which partial thyroidectomies had been done. Two of these had been most successful, but the third died from subacute thyroidism ten days after the operation. Mr. Gunn thought that operation, while undoubtedly attended with risk, holds out the best prospect of cure for the patient. The use of cocaine as an anæsthetic was not approved, the author holding that chloroform was no more dangerous for the patient, and far more comfortable for the operator.

Dr. **Stokes** inquired as to the average comparative mortality of the medical and surgical treatment of exophthalmic goître. He also wished to know if the communicators could explain how it was that, in the worst cases, the pathological changes were those of atrophy, the gland apparently removed itself, and yet those were the cases which died He asked also if any pathological changes had been found in the parathyroids?

Dr. **Kirkpatrick** said he did not think physicians would raise much objection to patients suffering from exophthalmic goître being taken from under their care, provided the surgeon could give better results. But he did not think that surgeons had yet got a method of treatment which was any more satisfactory than the medical. In order to prove curative, operation would have to be undertaken before serious symptoms had arisen; and, in order to be able to recommend patients to submit to operation at an early stage, the operation must be a comparatively safe one, and one from which good results could be promised. At present, however, the mortality of the operation was considerable, and permanent cure was not by any means established. Before they could come to any conclusion on the disease, something more would have to be known of its pathology and causation. The question of anæsthesia was of great importance. He believed that the mortality under general anæsthesia would be found to be greater than under local anæsthesia. Although it was not possible to get complete freedom from pain by any local anæsthetic, he thought they could get a working anæsthesia which would, on the whole, give a better result than a general anæsthesia. Of all forms of anæsthetic, chloroform was the most dangerous in such cases. He did not believe it was correct teaching that there was much less congestion and cyanosis, as well as bleeding, with chloroform than with ether. If the ether anæsthesia was satisfactory, and was not too deep, it would, to his mind, be very much safer than chloroform.

The **Secretary** said that although there was considerable question as to the pathology of exophthalmic goître, there was no question as to the pathological change from which the symptoms arose, viz., an increased production of thyroid extract. The case for the removal of the source had received additional support in the instances brought forward in the papers which had been read, but it was only by comparing results in a large series of cases which were operated on with those in which there was no operation that any conclusion could be arrived at. In ordinary goître he used ether anæsthesia. One of the results of thyroidism was to affect the cardiac muscle, and since chloroform had a very depressing effect on the cardiac muscle he preferred ether.

Mr. **Kennedy** attributed considerable importance to the position of the patient during operation. He believed that many deaths had occurred through interference with the recurrent laryngeal nerve. The danger of thyroidism was greater the more gland was left. To get a good result they had to remove practically the whole of the gland. The central lobe would be quite sufficient for the needs of the patient afterwards. If the surgeon got the case before pathological changes had occurred in other organs, the cure of the disease could be practically assured.

The **Chairman** was inclined to agree that local anæsthesia was the safest, but he would rather use a general anæsthetic in this country. Kocher's patients were bound hand and foot, and were in a much better state of surgical training than could be got in Dublin.

Mr. **Taylor**, in reply, said he was not aware of the comparative mortality of surgical and medical treatment. It was the few cases that got well without apparently any treatment that prevented cases being handed over to the surgeon at an early stage. Recent experience had led him to prefer ether anæsthesia by the open method.

Mr. **Gunn**, in reply, said that fibrous changes had been described in the parathyroids.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held March 11th, 1908.

The President, Dr. James Ritchie, in the Chair.

Mr. George Chiene showed two patients operated on for perforated gastric ulcer, in whom the plan of complete closure of the abdominal wound, without drainage, had been adopted. In both cases primary union had resulted. Such cases showed how great was the power of the peritoneum in dealing with infected material.

Mr. **Alexis Thomson** showed a boy, æt. 16, who was unable to extend his elbow completely. The condition had been in existence for several months; there was no history of accident, and no signs of disease of the elbow-joint were present. Skiagrams showed the limitation of movement was due to a slight displacement inwards of the epiphyses of the olecranon. As the condition was giving rise to no discomfort operation had been declined.

Dr. F. M. **Graham** showed a photograph and skiagram of a case of absence of both forearms.

Mr. **Alexis Thomson** read a paper on "Diverticula of the Ileum," an abstract of which will be found on p. 345 of the present issue.

Mr. **Wallace** and Mr. **Scot Skirving** discussed the paper.

Dr. A. **Walker** read a paper on

THE PROVISION OF SANATORIA FOR THE TREATMENT OF PHTHISIS AMONG THE POORER CLASSES.

His interest in the question was, he said, a very personal one, because in his youth he had been threatened with phthisis, and had been compelled to relinquish a city practice for that reason. He proposed to limit his remarks chiefly to the financial aspect of the question, and to eliminate from discussion such important topics as the dispensary for phthisis, methods of cure, and the question of the segregation of advanced infectious cases. The discovery of the tubercle bacillus and its life history had revolutionised our opinions as to the cause and treatment of the disease. We knew that the bacillus was readily destroyed by air and sunlight, though in its dried state, like other spore-bearing organisms, it was very resistant. Both pathology and vital statistics showed that Nature plays a very important *rôle* in the prevention and cure of phthisis. Post-mortems showed how large was the percentage of persons who had old-healed tubercle, while vital statistics proved that the death-rate was on the decline. Some asserted that Nature alone would operate in controlling the disease, but philanthropic motives, economic considerations, and self-interest alike pointed against this view. Dr. Walker then recounted the history of an attempt he had made to establish a municipal sanatorium at Aberdeen, which had been frustrated through the issue of the Circular of the Local Government Board. He criticised some of the provisions of this circular, and urged that an amending Act was urgently wanted to deal with the special features of phthisis. He urged that the State ought only to control the disease in so far as it is infectious, and is not suited to undertake curative treatment. In the course of his attempt to establish a sanatorium he had made investigations concerning all the sanatoria for the working classes in existence in Great Britain. Apparently, there were only some 10,000 beds in all available, which was very far below the number of persons who were suffering from the disease. The sanatoria derived their incomes from several sources—from charitable funds, from paying patients, from friendly societies, from rating bodies, and also from working men. He had been surprised and pleased to hear that in some institutions a very large part of the funds was drawn from regular small subscriptions of the class for whom the benefits were destined. The average cost per bed was, as a rule, far too high. In some sanatoria it worked out at £300, which was folly. It was absolutely necessary that no superfluous decoration or expense of any kind should be incurred if sanatoria treatment on a large scale were ever to be provided. The same applied to the cost of maintenance, which averaged about 30s. per week. From a comparison with asylums, he was convinced that it ought to be possible to keep the cost per patient per week down to about 16s. As showing that the results of sanatorium treatment were such as to justify economically its adoption, he pointed to the action of the German insurance companies, which found it cheaper to build sanatoria and cure cases of phthisis among workmen than to pay sick wages and death compensation. In conclusion, Dr. Walker showed designs for a model sanatorium, which combined efficiency and economy, and could be built at a cost of £50 per bed.

Dr. **Lawson** and Dr. **Caverhill** discussed Dr. Walker's paper.

Dr. **Peel Ritchie** read a paper on "Observations on the Use of Inoculations of Bacterial Suspensions," an abstract of which will be found on page 345 of present issue.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Thursday, March 12th, 1908.

The President, Mr. R. Marcus Gunn, F.R.C.S., in the Chair.

The following cases were shown:—

Mr. E. E. **Henderson**:—An orbital case, for diagnosis.

Mr. G. H. **Goldsmith**:—A case of retinitis.

Mr. **Arnold Lawson**:—A case of (?) albuminuric retinitis in a child, and a case of (?) Parinaud's conjunctivitis.

Mr. A. H. **Thompson**:—Punctiform remains of pupillary membrane, both eyes.

Dr. J. F. **Cunningham**:—Unusual form of choroido-retinitis.

The meeting then resumed the discussion on Mr. Leslie Paton's paper read at the last meeting on

OPTIC NEURITIS IN CEREBRAL TUMOUR.

Mr. **Paton** first modified his paper in respect of some of the percentages, sub-dividing them into more convenient classes. He also stated that since reading the paper he had been through the records of 60 additional cases, which bore out the conclusions he had formed on those already published.

Mr. **Herbert Parsons** said the paper was essentially statistical, and statistics did not lend themselves well to discussion: the only part open to debate was the conclusions which the author had formed on the figures. The records of the cases were of great value, because the ophthalmoscopic appearances were observed by the President. There was a distinct apparent discrepancy between the details in this series and those previously published by others. A recent series by Uhthoff, of Breslau, more nearly coincided with those of Edmunds and Lawford than with Paton's. Mr. Parsons insisted on the importance of not only recording the amount of swelling of the disc, but the stage at which it was observed. He was not in agreement with Mr. Paton's explanation of sub-cortical and pontine tumours in regard to vascularity. He did not regard the star at the macula as a mere result of the violence of the neuritis; there were cases equally violent in which no star was present. The latter he had seen more commonly in children than in adults. He considered that suggestions as to the cause of optic neuritis should be omitted from the discussion, as it did not really arise out of the paper.

Sir **VICTOR HORSLEY**, speaking as a visitor who had not heard the paper, but had an opportunity of looking it through, said the contribution was really founded on records of his own cases, and yet he was diametrically opposed to one of its most important conclusions. He protested against Mr. Paton's conclusion going forth under the ægis of that great Society as the one justified by the records of the Queen Square cases. He, Sir Victor, had taught for years, and had supported it by operative proof, that one was justified in regarding the homolaterality of the lesion as a point of clinical value. Every case must be dealt with on its merits, and he thought the difference of opinion between Mr. Paton and himself was due to the treachery of clinical statistics. He had long taught that it was essential to study the neuritis by the character of the changes in the disc, not the mere swelling. It was necessary to know whether it was an exudate, and indeed the minutest details of it. He had often seen a macular fan entirely disappear after the removal of a cerebral tumour. One point, which was learned from the Queen Square cases 20 years ago, but which did not find a place in the paper, was the question of pressure. Free opening of the dura mater would cause subsidence of the neuritis. The records contained very much information on that point, and he hoped Mr. Paton would be able to include it in his paper.

Sir **WILLIAM GOWERS** sent a communication, supporting some of Sir Victor Horsley's criticisms.

Dr. **BEEVOR** agreed with Sir Victor Horsley's remarks concerning the age of the neuritis. In 50 cases of cerebral tumour of all kinds which he investigated for his Lettsomian lectures last year, the optic neuritis was most severe on the same side as the tumour.

Dr. **FARQUHAR BUZZARD** complained that Sir Victor Horsley had not brought forward figures to support his view on homolaterality, valuable though his opinion was. The number or proportion of cases in which the neuritis occurred on the same side was not great enough to make it diagnostically important. Placing too much stress on the doctrine might lead to serious error.

The **PRESIDENT** thought the truth in the matter lay between the views of Mr. Paton and Sir Victor Horsley, in the way mentioned by Dr. Farquhar Buzzard.

Mr. **PATON** replied, quoting cases from his paper in confirmation of his previous contention.

Dr. **THOMSON HENDERSON** (Nottingham) gave a lantern demonstration on the venous connections of Schlemm's canal. He said the channels of the aqueous outflow were: Schlemm's canal, the suprachoroidal space, the iris. The last was an absorbing surface only because of its crypts. His object was to show the close venous connection beween those three channels. The vascular supply of the ciliary body was derived from the arteriosus iridis major, formed by the two long posterior ciliary arteries, reinforced by the eight anterior ciliary arteries, two from each rectus. The whole of the venous blood was returned *viâ* the venæ vorticosæ, except the small area drained by the anterior ciliary veins. A study of a large number of series of consecutive radial sections brought out the following points. In each mm. of the scleral circumference (42 sections equal 1 mm.) there was never less than one anterior perforating scleral vessel, frequently two, and occasionally three. There was free anastomosis among the vessels. Each perforating vessel sent or received an efferent branch from Schlemm's canal. He had not been able to find a perforating scleral vessel not connected with Schlemm's canal. Therefore, all those vessels were veins, and the so-called circulus arteriosus iridis major was a sinus venosus iridis. Schlemm's canal was nothing more than an offshoot of the iris veins. Before perforating the sclera, the iris veins were in free communication with the ciliary veins and radicals of the venæ vorticosæ. In chronic glaucoma, when adhesions of the iris root had been long enough established, serial sections showed new-formed vessels perforating the pectinate ligament, and connecting directly the iris veins with Schlemm's canal. This bore greatly on glaucoma and its treatment by iridectomy, as the success of the latter depended on the iris being an absorbing surface only by virtue of its crypts. Its effect was that of a large crypt occupying three sides of a square, for in a healthy iris the cut surfaces forming the base and pillars of the coloboma never healed. Cicatrisation was a protective process following as a result of the reaction of the cells of a tissue to irritation or altered condition of life. A successful iridectomy left the tissue cells bathed in aqueous, so that no stimulus was imparted to them to cause the formation of a dense protective layer. The cut iris tissue thus remained unaltered, and so presented a large raw surface, by means of which the aqueous could readily drain away, provided (a very important point) the operation were done before atrophy and damage to the iris structure had proceeded too far.

CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, MARCH 19TH, 1908.

Dr. CHAMPNEYS in the Chair.

THERE were also present Dr. Stanley Atkinson, Mrs. Latter, Miss Paget, Mr. Ward Cousins, Mr. Parker Young and Miss Wilson.

After the minutes of the last meeting had been signed, it was announced from the chair that Mr. Ward Cousins had been re-elected to represent the Royal College of Surgeons, and Mr. Parker Young to represent the Society of Apothecaries. Letters were read from the Under-Secretary of State for the Home Department, informing the Board that the Chief Constables of Counties and Boroughs, and the Commissioners of Police in London had been requested to report convictions of midwives direct to the Board; and from the Clerk of the Council stating that arrangements had been made by the Treasury for the supply and distribution of copies of the Midwives Roll to the coroners of England and Wales.

The following resolution, proposed by Mr. **WARD COUSINS**, and seconded by Dr. **STANLEY ATKINSON**, was passed :—

"That as no arrangement for the payment of fees to medical men summoned to assist certified midwives has been made satisfactory to the medical practitioners and certified midwives of the country, the time has arrived for the Board to reconsider the question, with special reference to the efficient operation of the Midwives Act, 1902."

Some discussion followed, both Mr. **WARD COUSINS** and Mr. **PARKER YOUNG** asserting that the question had not been seriously dealt with either by the Central Midwives Board or the Government; and that the recommendation of the Local Government Board to the Guardians empowering them to pay fees to medical men called in by midwives, "if they thought fit," was not effective or satisfactory. They considered that the Lord President of the Privy Council and the President of the Local Government Board should be asked to receive a deputation of the Central Midwives Board, which would proceed to explain the case to them, making clear the impossibility of the efficient working of the Act under present conditions.

The **CHAIRMAN** thought the Board ought to be grateful to the Local Government Board for its recommendation to the Guardians, which was the first step in the right direction. He maintained that the Central Midwives Board had concerned itself very much in the matter, and made several attempts towards removal of the difficulty.

Dr. **STANLEY ATKINSON** urged that before any steps were taken with regard to a deputation to the Lord President, it should be ascertained either by a question in the House or by the Secretary how far the Boards of Guardians throughout the country had adopted the recommendation of the Local Government Board.

Another suggestion was made by Mr. **WARD COUSINS** to the effect that a scale of payment to medical men called in by midwives should be drawn up by the

Board. It was agreed that the matter be referred to the Standing Committee.

On the motion of Mr. **PARKER YOUNG**, the Board agreed to rescind its resolution of December 19th, 1907, refusing the application of Dr. W. Colquhoun, of Govan Road, Glasgow, for approval as a teacher of pupil midwives, and that his name be added to the list of recognised teachers.

In the report of the Standing Committee, the question of making Plymouth a centre for examinations of the Board was dealt with. At present the number of candidates is insufficient. When not less than 20 can be guaranteed, the Board will re-consider the matter.

A letter was read from the Registrar of the General Medical Council in reference to the communication made to it by the Board with reference to Dr. Stevens, late Master of the Coombe Hospital, Dublin, stating that the Council does not propose to take any steps in the matter.

In reply to a letter from Dr. H. Handford, C.M.O. for Notts, it was agreed that Dr. Handford be informed that the case of a midwife suffering from septic ulcers or kindred complaints appears to fall within the terms of Rules E., 1 and 5, or might be dealt with by the Local Sanitary Authority under the Public Health Acts.

A resolution was passed that the Coombe Hospital, Dublin, be reinstated as an approved training school, and the **CHAIRMAN** remarked that the Board was quite satisfied with the straightforward manner in which the Governors of that hospital had dealt with the matter.

Referring to the proposed scheme for the training and supply of midwives discussed at the last meeting, when the Act shall come into full force, it was resolved to forward a copy of the following to the Privy Council:—

(1) That midwives (who are "a necessity") will be unable to make a living in many localities without extraneous aid.

(2) That such localities are very often exactly those in which their presence is most necessary from the poverty and (in some cases) the sparseness of the population.

(3) That voluntary contributions cannot be relied upon to supply the whole of the necessary financial aid.

(4) That for this purpose a Government grant is a necessity.

(5) That, if such a grant were provided, the Board thinks that a representative Council of competent persons should be appointed to administer the fund thus constituted.

Eight more midwives (*bonâ fides*) were removed from the Roll at their own request. Applications for approval as teachers were granted to A. Cambell, M.B., and Mary E. H. Morris, M.B.

In the Secretary's report of the February examination, a remarkable difference in percentage of failures was commented upon. The percentages were as follows:—London, 15 per cent.; Birmingham, 6 per cent.; Bristol, 13.6 per cent.; Newcastle, 18.4 per cent.; Manchester, 33 per cent. It was agreed that a visit of inspection should be paid to Manchester to inquire into the reason.

The next general meeting will be held on April 9th, and the Board will sit to hear the penal cases on March 26th and 27th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 6TH, 1908.

The President, Mr. RICHARD LAKE, F.R.C.S., in the Chair.

DR. ANDREW WYLIE read a paper on

FOUL BREATH: ITS CAUSES, PATHOLOGY AND TREATMENT.

He said fœtor of the breath is either purely subjective, entirely objective, or both. There are several different kinds of fœtor, such as the putrefactive, the sulphuretted hydrogen, the garlic, the sweetish, and the toxic types. Fœtor is classified according to the different regions responsible for its source: as diseases of the nose and the accessory sinuses, nasal obstruction and growths and naso-pharyngeal diseases, imperfect deglutition and carelessness in oral and dental hygiene, affections of the tongue and gums, caries of the teeth and imperfect dentures, diseases of the follicles of the tonsils, tubercular, syphilitic and malignant diseases of any part of the nose, pharynx or larynx; if cartilage or bone is involved, suppuration of the middle ear, bronchiectasis and abscesses of the lung, foreign bodies in any part of the upper air passages, gastro-intestinal diseases, and in paralytic patients. Fœtid breath is found more or less in spirit and beer drinkers, in smokers, in those who take certain drugs, and in those who follow certain occupations. Bacteria are the cause of the trouble, and the treatment is to find the cause and remove it, or at least reduce the activity of the bacteria.

Mr. W. H. BOWEN read a paper on

PNEUMOCOCCAL OTITIS MEDIA.

He stated his opinion that the pneumococcus was the organism usually causing acute otitis media at any age. The occurrence of otitis during epidemic diseases was not considered. Special attention was called to the onset of otitis media after operation on the nose and nasopharynx, and their etiology carefully considered. The sponging over the face with cold water was strongly condemned, and the importance of avoiding draughts and keeping the patients warm emphasised. The otorrhea of babies up to 18 months old was considered, and the comforter looked upon as the strong etiological factor, so much so that the speaker labelled them "Comforter Otitis Media." They were pneumococcal, and should be treated by cleansing the mouth in addition to local treatment to the ear. The paper finished with a consideration of the signs and symptoms of acute infection of the mastoid antrum and cells, which was practically always due to the pneumococcus.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 22nd, 1908.

TREATMENT OF COXALGIA.

PROF. CALOT, of Berck-sur-Mer, gave a very interesting clinical lecture at one of the Paris hospitals, and reproduced by the *Journal des Praticiens*, of which the following is an extended *resumé*:—

Although I am here to speak to you on the treatment of coxalgia, I must say a few words as regards the diagnosis of the disease, which you will be called on, in your general practice, to treat. Where the affection is well established the diagnosis is easy, but at its *début* it is not always so easy. However, if you bear in mind the following points you will not encounter much trouble:—

(1) Coxalgia should be suspected each time that a patient suffers, without apparent cause, from lameness or pain in the hip or knee.

(2) If examination of the hip reveals pain on pressure over the head of the femur, which is found, as you know, in the inguinal region about one-quarter of an inch from the artery, and a more or less limitation in the movement of abduction, coxo-femoral arthritis may be affirmed.

(3) If there exists, besides, a lengthening of the limb, this arthritis is tuberculous, and constitutes true coxalgia.

Once the diagnosis firmly established, the treatment, both general and local, will be applied.

Of the former it is not necessary to say anything, the malady being tuberculous, the general treatment will be prescribed accordingly.

As to the local treatment it consists in rest in the horizontal position and immobility of the articulation. This immobility is obtained by *continued extension* for private patients who can be closely watched, and a *plaster apparatus* for hospital patients, or those belonging to the poorer classes.

Such is the constant treatment, rest and immobility, of every form of coxalgia.

But complications may appear that require special treatment. They are three in number: *deviation, abscess, fistula.*

If a deviation exists you will correct it, not suddenly, but gently and slowly to avoid danger of general infection. Correction can be obtained by increasing the tension 10 or 20 lb., or by applying the plaster splints every fifteen or twenty days. Chloroform is not necessary.

If an *abscess* appears, it will be tapped, but *never* opened with a bistoury, nor should it be allowed to open spontaneously. Once the abscess is tapped a modifying liquid should be injected.

If the patient comes to you with a fistula, you will dress it antiseptically and no more. Neither resection nor curettage should be permitted.

To resume, the classical treatment of coxalgia amounts as follows:—Make a plaster apparatus, correct a deviation, tap an abscess, dress a fistula.

This treatment is continued until the patient feels no more pain on pressure of the head of the femur. However, if, clinically speaking, the patient is cured, anatomically, he is not, consequently I would advise you to wait four or six months longer before allowing him to get up and walk. At the end of that time he may begin to move about, either alone or by the aid of a celluloid support, in private practice, or one of plaster for hospital patients. This support will be worn as long as the limb has a tendency to deviate.

Such is the whole treatment which, as has been seen, is entirely *medical* from beginning to end.

As to the results, they must be studied as regards the cure of the patient and the nature of the cure itself.

In the first place, the treatment saves the life of the patient, which was, some twenty years ago, so frequently sacrificed, so that Gosselin used to say, "Coxalgic patients generally die." And why did they die then, whereas now they live? Because formerly abscesses were freely opened as well as the tuberculous joint. But to-day intelligent surgeons content themselves, in the treatment of coxalgia, with accepting the *rôle* of the physician.

As to the quality of the cure, it is not sometimes very brilliant where the patient is condemned to limp all his life. As a general rule, coxalgia requires from three to four years to get well—seldom less; in some benign forms one or two years, but frequently more.

I am going to show you now the manner in which patients get well of their coxalgia, for I have invited to come before you about thirty of my old patients living in Paris, whom I treated as I have just explained to you. As you see, there are a certain number, about a fourth, who walk very well, without a limp; about as many more walk well, but with a slight claudication; while the remainder limp considerably.

Are you satisfied with these results? I confess that I am not. It is true that it is thus that coxalgia is cured in general; but I cannot accept with equanimity such an incomplete cure.

It is for this reason that, for several years I have been studying the means of correcting, if possible, this claudication, which, the sombre point in the prognosis of coxalgia, is due to the destruction of the articular extremity. The classical treatment saves the life of the patient, but not the head of his femur. If we want to cure him completely without limping, we must find something better. The cause of the mischief is due to tuberculous fungosities which, first limited to the articulation end by penetrating the bone, soften and dissolve it. The fungus, consequently, must be attacked before it succeeds in destroying the bone, and, provided that the malady is recognised in time, that can be done by the inoffensive and efficacious method of early injection into the articulation of a mixture of olive oil, iodoform, creosote and ether:—

Olive oil, } āā 1½ oz.
Ether, }
Creosote, ½ dr.
Iodoform, 1 dr.

This treatment may be employed within the first few weeks, or even three or four months, after the disease has been clinically confirmed, since as yet the bone is neither destroyed nor softened to any appreciable extent. Placed in contact with the fungosities, the liquid provokes sclerosis of the morbid tissues or dissolves them completely, but from 7 to 10 injections are necessary to arrive at this result. (Here M. Calot presented several children radically cured; neither lameness nor shortening could be detected.)

The technical difficulties of these injections might discourage you at first, as the access to the articulation of the hip is not very easy. However, if you will bear in mind the two landmarks I give you, you will have but little difficulty in penetrating the capsule of the joint. The first is an horizontal line passing through the spines of the pubis; the second the femoral artery as it emerges under Poupart's ligament.

You will employ a Collin's needle, No. 2, or a fine trocar like the one I use, 4 in. in length, and insert it 1¼ in. below the horizontal line, and ¾ in. outside the artery.

In children from nine to twelve years of age the distances would be 1 in. and ½ in. respectively. The instrument should be inserted directly from before backwards, until the bone is felt—that is to say, to a depth of 2 in. At that moment the limb is slightly flexed, abducted, and rotated externally to facilitate the penetration of the liquid. The canula is held in contact with the bone with the left hand, while the trocar is withdrawn, and the syringe containing the solution adapted to the canula. When the injection is terminated, a plug of cotton is placed over the little wound, and the limb is returned very gently to its normal position. The injections are repeated once a week, until nine or ten are given. At the end of this period (two months) compression of the articulation by means of cotton wadding, with continued extension or plaster apparatus, is applied during two or three months. But four or five months more are necessary before the patient can be allowed to get up, and at that moment he is cured.

Consequently, by this method coxalgia can be completely cured within a year, whereas under the old treatment, three or four years were necessary, and even then claudication was the rule.

GERMANY.

Berlin, March 22nd, 1908.

AT the Medical Society Hr. Fleischmann gave an address on the

SERUM DIAGNOSIS OF SYPHILIS.

The essentials of Wassermann's serum diagnosis of syphilis were the following:—The combination of a substance with its anti-body had the property of combining with its complement; by this the blood corpuscles were dissolved, hæmolysis took place, which did not do so when the complement did not enter into combination. This was first done with the liver of children suffering from hereditary syphilis, which showed itself to be peculiarly antigen. Doubts arose as to the specificity of this body, when it appeared that the same reaction took place with extracts of non-syphilitic livers. Endeavours were made to isolate the active principle of the liver, and it was found that an alcoholic extract of liver was suitable for the reaction; from this it was believed that the conclusion might be drawn that lecithin was the essential constituent that formed the basis of the reaction, and as a matter of fact it was shown that an emulsion of lecithin did combine the complements. For practical purposes, however, the organ extracts proved more suitable. The speaker then tried cholesterine, vaseline, glycogen, kaolin, and mastic emulsion, and determined that the three latter did not give any complement formation.

The result of investigations hitherto was that a material was met with in many syphilitics that formed complements in combination with organ extracts and lipoid substances, and did not do so in the normal individual.

The speaker had examined a total of 230 cases, amongst them 38 control cases, the men being healthy, and in these the result was always negative. Amongst the remaining 192 were 160 who were undoubtedly syphilitic, and of these 117 gave positive results;

89 were certainly syphilitic with manifest symptoms, and of these 83 gave positive results, the other 6 were old cases that had been treated several times.

Those who were certainly syphilitic, but without symptoms, were 64, and 33 of these gave a positive reaction. The positive reaction here showed that the cases were still uncured, and that treatment had still to be continued. On the other hand, however, the absence of the reaction was not a proof that recovery had taken place, as experience had shown that the reaction might become positive again even when the symptoms had disappeared.

Five primary sores gave a positive reaction. Of 18 tabetics 16 showed a history of syphilis, and 13 gave a positive reaction; 32 cases in which there was a suspicion of syphilis showed a positive reaction 16 times.

The speaker concluded that further investigations should be made. When a case showed a positive reaction, it was proof that syphilis was still present, but when the result was a negative one no conclusions could be drawn at all.

Hr. Blaschko, in conjunction with J. Citron, had examined 400 cases. All cases undoubtedly non-syphilitic gave a negative reaction. In doubtful cases the result was sometimes positive, and this was evidence that syphilis was present, but no conclusions could be drawn from a negative reaction.

In cases in which the primary sore was still present the reaction was positive in 90 per cent. of the cases; in the first years of the disease so long as symptoms were present, the reaction was present in 98 per cent., but in latent cases in only 80 per cent. In late cases with symptoms it was present in 91 per cent., without symptoms in 57 per cent.

The reaction always occurred before the roseola, if it was absent when there was a primary sore, it might be from abortive treatment. It continued for years, and disappeared to show again when fresh symptoms made their appearance. In the later stages it could not be determined whether the reaction showed any connection with the original severity of the disease or the intensity of the treatment. He had made inquiries as to the statistics of life insurance societies, and had found that one-third of all those contracting the disease died of it in the end; but in this estimation all those diseases were included that were not unconditionally separated from syphilis. Another calculation showed that syphilitics had a mortality of 68 per cent., the majority of them dying from diseases of the system. For practical purposes it did not yet appear that the test was of any practical value; it did not show that the disease was still uncured, and that the patient must not marry.

Hr. Citron showed the reaction of Klausner, of Prague, which depended on the fact that when syphilitic serum was added to distilled water a deposit took place in the course of 15 minutes. This consisted of globulines, which in syphilis as well as in some other infectious diseases, not infrequently increased in the blood.

AUSTRIA.

Vienna, March 22nd, 1908.

Epidermolysis Bullosa Hereditaria.

At the "Gesellschaft für Innere Medizin," Leiner exhibited a boy, æt. 10, with a peculiar dermatose condition which appeared to be hereditary from the family history. Any pressure on the skin produced large vesicles, no matter whether applied to the palms of the hands, the soles of the feet, or any other part of the body. According to the mother's report, these bullæ were observed the first week after birth on the hands and feet. Since that time the child has suffered more or less from the same eruption on different parts of the body. The nails are abnormally bent and frequently changed, particularly the second and third fingers of the left hand, which are very friable and greatly twisted. Therapeutics were of little use in such cases.

Diphtheritic Liver and Spleen.

Popper showed preparations of liver and spleen taken from a boy, æt. 11. Both of these organs were greatly atrophied and hardened. The cirrhosis was not due to either alcohol or syphilis, but presumably due to diphtheria, which the boy had two years ago. During the last year he vomited blood frequently, as well as passing it by the rectum. There was throughout icterus and oppressive anæmia, the red blood corpuscles not rising above 2,000,000. The thoracic organs were normal, but the abdomen contained fluid and was not tender on pressure. The hepatic dulness lay between the fourth and seventh ribs, which indicated atrophy. The lower extremities were greatly swollen. The diagnosis excluded both tuberculosis and syphilis, but could not deny hepatic cirrhosis with atrophy and extreme anæmia.

As the atrophy must be due to cirrhosis, Talma's operation was decided upon, without any relief. This operation was to relieve all cirrhotic troubles, as Talma's theory was that the liver cells are destroyed by the interstitial fibrous tissue cutting off the blood supply. He believed a co-lateral circulation would restore this morbid defect by connecting the circulation with the stomach, or, better, by entangling the peritoneum in a wound of the abdomen along with a section of the liver, with the hope of establishing a co-lateral circulation through the peritoneum. The boy only survived 4½ months after this operation.

The post-mortem revealed a liver 480 grammes in weight, or 17 oz., just about half the weight it should be at this age. The section showed the typical granular interstitial diffuse hepatitis, confirmed by the microscopic examination, and in the spleen a large infarct was present. As stated above, alcohol, syphilis and tubercle were carefully eliminated, which left nothing to rest on but the effect of the severe attack of diphtheria two years previously.

Sterilisers.

These apparatus are now legion, but Weiss is anxious to add another to the number. His has a funnel-shaped neck, into which a fitting of gauze and cotton is placed, which removes all gross material from the milk. The metal bottle holds a litre, and is covered with a kind of hard cork. For cooling it is placed in a mixture of 1 kilo. of ice, 100 grammes of salt and sal ammoniac. This will cool the milk from 7° to zero C. in 40 minutes, where it may remain nine hours without developing a single germ or producing any decomposition.

Neurath asked how we were to know when the vessel was nearly full? Genser wanted to know if the milk would not be frozen when wanted?

Weiss thought the person who bought the milk would know; and, for the freezing, it did no harm to the milk.

Cane Sugar in Urine.

Reuss reported the case of an infant with cane sugar in the urine, which, he said, was an uncommon circumstance, and did not appear in the literature of the subject. The lactose seems to be fermented or absorbed in a split or complete form. The split or decomposed form goes to make grape sugar and galactose in the organism, while the unsplit or complete lactose cannot be digested. The grape sugar may either be oxydised directly or polymerised into glycogen; but the pancreas plays a part in the digestion and assimilation of grape sugar which cannot, with any degree of accuracy, describe what gives rise to his hypothesis on the subject. Be this as it may, galactose and levulose or cane sugar are usually admitted to be turned into glycogen. This molecular transition is usually demonstrated by the glycogen found in the liver, which passes hence by the urinary tract.

Hitherto, lactosuria was not unknown, although undescribed by clinicians in pediatrics, but is usually found in combination with galactosuria, probably caused by gastric disturbance, without any morbid intermediary being present. It seems the milk sugar escapes the splitting process in the bowel probably for want of a ferment, though no proof is forthcoming, or the wall of the intestine may become so injured or changed as to allow the lactose to pass on unchanged. Galactosuria in severe cases will produce intoxication from an alimentary source alone, but the presumption is that there is a degenerative process going on in the liver, when the levulose may be found present also.

Chlorate of Potassium Poisoning.

Weichselbaum showed two preparations from this form of poisoning. One had taken 100 grammes, and died within 36 hours; the other 30 grammes, and died in 10 hours. Though the stomach had been washed out in both cases, a large quantity of the salt was found in the organ after death. The principal changes observed were a large quantity of methæmoglobin in the blood, found in the spleen, liver, kidneys, and marrow of bones. There were also thrombic masses of methæmoglobin found in the aorta, veins and capillaries. The spleen had a rupture in its capsule, the stomach hæmorrhagic infiltration at the pylorus, while ulcers and erosions were strewn over the mucous membrane of the organ.

Schrötter thought the intoxication was due to the anuria produced by the potassium chlorate, which should be carefully used on this account.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE MEDICAL EDUCATION OF WOMEN IN EDINBURGH.—For some years past a movement has been on foot among those who interest themselves in the Edinburgh School of Medicine for Women to obtain for the students further privileges from the University. At present the women are admitted to graduation, but their teaching is almost entirely in the hands of special extra-mural lecturers, and what many desire is to see the University thrown entirely open to women on the same footing as to men. The premises which the Women's Medical School at present occupy have recently been sold, and will soon cease to be available, so that the authorities have to face the rather difficult question of housing their students, and have thereby been provided with an appropriate opportunity of raising the whole question of the relation of women to the University teaching. The Court of the Association for the Medical Education of Women has been in communication with the Carnegie Trustees and with the University Court. The Trustees, it is understood, indicated their willingness to give asisstance, but the cost of providing for separate classes would be greater than the number of students justifies, so that, practically, the question resolves itself into whether or not the University will sanction mixed classes. The University Court declined to meet the Court of the Association and the Carnegie Trustees, on the ground that it was not impossible to continue the work of the School on the present lines. The annual meeting of the Association for the Medical Education of Women, which took place on Friday last, was largely attended, and much interest was taken in the proceedings. Sir Alexander Christison stated that what they now proposed to the University was to make arrangements for (1) the teaching of anatomy to women; (2) the admission of women to the classes for the preliminary scientific subjects; (3) the teaching of physiology; (4) as regards the remaining classes, that the University should admit women where the Professors are appointed under the new ordinances, and where the Professors are unwilling to teach mixed classes, should appoint special lecturers; or (5) while the University admit women to the science classes with anatomy and physiology, the remaining classes should, as in the past, be empowered to arrange with extra-mural lecturers for the teaching of the other professional subjects. It was also stated at the meeting that the Association had proposed an eligible site for the anatomical department to the University, and that Prof. Cunningham had undertaken, if that site were selected, to organise and supervise the teaching of women. At present the women students are allowed the use of the physiological laboratory for certain stated periods before each examination, and it is suggested that a further extension of this system might be tried. The numbers of women who qualify in medicine here are not very great. The following are some of the recent figures:—1900, 23; 1901, 10; 1902, 18; 1903, 18; 1904, 17; 1905, 11; 1906, 26; 1907, 20. The difficulties which the students feel most are, undoubtedly, in connection with the scientific and earlier classes. The disadvantages of a private school in comparison with the University are most keenly felt in the teaching of subjects such as chemistry, anatomy, and physiology, which depends so largely on expensive apparatus and material, and involves large outlay. On the other hand, so far as the final subjects are concerned, and especially as regards clinical teaching, the students have little to complain of. They have exactly the same facilities as the men, though, naturally, their choice of teachers is limited, so that as regards the final year it is doubtful whether they would be as much better off as they imagine, if they were admitted to the "hallowed portals" of the University.

LORD RECTORSHIP OF EDINBURGH UNIVERSITY.—The Right Hon. George Wyndham, P.C., has consented to stand as Unionist candidate, and the Right Hon. Winston Churchill, M.P., as Liberal candidate for the Lord Rectorship.

SIR HENRY LITTLEJOHN'S RESIGNATION.—Sir Henry Littlejohn's resignation has been formally tendered to the City of Edinburgh. Since 1854 he has been Surgeon to the Police, and since 1862 Medical Officer of Health; to few of her citizens, whether officials or private individuals, does Edinburgh owe more than to Sir Henry Littlejohn. Although he is now approaching his 84th birthday, few would imagine, looking to his alertship and bearng, that he was within 20 years of that age. He took his degree of M.D. in 1847, and in 1855 became a lecturer on medical jurisprudence in the Royal College of Surgeons. He continued lecturing to crowded class-rooms there until 1896, when he was elected successor to Sir Douglas Maclagan. This post he resigned in 1906, and was followed by his son, the present Professor—an appointment which was hailed with unanimous approval as the best choice possible. Sir Henry Littlejohn's work in the city has throughout all his term of office been of the greatest value. He was the guiding spirit in pulling down slums and driving open thoroughfares through them, which about the Sixties led to the practical abolition of typhus fever, which had previously been endemic. He introduced the Infectious Diseases Notification Act, and applied it to Edinburgh. The death-rate of the city has fallen from 26 per 1,000 to 14 per 1,000 during his term of office. Sir Henry Littlejohn has enjoyed a great reputation in medico-legal matters, and has figured as a witness in almost every important criminal trial of late years. About a year ago he was presented by his friends in legal and medcal circles with his portrait from the easel of Sir George Reid. It is difficult to think of Sir Henry Littlejohn as ceasing to play a part in the administration of sanitary affairs of Edinburgh, but that he has more than earned the right to rest now none who are acquainted with his strenuous activities will deny. His wide circle of friends unite in wishing him well on the occasion of his withdrawal from work, and very cordially hope that he may long enjoy a well-merited leisure in his retirement.

BELFAST.

HOSPITAL ABUSE.—A conjoint meeting of the Ulster Medical Society and the Ulster Branch of the British Medical Association was held in the Medical Institute, Belfast, on Thursday evening, February 20th, to which all medical practitioners in the district were invited by special circular to consider the question of hospital abuse. On the motion of Dr O'Neill, seconded by Dr. Darling (Lurgan), the chair was taken by Dr. John McCaw, President of the Ulster Medical Society. The discussion was opened by Dr. John Campbell, who dealt first with the causes, and secondly with the remedies, as he believed. The persons mainly responsible he considered to be the Governors of charitable institutions and the working classes who attended them. Three remedies had been suggested and tried:—(1) The patients might be questioned by the medical man who saw them at hospital: this he considered *infra dig.* and objectionable. (2) There might be a special inquiry officer attached to the institution. (3) Patients might be referred back to their own medical man for information. This last he believed to be the best plan of the three, but it necessitated the help of the general practitioner, and without his support it would not work. Mr. Andrew Fullerton, who was the original promoter of the meeting, divided those attending hospitals into four classes as he saw them:—(1) The necessitous poor; (2) the "border-lander"; (3) the unprincipled sponger; (4) the penny-a-week subscriber, who comes as a matter of right. The discussion was continued till a late hour, the following taking part:—Drs. O'Neill, Kevin, A. McConnell, Darling (Lurgan), St. George (Lisburn), Robert Campbell, A. B. Mitchell, Trimble, Killen, Burns, McKisack, Kirkhope, P. O'Connell, Fraser, Walton Browne, J. Simpson, Morrow, R. J. Johnstone, T. Davidson, Gaussen, and the President. Mr. Fullerton replied, and proposed two resolutions, which were passed:—(1) That a circular should be sent to all practitioners in Ulster, asking them to second the efforts of the medical staffs of the hospitals to prevent hospital abuse. (2) That a committee of general practitioners should be appointed to carry this out, to consist of the President, Drs. Elizabeth Bell, Burns, T. Davidson, Fraser, Kevin, Watson and Trimble, the last to act as convener.

BELFAST MATERNITY HOSPITAL.—The 114th annual meeting of this institution was held last week. The report showed that 378 cases had been admitted last year, and 306 children were born. Five deaths occurred among the intern cases, but all five were hopeless when admitted. The extern cases numbered 283, and there were no deaths. Sir Charles Brett, in seconding the adoption of the report, vigorously defended the newly-formed Women's Health Association from a very uncalled-for and injudicious attack made upon it a few days before by the City Coroner, Dr. Graham. The latter, at an inquest on a child, went out of his way to refer to the Association, which has just been founded, under the auspices of H.E. Lady Aberdeen and the Dowager Marchioness of Dufferin and Ava, with a lady doctor and the wife of a leading physician as honorary secretaries. He gave it as his opinion that it was pure hypocrisy for these ladies to try to teach poor mothers to bring up their children, as most knew well enough how to do it, and practical help was what was wanted. Medical men generally will agree with Sir Charles Brett that there is ample room for the Ladies' Health Association to work in Belfast, and that the ladies can be relied on to see that, where practical help is needed, the aid of one of the numerous societies giving such help will be called into the case.

ST. PATRICK'S DAY DINNER.—The annual dinner of past and present Queensmen was held in Queen's College on St. Patrick's Day, the chair being occupied by Professor Letts. Among other speakers, President Hamilton, Professor Symington, and Dr. A. B. Mitchell referred at some length to the University question. As the time of publication of Mr. Birrell's Bill approaches, the interest in it grows greater, and the belief gains ground that there is at least a better chance than on any previous occasion of a settlement being reached. Dissatisfaction with the Royal University is very general, and the number of Ulster men who wander off to Glasgow and Edinburgh in consequence of the unsettled state of Irish University affairs shows no signs of growing less. There is also a strong feeling among those more closely associated with the College that the Belfast school should be free to develop on its own lines, and not be tied to other schools whose environment is different and whose students are of a different character.

LETTERS TO THE EDITOR.

BRITISH MEDICAL ASSOCIATION—THE REFERENDUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The welfare of the whole profession, if not closely bound up with, is at least very closely connected with, the welfare of the British Medical Association. The Association numbers over 20,000 members; it is the sole organised representative body through which the profession has the power to make its voice heard, its influence felt; it might be made a tremendous force in promotion of progress in every direction. By the behaviour of the members in the matter of the Referendum—the result of which is published to-day—it is, however, made quite evident that the vast majority care literally nothing at all for these objects, and are absolutely indifferent with regard to the constitution and government of the great Association to which they belong. The questions which the Referendum was to decide were vital; they were brought forward with the utmost energy; they were discussed in endless articles and in a voluminous correspondence in the *Journal;* they were forcibly presented before the notice of branches, divisions, and individual members, so that no one could be ignorant of the magnitude of the issues involved; and yet, when the 159 divisions within and without the United Kingdom are called upon to vote, the aggregate attendance of members at the meetings amounts to 1,978. The most astonishing indifference has been displayed in every direction, and especially in divisions where the keenest interest might have been expected. In Aberdeen, with 153 members, not one came forward to vote. In the Cambridge division, out of 140, only 14 attended; in the Liverpool Central, out of 66, only 9; and in the Manchester Central, out of 75, only 4. In the Metropolitan Marylebone division, with 589 members, only 12 voted; whilst in Birmingham, that centre of light and leading, out of 302 in the Central Division, only 20 took the trouble to vote; and these are fair samples of the whole. It is amazing, it is deplorable; it is to me inexplicable. Some few years ago I ventured to express the opinion in your pages that the Association seemed to be at that time in danger of falling into the position of a mere co-operative society for the publication of a cheap medical newspaper, albeit I pointed out that, whilst the *Journal* was being supplied to the members at a low price, it was being produced at an enormous cost, absorbing, as it did, the greater part of the Association's huge income. The almost complete apathy of the members in this matter of the Referendum goes to show that I was not far out in my estimation of the Association's real position. Until that position be fundamentally altered, and until the Association becomes able unquestionably to speak in the united voice of the great majority of members, the political power of the profession will remain at its present negligible quantity, and neither medical law reform nor any measure for improving the status of the profession, will have the remotest chance of success.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

March 21st, 1908.

HOSPITALS FOR THE LOWER MIDDLE CLASS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A line and a half in your present issue opens a question as to the need for the ventilation of which I have long been convinced. I refer to the entire absence of provision for the class known as the "lower middle" in the matter of hospital accommodation and advantages.

This class, heavily burdened with taxation, and with the necessity of considerable and constant effort to maintain appearances, is, of all, the most heavily handicapped in case of a sudden or prolonged drain upon resources in case of severe or urgent sickness by accident or disease.

The methods of the King's Hospital Fund prevent the admission of this class to general hospitals, or, indeed, to any supported by that Fund to any useful extent, though without the contributions of the same class it would find its income greatly diminished. The best medical and surgical skill, and unrivalled nursing, are at the command of the artisan class, and in chronic cases the parish infirmary falls but little short of the same standard, whilst the struggling schoolmaster or clerk or tradesman is practically debarred from both. Thirty years' experience in practice have proved the truth of the above statements in my own knowledge in scores of cases, and whilst I admit that the matter is not free from difficulty, there seems no real reason why some start should not be made in the direction indicated. Such an institution, once the capital expenditure was covered, might be made largely self-supporting, and in the face of the abundant eleemosynary provision for the artisan class, the latter would have no valid ground of complaint if a portion of the funds subscribed for its benefit were permitted to return to its source in the manner suggested.

Personally, I should be extremely willing to assist in starting some scheme on the lines indicated.

I am, Sir, yours truly,
March 18th, 1908. EDWD. C. BOUSFIELD.

OBITUARY.

DAVID RAMSAY MILLER, M.B., C.M.GLASG.

WE regret to announce that Dr. D. R. Miller died on March 12th at the early age of 35. Dr. Miller was the only son of Mr. William Miller, of Glasgow. After taking his degree in medicine and surgery at Glasgow University, he made two voyages to Bombay as a ship's surgeon. He then commenced practice at Scunthorpe, in Lincolnshire, where he remained twelve years. A few months ago he went to reside in Chesterfield Road, Sheffield, but unfortunately his health gave way, following an attack of influenza. He leaves a widow, but no children.

SURGEON-MAJOR BREW.

WE regret to record the death of Surgeon-Major Brew, which occurred at Bray, Co. Wicklow, during the past week. Dr. Brew was for many years the Medical Officer of Health for Bray, and Dispensary Medical Officer for a quarter of a century. He was also Medical Officer to the Royal Irish Constabulary in the district. The crowds of poor who attended his funeral bore an eloquent testimony to the regard in which he was held.

DR. F. W. STAUNTON.

THE many friends of Dr. F. W. Staunton, of Waterford, heard with feelings of deep grief the news of the tragedy which deprived him of his life just five weeks after his marriage. Dr. Staunton, who was a keen follower of hounds, received a severe fall whilst riding in the Waterford Hunt Point-to-Point races on March 12th, and dislocated his thigh. He was conveyed to his home and attended by Dr. Morrissey, of Waterford, but the following day his condition became much worse, and he developed symptoms pointing to acute peritonitis. Mr. Heuston, of Dublin, was brought to see him, and decided to operate, but without avail, and Dr. Staunton died on the 18th inst. Whilst Dr. Staunton was still a student, he, on several occasions, was threatened with peritonitis, the presumed result of injuries received whilst playing football, and on one occasion had to be operated upon for what was then termed perityphlitis. Doubtless, his untimely death was due to a lighting up of his former trouble. Shortly after he became qualified, Dr. Staunton was appointed to Portlaw Dispensary District, and this post he held for several years. He then moved to Waterford, where he practised until his death. He held the posts of Surgeon to the Waterford Infirmary and Medical Officer to Waterford Prison. The deepest sympathy has been expressed with his bride in her bereavement.

WILLIAM WOOD, M.R.C.S., L.S.A.

WE regret to announce the death of Dr. William Wood, of Middleton-on-the-Wolds, which took place on March 13th. Dr. Wood was one of the oldest practitioners in the North of England, having been qualified in 1857. He held many local appointments, and was greatly esteemed for his skill and kindness.

A NORTHERN Counties' branch of the Incorporated Institute of Hygiene was inaugurated at Newcastle-on-Tyne on Monday last by Prof. Sims Woodhead, M.D., F.R.C.P., who was supported by Sir Isambard Owen, Prof. Thos. Oliver, Prof. Geo. Murray, Mr. Geo. Lunn, J.P., Mr. Johnstone Wallace, Dr. Thresh (Chairman of the Council), and others. Sir Geo. Hare Philipson, M.A., M.D., D.C.L., LL.D., F.R.C.P., occupied the chair.

REVIEWS OF BOOKS.

INTERNATIONAL CLINICS. (a)

NUMEROUS interesting clinical and scientific papers are included in the present volume of this popular quarterly. Prof. Calmette contributes a short paper on his now celebrated Ophthalmo-reaction. Dr. Henry now writes on Meltzer's treatment of tetanus by intraspinal injections of magnesium sulphate. The value of fresh blood serum in disease is discussed by Weil, and a useful summary of what may be expected from the X-ray treatment of leukæmia is written by Warthin. Mr. Connell's paper on Pseudo-myxoma of the Peritoneum, secondary to cystic disease of the appendix, is useful and suggestive, and Lumoyez's discussion of the use of thiosinamine and its derivative fibrolysin in otosclerosis is of more than special interest, as it gives fresh proof of the value of this drug in causing absorption of connective tissue. Numerous other papers are included, but space forbids us to mention them in name. It is sufficient to state that material of interest to those engaged in every branch of medical work is provided.

BIOGRAPHY OF THOMAS SKINNER. (b)

THE name of Thomas Skinner is, we have no doubt, familiar to many medical men who have no knowledge of the man further than that he has given his name to an apparatus for the administration of chloroform. This ignorance is no doubt due to the fact that during the last thirty years of his life Skinner deserted the practice of legitimate medicine for what most of us believe to be the errors of homœopathy. Born in 1825 of Scotch parents, Skinner was educated in Edinburgh, and started work in a business house in that city. At twenty-four years of age he deserted the office stool for the study of medicine in the University of Edinburgh and the School of the Royal College of Surgeons of that city. He obtained the Licentiateship of the latter corporation in the year 1853, having obtained the gold medal in Sir James Simpson's class of obstetrics in the University. Skinner then became private assistant to Sir James Simpson, in which position he continued for two years. It was while working at this time in association with Simpson that Skinner described the chloroform mask and drop bottle to which his name has been ever since attached. Leaving Edinburgh in 1859, Skinner started practice in Liverpool, and was appointed Obstetric Physician to the Liverpool Lying-in Hospital. His knowledge and skill as an obstetrician soon gained for him a large practice, but his health broke down under the strain, and he was obliged for some years to travel in search of health. He is stated to have suffered from acid dyspepsia, constipation and sleeplessness. For these symptoms he was treated by a variety of drugs without any benefit, and eventually, in 1873, put himself under the care of Dr. Berridge, a homœopathic practitioner. According to his own statement, he appears to have been cured of all his troubles by a single dose of sulphur prescribed in "the mm potency." As a result of this success, Skinner devoted himself to the study of the works of Hahnemann, and two years later he resigned his medical appointments and started practice afresh as a homœopath. In this practice he attained considerable eminence both in Liverpool and London, to which city he moved in the year 1881.

This much we gather from the biographical sketch before us, and we could wish that our author had devoted more space to the description of Skinner as a man, and less to the explanation of the principles which he adopted in his later life. The work, however, appears to be written for homœopaths, and to them, no doubt, the various opinions which Skinner adopted and combated will be interesting, for he was a leader in their ranks. To us who differ from his views these disputes have little interest, but we cannot withhold our admiration for his honesty and for the ability with which he supported his mistaken views.

(a) "International Clinics." Vol. iv. Seventeenth Series. Philadelphia and London: J. B. Lippincott and Co. 1907.

(b) "Biography of Thomas Skinner, M.D. A Biographical Sketch." By John H. Clarke. 8vo. Pp. xiv. and 93. London: Homœopathic Publishing Co. 1907.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Treatment of Tetanus by Intraspinal Injections of Magnesium Sulphate.—This treatment was first suggested by Meltzer, but has hitherto been used in too few cases to allow any conclusions regarding its value to be formed. From the symptomatic point of view, it is undoubtedly satisfactory, relieving the patient from tonic and clonic spasm, and permitting prolonged sleep. When employed on monkeys inoculated with tetanus, it seemed to be of great value, but too large doses caused sensory and motor paralysis, followed by death from general respiratory failure. Henry now reports four clinical cases treated by the method (*International Clinics*, Vol. IV., 17th Series, page 1). In the first case 9 c.c. in all of a 25 per cent. magnesium sulphate solution were injected by lumbar puncture. On the first injection of 3 c.c., relaxation occurred after 15 minutes, and the two subsequent injections were followed by even more rapid relaxation lasting for several hours. This case recovered, but the other three cases proved fatal. Cases II. and III. were samples of hyper-acute tetanus, but Case IV. was mild, and the writer fears that the treatment may have been in part the cause of the fatal result. In this case there was very severe bronchorrhœa following the injections, and after the second and last the patient remained relaxed, dull and stupid, and finally died in coma. M.

Cholecystitis in Typhoid Carriers.—Simon (*Klin. Jahrbuch.*, Bd. XVII., p. 363) describes a case of chronic cholecystitis with pus in the distended gall-bladder, from which there resulted a chronic infection of the intestines with typhoid bacilli. Surgical cure followed an operation, but not a bacteriological cure, and the patient has continued to be a chronic typhoid carrier. Apparently she has been the cause of transmitting the disease to at least two other individuals. M.

The Ophthalmo-Reaction for Typhoid Fever.—Kraus and others have attempted to determine the value of Chantemesse's ophthalmo-reaction for typhoid fever (*Wiener. Klin. Woch.*, 1907, No. 43). Extracts from toxic typhoid cultures, from cultures of the colon bacillus, and from cultures of the paratyphoid bacillus B., produce no reaction, or at most the slightest redness, when introduced into the conjunctivæ of healthy persons. The same extracts cause an inflammatory reaction, for the most part limited to the conjunctiva of the lower eyelid, when introduced into the conjunctival sac of typhoid patients, but also unfortunately react on patients ill from other diseases. The writers conclude that the agglutination test is still the only exact and reliable method for the diagnosis of typhoid fever. M.

Sudden Death in Pleural Effusion due to Change of Position.—Dr. Calvert discusses the mechanical cause of sudden death in cases of pleural effusion from change of position (*Johns Hopkins Hosp. Bulletin*, February, 1908). He points out that the pressure exerted by an effusion upon the veins and the heart is a compound of two factors. The first of these may be called the constant pleural hydrostatic factor, and is the pressure with which fluid has been forced into the pleural cavity. The second is the variable factor, and is the hydrostatic pressure caused by gravity. This factor varies with the height of the column of fluid, and will therefore obviously vary with change of position. When the sum of the two factors is greater than the venous pressure, the veins must collapse, giving rise clinically to dyspnœa and irregular pulse, followed almost immediately by fatal syncope. Even though the syncope causes the resumption of the horizontal position, and consequently a fall in the total pleural pressure, it is seldom that the heart is capable of again beating under the renewed stimulus caused by the inflow of blood. Clinicians should, however, under these circumstances employ prolonged stimulation of the heart, and should turn the patient on the affected side, as experiments on animals have shown that good results may follow such measures. M.

The Persistence of Widal's Reaction after Typhoid Fever.—Louisson and French have investigated the above indicated subject in 135 cases, and have arrived at some valuable conclusions (*Guy's Hosp. Reports*, Vol. LXI., p. 235). They summarise these as follows: (1) In most cases the Widal reaction disappears rapidly after the typhoid fever. (2) In 7.5 per cent. of their cases the test remained positive for varying periods up to eight years. (3) The age of the patient at the time of the typhoid fever does not seem to influence the persistence or otherwise of the reaction. (4) The reaction is apparently more liable to persist in males than in females. (5) The presence of post-typhoidal suppuration increases the likelihood of this persistence. (6) The cause of persistence is not known in most cases, and it is only possible to determine by trial what patients will and what will not give a positive test. M.

Graves' Disease and Its Treatment.—Thomson (*Amer. Journ. of the Med. Sciences*, March, 1908) enters a plea for the non-operative treatment of this disease. He bases his views on the pathology and therapeutics of the disease, on clinical observation rather than on laboratory experiment, and justifies his treatment, and incidentally his pathology, by the results he has obtained in practice. He is satisfied that all the symptoms of the disease are due to a universally acting poison or toxæmia, that the disease is one that cannot be confounded with anything else, even though such characteristic symptoms as the exophthalmos and the goitre are absent, and, further, that this poison "causes no more tissue changes, except, indirectly, on nutrition, than does opium or aconite." Thomson believes that this poison is generated in the alimentary canal, and normally is neutralised in the thyroid gland, and excessive amounts of this poison excite the thyroid to over-action, and "thus often, but not always, lead to its hypertrophy." He explains the fact that the disease has been cured by partial removal of the thyroid by assuming that "due to a physiological affinity the thyroid may accumulate a store of enzime-like toxin brought to it by the circulation which may then act as a nidus for discharging the agent from time to time when the gland is stimulated by fresh supplies of the toxin derived from improper diet." The formation of this toxin in the intestine is associated with, or due to an inability of the organism to assimilate properly proteids, much as diabetes is associated with or due to an inability to assimilate the carbohydrate elements of diet. The treatment based on these views is partly dietetic and partly medicinal. The standard article of diet is milk which has been fermented or peptonised, and butchers' meat is never to be allowed. The patient may also use vegetables, most cereals, and some fruit; strawberries and uncooked apples are forbidden. As regards medicine, 30 grains of phosphate of sodium are to be taken at the beginning of each meal, and a blue pill or other mercurial laxative as a routine twice a week. At bedtime the patient is to take some intestinal antiseptic, such as naphthalene and sodium benzoate, or phenol bismuth and ammonium benzoate. The treatment must be extended over a long period, and Thomson states that if it is continued, good results will be obtained; but too early a return to a meat diet is always attended with a recurrence of the symptoms, often in an increased severity. K.

Specific Immunity and X-Ray Therapeutics.—Chane (*Amer. Journ. of the Med. Sciences*, March, 1908) has investigated the results of X-ray therapeutics in bacterial diseases by the estimation of the opsonic index for the specific bacterium involved. He finds that the opsonic index after X-ray treatment behaves in a manner quite similar to what it does during the treatment by bacterial vaccines. The correctness of these views he has demonstrated in a case of lupus, where the tuberculo-opsonic index was raised by X-ray treatment, and remained high till the patches of lupus had completely healed, after which time it gradually fell, in spite of the continued application of the rays. Chane concludes that X-ray treatment should be of sufficient intensity to set free in the tissues what is an equivalent to an autogenous vaccination, and that the duration of the exposure and the extent of the diseased tissue exposed should be so regulated as to induce either a small negative phase or none at all. The repetition of the exposures should also be regulated by the length of the negative phase. If the bacterium causing the disease is not known, then the treatment is still applicable, but must be regulated by analogy with those cases in which opsonic estimations can be made. K.

Pneumothorax in a Boy Two Years Old.—Huber (*Archives of Pediatrics*, February. 1908) reports the sudden occurrence of this condition in a boy of two years of age. The child, with the exception of an attack of measles and pneumonia during the first year of life, had been perfectly healthy until 14 days prior to his admission to hospital. He was then suddenly attacked with fever and vomiting, but appeared to recover, and was about again for nearly a week. He was then attacked with severe cough, vomiting, some fever, and considerable dyspnœa, but no cyanosis. On admission to hospital the signs of pneumothorax on the left side were quite evident. The child made a very satisfactory recovery without the intervention of any surgical treatment. Repeated examination of the sputum failed to demonstrate any evidence of tubercle bacilli, but the fluid in the thoracic cavity was not bacteriologically examined. K.

Pneumonia.—Thompson (*Amer. Journ. of the Med. Sciences*, January, 1908) relates his experience with an open-air treatment of pneumonia in the Bellevue and Presbyterian Hospitals, New York City. The treatment is carried out by placing the patient on a balcony, or at least at an open window, the air of the ward being more or less excluded by a screen. The balcony floors are of wooden slats, and sometimes it was so cold that the sputum froze in the cups. In alcoholic subjects it was found that much less stimulation was required, and it was often possible to do without it altogether. The open-air treatment is to be regarded as an adjunct to the measures usually employed, and the author concludes:—With this simple but effective armamentarium one may deal satisfactorily with the greatest number of the more serious cases of pneumonia; but it will be found that much of it, simple as it is, may be unnecessary if the patient has continuous access to fresh, free-blowing air. D.

Post-Delirious Alcoholic Stupor.—Stillman (*New York Med. Journ.*, January 25th, 1908) describes the peculiar stupor that sometimes follows alcoholic delirium. Pathologically, œdema of the meninges occurs with surprising regularity in these cases. However, inasmuch as considerable degrees of serous effusion of the meninges are found post-mortem in cases that during life have given no special symptoms, the writer believes that the causation of the œdema had probably better be looked for among the general conditions underlying the stupor. He reports a series of 98 cases, or about 1 per cent. of the total number of cases admitted to the alcoholic wards of the Bellevue Hospital. Approximately 80 per cent. died. Exhaustion was the cause of death in many cases. The constant features, in addition to the stupor, are muscular rigidity, stiff neck and hyperæsthesia. The temperature is very slightly elevated. There may be considerable difficulty in the differential diagnosis from tuberculous meningitis. Treatment consists of forced feeding combined with stimulation. Citrate of caffeine in 5 gr. doses is spoken of highly. D.

The Fibrolysin Treatment of Perigastric Adhesions.—Michael (*Berlin. Klin. Woch.*, December, 1907) reports two cases of severe perigastric adhesions which were much benefited by injections of fibrolysin. The first was a man, æt. 32, in whom severe gastric symptoms developed, due to adhesions about the stomach following a gastric ulcer. He was treated three distinct times for gastric ulcer, and operated on once without relief of symptoms. Great relief resulted from a course of fibrolysin injections, after which the patient was well enough to resume work. The second was a seamstress, æt. 26, who had been through several gastric ulcer "cures" without relief of distressing pain in the region of the stomach after eating. On entrance to hospital, a tumour near the pylorus was palpable. After 18 injections of fibrolysin, this tumour had disappeared, the symptoms were much improved, and the patient was able to resume work. The author used Merck's fibrolysin (thiosinamin sodium salicylate) in doses of 1.15 c.cm., injected into the abdominal wall in the region of the stomach. No untoward symptoms were noted. The article ends with a review of the few reported cases of adhesions in the gastro-intestinal tract treated by fibrolysin. D.

Amyl Nitrite in Tuberculous Hæmoptysis.—Braga (*Gazz. deg. Ospedali, Milan*, December, 1908) has used amyl nitrite 15 times in severe cases of hæmorrhage from tuberculous lungs, and each time has been impressed with the prompt action of the drug and its efficiency in these conditions. The hæmorrhage was arrested as if by magic, blood ceased to accumulate in the bronchial passages, and thus the evil effects of its decomposition were avoided. Five or six drops of amyl nitrite on a wad of cotton were inhaled, and the hæmorrhage ceased at once, and did not recur in the majority. The inhalations were repeated several times afterwards during the day. It proved effectual, even in cases in which no other measure had given relief. He supplemented the nitrite by the slower acting action of an enema of gelatin, to which calcium chloride had been added, with fluid extract of hydrastis internally. Since this technique has been adopted, no patient has succumbed to hæmoptysis, and whenever it appears it is speedily controlled. D.

MEDICAL NEWS IN BRIEF

International Medical Congress—Prize for Ophthalmology.

Prof. Emile Grosz, the Secretary-General, gives notice that the sixteenth International Medical Congress will be held at Buda-Pest from August 29th to September 4th, 1909, under the patronage of His Imperial and Royal Majesty Francis Joseph I. The work of the Congress is divided into 22 divisions, with a special sub-section of orthopædics attached to the section of surgery. The Royal Hungarian Minister of the Interior offers a prize of 1,000 crowns for the best essay on the Ætiology of Trachoma. All works, whether in manuscript or published for the first time in 1907 or 1908, will be eligible for competition provided they are in English, Hungarian, French or German. Essays are to be sent to the Minister of the Interior (Belügyministerium, Buda-Pest, Hungary) before December 31st, 1908. The jury will be appointed by the Minister of the Interior, and the verdict will be announced at the inaugural meeting of the Congress. The subscription to the Congress is 25 crowns (about £1 sterling), the wives and daughters of members paying 12½ crowns. The officials of the English National Committee are a President, Dr. F. W. Pavy, F.R.S., and two Honorary Secretaries, Dr. Clive Rivière and Mr. D'Arcy Power. The address of the Hon. Secretaries is 10A, Chandos Street, Cavendish Square, W.

West London Hospital Conversazione.

THE Duke of Abercorn held a reception at the Post-graduate College, West London Hospital, Hammersmith-road, last Thursday, on the occasion of the annual *conversazione* of the staff. The guests numbered over 200, and included Sir Havelock Charles, Sir Joseph Fayrer, Surgeon-General Charlton, many members of the medical services, and medical practitioners from al parts of the country. Mr. L. A. Bidwell, the Dean of the College, Dr. D. W. C. Hood, C.V.O., physician, Mr. C. B. Keetley, the senior surgeon, Mr. Percy Dunn, and Dr. J. Barry Ball were also present. During the evening the guests were afforded the opportunity of inspecting some valuable and interesting exhibits representing the latest medical and surgical appliances. Dr. G. C. Low exhibited some pathological specimens, microscopic sections, and apparatus from the pathological laboratory, while Dr. David Arthur gave an exhibition of X-rays, high frequency, and ultra-violet light, etc. A musical programme was provided by the London Concert Quartet.

Irish Medical Schools' and Graduates' Association.

ABOUT 200 ladies and gentlemen sat down to the annual festival dinner of this Association on Tuesday, March 17th, under the Presidency of Sir Charles MacDonagh Cuffe, K.C.B., at the Wharncliffe Rooms, Hotel Great Central. Amongst those present were the Right Hon. Sir Edward Carson, K.C., M.P., and Lady Carson, Dr. Windle, F.R.S., Insp.-Gen. W. H. Lloyd, Mr. and Mrs. Watson Cheyne, Messrs. Charles and Canny Ryall, Dr. J. T. Mason (Chairman of Council), Dr. Kenneth Fraser (Vice-Chairman of the Council), Dr. Michael Bulger (Hon. Treasurer), and the Hon. Secretaries (Dr. Wm. Douglas and Mr. G. W. Dawson). After the usual loyal toasts, Dr. Leonard Strong McManus proposed "Our Defenders" in a humorous though slightly pessimistic speech, the response being divided between Inspector-Gen. Lloyd, Col. Moorhead and Major Moyle O'Connor. Dr. H. MacNaughton-Jones next gave "Our Guests" in a patriotic and friendly discourse, in response to which came the speech of the evening from Sir Edward Carson, who so thoroughly held his audience that when he drew near to the end of his remarks and said he had spoken long enough, he was greeted by "No—go on," a very rare episode in after-dinner oratory. In answer to the same toast, Dr. Windle worthily kept up the reputation of the medical profession, not to be left far behind in oratory even by the law. "Ourselves" was proposed by Mr. R. G. Webster, and responded to by the President, who also had to respond to the toast of his own health, proposed by Dr. F. Mouillot. A very enjoyable, breezy evening, although the music, with the exception of Miss Muriel Warwood's violin solos, was hardly up to the mark.

Causes of Sleeping Sickness.

A MEETING of the African Society was held at the Royal United Service Institution last week, when Colonel David Bruce read a paper on "Sleeping Sickness." The chair was taken by Sir West Ridgeway, who recalled to the audience the fact that Colonel Bruce's achievement was the discovery of the germ of Malta fever. His great researches into the tsetse-fly disease were well known, especially in regard to sleeping sickness. Colonel Bruce said that sleeping sickness had been known on the West Coast of Africa ever since those parts were known, but it was looked upon more as a pathological curiosity than as a disease with a great power for evil. It was first discovered in Uganda in 1901, and the most common theory was that it was brought there by Emin Pasha's Soudanese soldiers. The proven facts were that sleeping sickness was caused by a small blood parasite, a trypanosome, something like that which was carried from animal to animal by the tsetse fly, that this fly took the trypanosome from the blood of wild animals and passed it on to horses, and that if trypanosomes were injected into the blood of a monkey it suffered from sleeping sickness. It was shown that in Uganda the distribution of sleeping sickness and the distribution of a particular kind of the tsetse fly were the same, and that the tsetse fly only flourished on that part of the lake shore where forests and deep jungle growths came near. The fly required clear water and forest. It was on the edge of the lake that the natives held their markets with the islanders, and were bitten by the tsetse fly as they lay on the shores. As to preventive measures, Prof. Koch had recently brought forward the theory that the chief food supply of *Glossina Palpolis* was crocodiles' blood. That theory required proof. *Glossina Palpolis* existed in places where crocodiles did not exist, and in the laboratory it fed on any animal food offered. As to cures, there was no single well-authenticated case of cure of the disease in man, and all attempts to render him immune by an anti-toxic serum had failed.

Medical Man sued for Motor Car Collision.

ON March 16th, at the Manchester County Court, a collision between two motor-cars in Stockport Road, Ardwick, on the 25th of October last year, was the cause of a claim of £22 18s. 6d. damages. The plaintiff was Mr. William Myerscough, pork butcher, and the defendant was Dr. Dyas.

The case for the plaintiff was that Mr. Myerscough, driving a small car was passing a horse and lorry, when a large car came at a rapid pace without having given warning. The big car swerved to the left to avoid the horse and lorry, and, seeing that an accident could not be averted, plaintiff swerved to the right. The front wheel on the right hand side of the big car struck the near back wheel of Mr. Myerscough's car, smashed it to pieces, and threw out three of the four occupants, with the result that one of them had not yet recovered from her injuries.

In answer to Mr. Pearson, who represented the defendant, Dr. Dyas described the plaintiff's speed as "terrific," and alleged that his own was only about five miles an hour.

The defendant's chauffeur said his own pace was about five miles an hour, while that of plaintiff was thirty or thirty-five. Other witnesses described plaintiff's speed as about thirty miles.

In giving judgment His Honour said the accident seemed to be one in which certain blame attached to each party, and the verdict would be for defendant without costs.

Phthisis made Notifiable.

AT a meeting of the Lanchester Joint Hospital Board, on March 12th, a letter was read from the Lanchester Guardians, intimating that in future phthisis must be regarded as a notifiable disease, and all patients sent to the Maiden Law Sanatorium must have the cost of their care and maintenance borne by the constituent authorities, in the same way as any other infectious disease. It was decided to forward copies of the letter to the various District Councils in the Union, asking for their opinion on the subject.

Pontypridd Medical Appointment.

PONTYPRIDD Education Committee on Wednesday night selected the following candidates as a short list for the appointment of a medical inspector of school children:—Dr. E. F. Thomas (Cardiff), Dr. L. W. Pole (Edinburgh), and Dr. E. J. Griffiths (Swansea). The position is worth £200 a year, rising to a maximum of £250.

Cardiff Medical Staff.

DR. HARVEY BAIRD, third assistant medical officer at Colney Hatch Asylum, London, was on Monday week appointed senior assistant medical officer of the Cardiff Mental Hospital at a salary of £200 a year, rising to £250. Dr. M. F. Caldwell, Belfast, was appointed junior assistant medical officer at the Cardiff Mental Hospital at a salary of £150, rising to £180.

Society of Apothecaries of London.

THE following candidate, having passed the necessary examinations, has been granted the L.S.A. Diploma of the Society, entitling him to practise Medicine, Surgery, and Midwifery:—A. H. Turner.

WE regret to learn that Mr. Sidney Appleton, senior member of the firm of that name of medical publishers, of Bedford Street, London, died suddenly a few days ago. The deceased will be remembered as publisher of such well-known works as "Osler's Medicine," "Holt's Infancy and Childhood," etc.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Locum Tenens.—You will find advertised in our present issue three vacant appointments at the Hospital for Sick Children, Great Ormond Street, probably the largest children's hospital in Europe. There is a small salary, with board and residence, attached to each post, and, if successful in your application, we think you will get just the knowledge and experience here required.

PLEA FOR A SIMPLER LIFE.

How few a simple life will lead,
Just eating what they only need
  And drinking when they're dry;
While many live to gorge and stuff,
And never think they have enough;
  And so, untimely die.

Ah! yes, it is "the pace that kills,"
In spite of homœopathic pills,
  Or Continental cure!
The rush, the hurry, and the race
For money, pleasure, power, or place;
  Better "live slow and sure."

A. D.

Mancastrian.—Beer is certainly not the only offender. Quite recently Dr. Cazeneuve, of the Faculty of Lyons, called attention to the fact that within recent years wine-growers in France have got into the habit of using arseniate of lead as a radical means of destroying insects and mildew on the vines. The arsenic contained in the mixture destroys the insects, but traces of both arsenic and lead are found in the wine derived from such vineyards. The percentage is something like one-thousandth of a milligramme per litre, but this is probably sufficient in the long-run to poison anyone's stomach. Six months of a regime of highly-arsenicated wine is, according to Dr. Cazeneuve, sufficient to tell on the system, and there is danger of wholesale poisoning.

Meetings of the Societies, Lectures, &c.

Wednesday, March 25th.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. R. Johnson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. E. F. Buzzard: Compression Paraplegia.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, March 26th.

Harveian Society of London (Stafford Rooms, Titchborne Street, W.).—Sir Almroth Wright: Some Points in Connection with Therapeutic Immunisation. (Harveian Lecture.)

Royal College of Physicians (Pall Mall East).—5 p.m.: Sir James Sawyer: Points of Practice in Maladies of the Heart.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. H. S. Clogg: Peri-colic Inflammation.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie)). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Lecture-Demonstration:—Mr. A. de Prenderville: Some Recent Advances in Anæsthetic Technique.

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Thursfield: Leukæmia in Children.

Friday, March 27th.

Royal Society of Medicine (Epidemiological Section) (20, Hanover Square, W.).—8 p.m.: Discussion on the Etiology of Typhoid Fever. Papers by Drs. E. C. Seaton, D. S. Davies, I. Walker Hall, Meredith Richards, J. H. Brincker, and Dr. W. H. Hamer: Relation of Bacillus Typhosus to Typhoid Fever.

Royal Society of Medicine (Electro-Therapeutical Section) (20 Hanover Square, W.).—8.30 p.m.: Papers:—Dr. J. Goodwin Tomkinson: Cauterisation as an Adjunct to Radiotherapy. Dr. A. Howard Pirie: On the Value of the Electrolytic Method of Measuring X-Rays.

Medical Graduates' College and Polyclinic (22 Chenies Street, W. C.).—4 p.m.: Mr. H. Tilley: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. M. Leslie).

Appointments.

Dewar, T. F., M.D., C.M.Aberd., Medical Officer of Health to the Fife County Council.

Glegg, R. Ashleigh, M.D., B.S.Edin., Medical Officer of Health and Chief Medical Inspector of School Children for the Parts of Lindsey.

McElligott, M. G., F.R.C.S.Irel., D.P.H., Honorary Surgeon to the Wigan Division of the St. John Ambulance Brigade.

McHattie, Thomas J. T., M.B., Ch.B.Edin., Casualty Officer to the Great Northern Central Hospital, London.

Rentzsch, Sigismond H., L.R.C.P.Lond., M.R.C.S., Clinical Assistant to the Birmingham and Midland Hospital for Skin Diseases.

Rowntree, Cecil, M.B., B.S.Lond., F.R.C.S.Eng., Registrar to the Cancer Wards of the Middlesex Hospital.

Stallard, H., L.R.C.P.Lond., M.R.C.S., Honorary Physician and Referee for Newark to the Royal Midland Counties' Homes for Incurables.

Stevens, Andrew Norris, L.R.C.P.Lond., M.R.C.S., D.P.H. Camb., Assistant Medical Officer of Health of the County Borough of Great Yarmouth.

Vacancies.

Borough of Ipswich.—Assistant Medical Officer of Health. Salary, £150 per annum. Applications to Will. Bantoft, Town Clerk, Town Hall, Ipswich.

Canterbury Borough Asylum, Canterbury.—Assistant Medical Officer. Salary, £140 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Kent County Council.—Medical Officer of Health. Salary, £800 per annum, with travelling expenses. Applications to W. B. Prosser, Clerk of the Kent County Council. Sessions House, Maidstone.

Newcastle-upon-Tyne Dispensary.—Resident Medical Officer. Salary, £250 per annum, with furnished residence. Applications to the Honorary Secretary, Joseph Carr, Bank Chambers, 26 Mosley Street, Newcastle-on-Tyne.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer for eight months Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician for eight months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

Births.

Bennett.—On March 21st, at Hillcrest, Northwood, the wife of Norman G. Bennett, M.A., M.B., B.C., L.D.S., of Brook Street London, W., of a son.

Lee.—On March 19th, the wife of William Edward Lee, M.D., F.R.C.S., of 45 Muswell Rise, N., and 36 Finsbury Pavement, London, E.C., of a son.

Marriages.

Cleverton—Thring.—On Feb. 11th, by special licence, at Singapore Cathedral, Thomas Charles Albert Cleverton, Surgeon, Colonial Service, youngest son of F. W. Cleverton, of Saltash, to Una Aileen Powlett, elder daughter of the late Major W. P. Thring, R.A.

Deaths.

Colvin-Smith.—On March 21st, at 5 Cresswell Gardens, South Kensington, Marian, the beloved wife of Surg.-General Sir C. Colvin-Smith, K.C.B., K.H.S., M.D.Aberd., after pneumonia succeeding a long illness, aged 76.

Stilwell.—On March 21st, at Lynwood, Beckenham, Ann Louisa Stilwell, daughter of the late George Stilwell, M.R.C.S., of Epsom, in her 68th year.

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Paris, 4th February, 1899.

Dr. E. Lancereaux,

Professeur à la Faculté de Médecine, Paris; Médecin honoraire des Hôpitaux;
President de l'Académie de Médecine.

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NOTES AND COMMENTS.

Mr. Bernard Shaw and Anæsthetics.

MR. BERNARD SHAW being now in full practice as a genius, finds it necessary to say something *bizarre* on every subject of passing interest, in order that his dutiful followers may know what line to follow, or, at any rate, to give them a fresh opportunity of applauding the freedom of their master's spirit from the toils of a wearisome conventionality. The Medico-Legal Society have lately had under discussion the question of "The Legal Liability of the Anæsthetist," which we should judge to be a technical matter admirably adapted for decision by gentlemen of medical and legal learning, and quite beyond the prowess of persons acquainted with neither subject. Presumably, however, the opinions of certain outsiders were invited, for a letter was sent by Mr. Bernard Shaw, and duly chronicled by an obsequious Press, to the following effect:—"The intelligent layman is no more interested in anæsthesia than in hanging, because he doesn't intend to get operated upon any more than he intends to be hanged. When he does get operated upon what annoys him is the discovery that the beneficent discovery that is to save him all pain not only makes him so abominably sick that he swears to do without it next time, but also spares him nothing but the actual knifing, leaving the pain of the wounds unalleviated—in short, that it makes things much easier for the surgeon than for him."

Fun v. Folly.

BEING, ourselves, so far removed from the plane on which genius operates as to be able to view its gyrations with an impartial eye, we can candidly express the opinion that we never read such an ineffably silly letter, even in the correspondence columns of "Home" magazines for ladies. That it represents the best effort of the discoverer of the nuciform sac is only credible on the supposition that the master having said all the clever things and all the funny things of which he is capable, is reaching a dotage in which he must make up in venom what he lacks in wit. The effusion leaves the point at issue untouched, and Mr. Shaw had a fine opening for a sally if he had kept to it; but the temptation of having a cheap scoff at one of the greatest boons which modern medicine can provide was too strong for a gentleman who delights to sneer at medical science when he gets a chance. It is true that the intelligent layman does not intend to get operated on if he can help it, but it is equally true that the layman—intelligent, inspired, or merely commonplace—who has not been operated on is becoming something of a rarity, and he who has so far escaped knows that the day may not be far distant when, for the relief of pain, for the avoidance of danger, or for the correction of deformity, he may be glad to undergo the "actual knifing," and then the assuaging influence of a general anæsthetic will be unspeakably grateful. We venture to predict that Mr. Shaw, should his misfortune be such as to require an operation in the future, will forget his bravado and silliness and thankfully accept the blessing of anæsthesia.

Feeding Stuffs.

AT the useful Conference on Infant Mortality which has been sitting at Caxton Hall, an effective paper was read by Dr. Eric Pritchard on the regulation and control of food and drugs for infants. The points he dealt with are subject to more popular misunderstanding than almost any others. Patent foods have a place in the dietaries of invalids and children, but it is a subordinate one, and much of the stuff advertised in the lay papers is trash of a bad type. Of soothing syrups and teething powders medical men know the harmfulness, but among mothers, especially the poorer ones, these poisons are considered indispensable adjuncts of infant life. In condemning these atrocities, Dr. Pritchard made a telling hit by showing that by the Fertilisers and Feeding Stuffs Act the purity and innocuousness of foods for cattle are supervised and guaranteed, yet for the human infant no such measure is thought necessary. A similar argument was used by the next speaker at the same meeting, Bailie Anderson, who mentioned that the Government gave legislative protection to the wild birds of the air, the trout of the streams, the cattle of the fields, and even to the soil of the fields. "Surely," said he, "it is not too much to ask that the human infant should have at least equal protection." It is more than a reproach to the civilisation of the country that the breeding of bullocks and pigs should be considered a praiseworthy and gentlemanly occupation, while the improvement and protection of the human race is held to be a hobby of faddists and busybodies. The reason, alas! is not far to seek. The better rearing of children connotes better living conditions for the parents, and better living conditions connote smaller profits to those who cater for them.

Publicity of Analysis.

AMONG the resolutions adopted by the Congress was one to the effect "that all preparations offered or sold as foods or drugs for infants should be certified by a Government analyst as non-injurious, and that each packet shall bear an analysis of its contents, and that provisions, similar to the Fertilisers and Food Stuffs Act, should be applied to drugs and foods sold, or purporting to be, for the use of infants." This resolution has a special interest for us. In its application to the purposes for which it is designed we cordially endorse it, and as introducing the principles of Government control and the displaying of the contents of would-be secret bottles or packages, we give it even more hearty welcome. These principles, we have long maintained, form the basis on which all quack medicine business should be regulated. In the Colonies, where it is proposed to introduce them, the trade is infuriated, and what is even more important from the point of view of political exigencies, the hireling press which battens on the advertisements of these preparations is vehemently on the side of the trade. Both interests know well that when only the truth can be told about medicines and foods, the demand for them will sensibly diminish and their profits will sink in proportion. Now, it is important to remember that the Congress on Infant Mortality, though attended by certain medical men, was not designed for the medical profession primarily, or, indeed, at all, but for all persons interested in the subject, and therefore was in bulk composed by lay people. The recognition by such a body of the evils of the trade in infant foods and drugs, and the need for control, is the most hopeful sign we have seen for years that the agitation against quacks and quack medicines is having effect, and that there are cultured people who recognise that medical men are opposed to this nefarious trade, not because they are afraid of their own interests, but for the protection of the public.

Homard au Pain.

AN amusing prosecution under the Food and Drugs Act took place at Blackpool last week. A Southport firm were summoned for selling potted lobster not of the quality, nature, and substance required. The Deputy Town Clerk who prosecuted, said that two sample tins of the "lobster" had been taken and sent to the borough analyst, who found that the contents consisted of 50 per cent. of foreign fish, coloured red with a coal-tar dye, 7 per cent. of bread, and 0.2 per cent. of boracic acid, together with 25 per cent. of genuine lobster. The defendant was deeply indignant, it seems, at the accusation, that bread had been found in his tins, and he produced some stuff in an envelope which he said had been mistaken for bread, but was really a preservative. This rare and costly preservative eventually turned out to be ground rice. Happily, in this case, beyond the 0.2 per cent. of boracic acid, there does not seem to have been anything deleterious to health in the savoury mixture, though the foreign fish dyed red makes one feel that even the air of Blackpool could hardly make it palatable. Perhaps it was this factor that induced the magistrates to deal leniently with the defendants, for they were only fined £3 and costs, but it is not easy to conceive a plainer and more wilful and more carefully executed fraud than to mix these substances together and sell them as "lobster." Considering the bread, we might almost have forgiven the vendors if they had called their goods "lobster sandwiches."

Medical Referees.

MR. HENDERSON, the Chairman of the Labour Party, elicited an interesting piece of information in a question he put to the Home Secretary last week. He ascertained that for the first six months after the Workmen's Compensation Act came into force only 117 cases had been submitted to medical referees under the Act. As Mr. Gladstone remarked, it is not fair to judge of the working of the system by the results of the first six months, but we think they do show in a more or less concrete form that the system is not one which has found the favour it deserves with the employers and workmen. We have little doubt that were employers only in question they would readily make far more extended use of referees, but as the consent of the workman is necessary for a reference, other than one from the court itself, the out-and-out malingerer knows he has a better chance of getting round an arbitrator than round an experienced medical man. It is obviously more to a dishonest workman's advantage to go to court and put his employer to all the expense involved, on the chance of a settlement being offered, than to submit to the simple process of going to a referee for a decision as to whether he is fit to work. It is a great pity that the Act does not make the question of fitness to resume work, which is purely a medical one, a matter for the referee and for him alone.

LEADING ARTICLES.

THE LEGAL POSITION OF THE ANÆSTHETIST.

THE adjourned meeting of the Medico-Legal Society on March 24th dealt mainly with the legal aspects of the administration of anæsthetics. Perhaps the most important outcome of the discussion is the unanimity with which most of the speakers advocated a reform of the law so that the administration of general anæsthetics should be confined to duly qualified medical practitioners. Dr. F. W. Hewitt, who moved a resolution to that effect, commented on the fact that everyone, whether qualified or unqualified, whether experienced or inexperienced, reputable or disreputable, may now administer an anæsthetic. That position was clearly stated by Mr. R. H. Wellington, Deputy Coroner for Westminster; all that the Medical Acts now provide is that the public shall have the means of finding out whether any given individual is or is not regarded by the General Medical Council as properly qualified to practice medicine and surgery. Any member of the public, therefore, is at liberty to employ any unqualified person at his own risk. On the other hand, the unqualified person administering an anæsthetic is in the position of any other quack, inasmuch as he cannot be punished unless he assumes a title implying that he is a properly qualified medical practitioner. Mr. Wellington went straight to the root of the matter by suggesting that the Privy Council should make it penal for any unqualified man to administer an anæsthetic, whether local or general, and that the County Councils should appoint a Registrar to abstract and report on the masses of waste material which exist in the depositions taken at inquests. Dr. Hewitt's resolution was carried, and will be duly forwarded to the General Medical Council. Its full text is as follows: "That, as the administration of any drug, or drugs, with the object of producing generalised insensibility to pain, during a surgical operation or during childbirth, cannot be safely undertaken without medical knowledge and skill, your petitioners humbly pray that legislation be granted whereby the administration of any drug, or drugs, with either of the aforesaid objects, by any person other than a duly registered medical practitioner, or someone acting immediately under his supervision, direction, and instruction, be made a penal offence." Speaking generally, and with full approval of the principle of this resolution, it is impossible to avoid the reflection that if the administration of an anæsthetic by an unqualified person is to be made an illegal act, then also the discharge of many other important acts and functions appertaining to a duly qualified medical man should also be rendered penal. Dr. Hewitt's second resolution, providing that special instruction in anæsthetics should form an integral part of professional education, was also carried. There are, of course, various points to be considered in reference to these resolutions. The Scotch members of the Society deprecate the Coroner's system of inquiry in favour of their own plan of private investigation by the Procurator Fiscal. It was asserted in so many words by one speaker that publicity lead to deaths under anæsthesia by scaring the public. In answer to that objection, the writer may be referred to Dr. F. J. Waldo's recent article published in The Medical Press and Circular of Wednesday, 18th March, wherein he plainly shows that no Scottish statistics exist that are worthy of the name. Until we have fully detailed and trustworthy returns of all cases in which general anæsthetics are administered, whether non-fatal or fatal, we can form no scientific conclusion as to the ratio of deaths to administrations, either generally or as regards the use of particular drugs. Under the circumstances, therefore, any gentleman who claims better results for one system of inquiry than another into fatal cases is simply acting on vague beliefs and non-scientific assumptions, incapable either of proof or of disproof. One practical point raised was whether the L.D.S., without a full qualification as physician and surgeon, is qualified to give any anæsthetic at all: whether, for instance, he may give ethyl chloride, nitrous oxide, or any other general anæsthetic. That is a detail, however, capable of ready settlement when principles have been formally adopted. For various reasons the subject of anæsthetics and their administration has been permitted to drift into a position of neglect that is not warranted by the facts of the case. It is to be hoped that the present revival of interest in the matter will not be allowed to drop until some solid progress has been made in our scientific knowledge of the whole matter, both in the interests of the public and in those of the medical profession.

CURRENT TOPICS.

Conjunctivitis Neonatorum.

The question asked in the House of Commons last week by Lord Hugh Cecil regarding "Infantile Ophthalmia" draws attention to the habit medical men have of using a term which should be obsolete. In the hoary days of old, "ophthalmia," no doubt, was a passable word; then it was that nothing was known of the etiology of the condition to which it was applied; then it was that the term implied anything and everything in the form of eye disease which was accompanied by a "discharge." Just so was it in the days of our forefathers,, when they thought that an inflammation could be "sympathetic" in origin, and thus they named diseases of the eye "sympathetic ophthalmia"—in this sense, from their own point of view, using the word "ophthalmia" wrongly. A correspondent in a contemporary urged that the term "ophthalmia" should be retained, inasmuch as it had been "sanctioned" by use. But, as it was very properly pointed out in reply, to "sanction" an error by anything was impossible. The point, of course, is that the medical student of the present day is taught in his bacteriological class that certain micro-organisms cause inflammation of the conjunctiva—that is to say, conjunctivitis. But afterwards he proceeds to the eye wards, and there the ophthalmic surgeons talk volubly of "ophthalmia." On inquiry, he is informed that "ophthalmia" means conjunctivitis, and he naturally cannot understand why a term to him of such meaningless import should be employed for one which expresses a definite morbid entity. Again, the medical student of the day hears still in many eye wards of "sympathetic" inflammation, and the natural question which he feels inclined to ask of his teachers is: "What is the pathology of sympathy?" Neither in his bacteriological nor pathological classes has he heard of such a term. Doubtless, it may be pointed out to him that both "ophthalmia" and "sympathetic inflammation" are clinical expressions, but being a man whose knowledge is being based upon the broad standpoint of science, he fails to comprehend how these clinical terms can be retained and justified when scientifically they are both inaccurate and misleading. Quite possibly the next generation of ophthalmic surgeons, realising fully the teaching of pathology and bacteriology in this regard, will discard these obsolete terms. Meanwhile, for official purposes, reports upon "infantile ophthalmia" should only contain the term *conjunctivitis neonatorum*.

The Position of the Medical School of the R.C.S.I.

There is no doubt that the letter which has been sent by the President, Vice-President, and Secretary of the Royal College of Surgeons in Ireland to the Chief Secretary for Ireland, in which the writers point out the effects on the College Medical School of the establishment of a new and endowed medical school almost at its door, is worthy of, and will receive, with few exceptions, the sympathy of the medical profession. The matter may be put thus in a nutshell. The College School is threatened both by direct competition and by the possible lowering of fees which the endowment of a new school will render possible. The life of the College is intimately bound up with the school, and the failure of the one may bring in its train disastrous consequences to the other. The Royal College of Physicians is, further, closely dependent on the prosperity of the College of Surgeons and its school, because so much of its income is received from the fees of students who present themselves for the conjoint examinations. Therefore, it may not incorrectly be said that on the welfare of the School of the Royal College of Surgeons depends the welfare of both Royal Colleges in Ireland. Mr. Birrell has been accredited from time to time with the desire to upset many existing interests and institutions in Ireland, but we cannot but believe that he will recognise the enormous importance of doing what he can to preserve the Irish Colleges. There are duties, appertaining to both Colleges, of importance to both the country at large and to the State, and they cannot be discharged by a non-medical body such as a university. Before the State adopts expedients calculated to impair the usefulness of the Colleges, it should consider well whether in doing so it is not injuring itself also. The suggestions offered by the writers of the College letter are, therefore, worthy of the closest consideration, and in pressing them forward we should be glad to see the Royal College of Physicians associated with its sister College.

Notification of Anthrax and Glanders.

LAST week a question in the House of Commons called attention to two recent interesting cases in the City of London Coroner's Court. The first was one of glanders in a man engaged in shipping horses from the Continent. The second was a sporadic case of intestinal anthrax in a nurse, who is supposed to have acquired the infection through food. The spleen was enlarged, and the bacteriological examination revealed unsuspected anthrax. At both inquiries the medical men in attendance agreed that the diseases in question should be added to the list of diseases compulsorily notifiable to medical officers of health. The question asked of the President of the Local Government Board was whether he would take steps to extend the provisions with regard to compulsory notification of disease to all cases of anthrax in human beings, arising from any cause, and to all cases of glanders in human beings, or of suspected glanders. Dr. Waldo, the Coroner, expressed a strong opinion that glanders should be notifiable, a view that is shared by the London Corporation and by Dr. Collingridge, their medical officer of health.

The Mosquito in Yellow Fever.

THE recent issue of the evidence taken by the Royal Commission on Vivisection for the last three months of 1907 contains a mass of interesting matter. Amongst other points, the usefulness of the practical methods of modern science were admirably illustrated by Professor Osler in the case of yellow fever. In 1900 a Commission was sent to Havannah by the United States Government especially to investigate the cause of that malady. That Commission recognised particularly the relations of the mosquito to the disease. The experiments which they devised were carried out in a United States Army camp in Havannah, and they were amongst the most remarkable that had ever been made. The camp was composed of a certain number of immunes—that is to say, persons who were no longer susceptible to yellow fever in consequence of having had it. In this camp a house was constructed of two compartments, divided from each other by a wire mosquito-proof screen. Into one side of this hut fifteen infected mosquitoes were placed. Men were selected, partly from the Army and partly from civil life, who had expressed and signed their willingness to submit themselves to experiments, and one or two of the medical men also volunteered. Into the compartment with the fifteen mosquitoes a non-immune went in the morning, in the afternoon, and on the following morning and submitted himself to the bite. Within five days he had the disease. At the same time, in the adjacent compartment, which was simply screened from these mosquitoes by a wire netting, for twenty-one consecutive nights two non-immunes slept. They did not get the disease. This series of experiments, Dr. Osler added, had already revolutionised life in those regions. Havannah within the following two years was cleared of yellow fever, the first time in the 300 years of its existence.

The Indian Plague Commission.

THE Indian Government has issued an interesting summary of the work of the Plague Commission, entitled "The Etiology and Epidemiology of Plague." The conclusions are as follows:—1. Pneumonic plague is highly contagious. It is, however, rare (less than three per cent. of all cases), and plays a very small part in the general spread of the disease. 2. Bubonic plague in man is entirely dependent on the disease in the rat. 3. The infection is conveyed from rat to rat and from rat to man solely by means of the rat flea. 4. A case of bubonic plague in man is not in itself infectious. 5. A large majority of plague cases occur singly in houses. When more than one case occurs in a house, the attacks are generally nearly simultaneous. 6. Plague is generally conveyed from place to place by imported rat fleas, which are carried by people on their persons or in the baggage. The human agent not infrequently himself escapes infection. 7. Insanitary conditions have no relation to the occurrence of plague, except in so far as they favour infection by rats. 8. The non-epidemic season is bridged over by acute plague in the rat accompanied by a few cases amongst human beings.

The Bona Fide Midwife.

AT a meeting of the Central Midwives Board last Thursday, charges against thirty midwives were investigated. Dr. Champneys announced at the outset that up to the end of February, 1908, the total number of midwives crossed off the roll for various offences was 118; of these, 115 were enrolled under the *bonâ fide* clause. The evidence produced in the hearing of the present thirty cases contained some interesting information as to the routine work of the "old style" country midwife—the kind that is passing away. Twenty out of the thirty were struck off the roll, one had died since she was cited to appear, and the neglect of the Local Supervising authority to notify this fact cost the Board some £5. The remaining nineteen were censured or cautioned. Most of the charges were concerned with uncleanliness, not using the appliances prescribed by the rules, and neglecting to send for medical aid where it was needed. Three were charged with intemperance, and were struck off. In the course of the evidence, twenty-two cases of puerperal fever were revealed in the practice of these women, some of them being fatal. One midwife, working in Manchester, charged with neglect of two patients, who both developed puerperal fever, proved that she had so many cases at the time that, being unable to find another midwife to relieve her, she could not possibly attend to them all personally. There were several letters from medical men and others, giving ample testimony to her good work and character, and the Board contented itself with passing a vote of censure, the Chairman adding a few words of caution to the midwife on the mistake of undertaking more work than she could perform, and her responsibility to those she took charge of. Eight of the cases came from Staffordshire, where considerable ignorance appears to prevail among the midwives, and the two inspectors of the county, Dr. Alexander and Miss Wooldridge, appeared to give evidence. In one case of a premature infant—one of twins, the other being still-born—both mother and midwife stated that the child would take no food, though they tried it with gruel! The child died seven days after birth, no medical aid having been called in.

The Irish Housing Bill.

It is a matter for congratulation that the Irish Housing Bill, which passed the second reading last week, has received the support of all parties in the House. It is said that the financial clauses of the Bill in their present condition are not quite satisfactory; but this is a matter which may be set right in committee. The principle of the Bill—to do away with the necessity of going to Parliament for sanction of every little slum clearance scheme and making the decision of the Local Government Board final—has been accepted, and if along with this the Treasury can arrange to advance money on easy terms, then a great advance will be made toward the good housing of the people of Ireland. The municipalities have not been unmindful of their duties in this respect, but they have been hampered by their limited borrowing powers, and the expensive necessity of obtaining parliamentary sanction for each individual scheme. In many of the towns of Ireland the provision for housing the poor is very inadequate. Thus in Dublin, of 59,263 tenements, 21,747 are tenements of one room. That is to say, over 20,000 families inhabit one room to each family. The proportion of such tenements in Manchester is 0.04 per cent., in Liverpool 0.22, London 0.57, in Edinburgh 1.80, in Glasgow 4.28, and in Dublin 8.64. We trust that the Bill will speedily pass into law, and that its expeditious working will go far to remedy this sad state of things.

Indecent Literature.

We are glad to see that a Committee of both Houses of Parliament has been appointed to consider and inquire into the law as to lotteries, and "as to indecent literature and pictures and advertisements relating to things indecent and immoral." Our columns have frequently contained protests against the ease with which indecent advertisements are sent through the post, and only last week we had to refer to the particular instance of respectable ladies who have recently given birth to children being insulted by receiving through the post advertisements of the most gross description. It is intolerable that the public mails should be used for such purposes. There should be some stringency exercised also towards the indecent advertisements which crowd the columns of the daily and weekly papers, notably the lower-class sporting and religious prints. The proprietors of these organs will not lightly deprive themselves of the subsidy they receive for the publication of this sort of matter, but they may be made to feel that they cannot any longer play with impunity the part of go-between in this vile traffic. We hope that these, as well as other matters of the kind, may be brought to the notice of the Select Committee.

PERSONAL.

The Prince of Wales personally presided on March 20th at the annual meeting of the President and General Council of King Edward's Hospital Fund for London, to receive the accounts and reports for 1907.

Dr. David J. Thomas and Dr. D. Jenkins Thomas have been placed on the Commission of the Peace for Glamorgan.

Dr. H. R. Dean, of Magdalen College, Oxford, has been elected to the Radcliffe Travelling Fellowship for three years.

Dr. William Duncan has resigned the post of Obstetric Physician to the Middlesex Hospital, which he has held for close on twenty years.

Dr. Joseph Hume Patterson, Senior Assistant Bacteriologist to the Corporation of Glasgow, has been appointed Bacteriologist to the Lanark County Council.

H. Stallard, B.A.Cantab., L.R.C.P., M.R.C.S., has been appointed Honorary Physician and Referee for Newark to the Royal Midland Counties' Home for Incurables.

Dr. Arthur Newsholme, Medical Officer to the Local Government Board, was entertained at dinner on March 21st by a large number of the leading citizens of Brighton.

On March 19th, Sir Malcolm Morris, K.C.V.O., was entertained at dinner at the Imperial Restaurant by a group of friends to congratulate him on the honour conferred on him by the King.

Drs. Henry Gervais and G. E. Herman have been elected Consulting Physicians to the Royal Maternity Charity, London, in place of Dr. Robert Barnes and Dr. Fancourt Barnes, both recently deceased.

Mr. George Canning is being sent out to Sekondi by the Colonial Office to assist Professor Simpson and other experts already in West Africa in dealing with the plague epidemic.

Captain F. J. Brakenbridge, R.A.M.C., has been allowed by the King to accept and wear the 4th Class of the Order of the Medjidieh conferred on him by the Khedive in recognition of his services.

Mr. H. N. Hamilton Hoare, who has been the hon. treasurer of the Hospital Saturday Fund since its establishment in 1873, has, to the great regret of the committee, resigned that position, in consequence of ill-health.

The Earl of Rosebery, in his capacity as Chancellor of the University of London, on March 26th visited University College, London, for the purpose of formally opening the new libraries and the south wing, by which the college has just been enlarged.

Dr. Scanes Spicer has been elected Consulting Surgeon for Diseases of the Throat to St. Mary's Hospital, on resigning his post on the active staff. The Board of Management, in passing the resolution, conveyed their best thanks to Dr. Scanes Spicer for his valuable services for the last twenty years.

Dr. Frederick Melland, of Victoria Park, Manchester, is one of the city's veteran surgeons. Though he has passed his ninetieth year he still enjoys vigorous health, and at the Oldham Chamber of Commerce dinner the other evening Sir Frank Forbes Adam remarked, as evidence of his remarkable vitality, that "he had not passed a single course nor yet one of the wines."

A Clinical Lecture

ON

TWO CASES OF

SUBACUTE INFECTIVE EPIPHYSITIS. (a)

By EDRED M. CORNER, M.C.Cantab., F.R.C.S.Eng.,

Surgeon to Out-Patients at St. Thomas' Hospital and at the Hospital for Sick Children, Great Ormond Street, London.

[In opening the lecture a patient who had been shown at the Clinical and Medical Societies in 1906 (*b*) with diffuse chondromatous enlargements of the ends of the bones in one leg was demonstrated, the conditions being illustrated by skiagraphs, photographs and drawings].

The two following cases have been selected to be discussed in the present lecture because they illustrate a pathological state of epiphysitis due to an infection with micro-organisms which we are only just beginning to recognise clinically. The second case will be more fully reported at a later date with a full account of the bacteriological findings.

Case I.—A. L., a little girl, æt. 5, was sent to me by Dr. J. D. Shapland, having been ill for 9 or 10 days previously. Dr. Shapland had come to the conclusion that there was a condition of infective inflammation in the hip-joint. Her maternal grandfather had died from phthisis. When five months old she suffered from "consumptive bowels." And later, she had rickets, measles, chicken-pox and whooping-cough.

Nine days previous to her admission to St. Thomas' Hospital she complained of pain in the back of the right knee. Four days before admission she complained of pain in the right hip. The fever which accompanied the condition ranged between 100° and 103°. At the time of her admission it was 101.6°., the pulse rate 120 and the respiration rate 32. The temperature quickly rose to 103°. The child lay with both thighs flexed. The left leg can be straightened but any attempt to move the right leg caused pain. There is nothing abnormal about the right knee. The right thigh is a little full in its upper part. In fact there was great paucity of physical signs. On the third day after admission the temperature was 102.4° and the pulse rate 120, whilst some swelling appeared over the great trochanter. It was decided to make an exploratory incision. Under chloroform an incision was made through the swollen tissues down to the trochanter, which was opened with a gouge. No pus was found. By raising the structures in front of the neck of the femur, the hip-joint was opened and explored, no pus being found. The wound was then closed partially. As a result of this not obviously successful operation the temperature fell to 97.6° and the pulse-rate to 100, on the second day. The patient became very comfortable and had no pain. An extension apparatus with a weight of four pounds was put on the limb. On the fifth day after operation the wound which had been left open in part began discharging freely, the temperature varying from 97° to 102° for the next seventeen days. The condition of the part did not appear to warrant such a temperature and my colleague Dr. C. R. Box saw the case. He could find nothing except a slight tonsillitis, and decided that the cause of the pyrexia must be sought in the local condition of the hip. On the 22nd day since the operation the temperature began to decline steadily, becoming normal on the 32nd day. Marked fullness was found in front of the hip-joint. There was no pain so long as the leg was not moved. The right leg was a little more than half an inch shorter than the left. A skiagraph taken by Mr. A. H. Greg showed extensive disease in the head and neck of the right femur. On the 50th day since her admission Mr. J. E. Adams explored the right hip-joint through the usual anterior incision. The head of the femur was found practically separated and was removed. It consisted of a shell of hard bone destroyed in parts, and filled with soft granulation and gritty *debris*. Immediately after operation the temperature rose to 102°, was 102.4° on the following day, after which it became normal. The hip was allowed to anchylose to the pelvis in the abducted position. The child was discharged on the 80th day since her admission with a slight discharge from both incisions. Dr. L. S. Dudgeon examined the head of the femur which he reported as a chronic granuloma with some acute inflammatory signs present, "no evidence of tubercle."

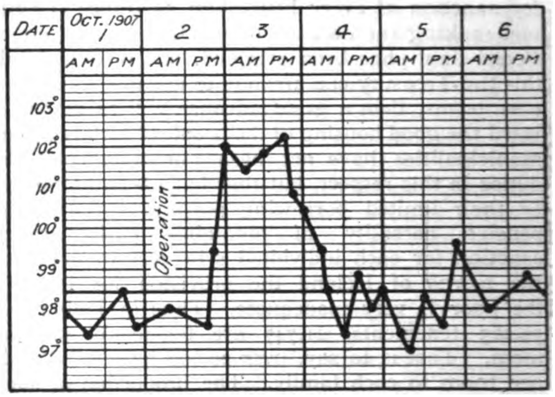

Chart of Case I, showing when the second operation was done and the subsequent rise of temperature

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(a) A Post-Graduate Lecture delivered at the Hospital for Sick Children, Great Ormond Street, London.

(b) Medical Society's "Transactions," XXX. 1907. Pp. 360-364 Clinical Society's "Transactions," XI. 1907. P. 244.

The point of greatest interest about the case is undoubtedly the origin of the disease; pathologically, it was an epiphysitis; clinically, there was considerable difficulty in ascertaining the precise locality of the disease which required an exploration, and later, an excision of hip; the result being some fibrous anchylosis and shortening of the leg. But what can have caused the trouble? Certainly not the tubercle bacillus (*a*) because no trace of it was found besides the clinical history is not consonant with it being too acute. It was undoubtedly caused by some infective agent of unknown nature which possibly obtained an entry through the tonsils which were found to be inflamed. It is a matter of great importance to realise clearly that such cases are due to the action of micro-organisms. And I would suggest that this case sheds light upon the still more obscure one about to be related.

Case II.—A boy, æt. 12, on September 6th, 1907, complained of pain in the outer side of the upper part of the right thigh, which lasted three days and made him quite lame. He was then perfectly well and running about for four days until on the 13th when he limped. On the night of the 13th he had much pain which kept him awake. On the 14th he was seen by Dr. Beddard who found the right leg held rigid and flexed at both the hip and the knee so that the toes only touched the ground. There was no pain when touched over the hip or the knee, but only along the outer side of the thigh. He had a good deal of pain that night. The sudden and acute onset was most unlike tuberculous disease. Whilst there was no history of any injury or of any disease such as tonsillitis or scarlet fever which might have given rise to the condition. A skiagraph was taken which showed no evidence of any disease of bone. The temperature rose to 102.8° in two or three days and then declined. The flexion of the hip was corrected in three days with an extension of the lordosis of the spine diminished. The pain quickly disappeared. And after remaining about 100° the temperature became normal on the 38th day. But there were two suspicious signs; there was continuous loss of flesh and the pulse rate had not subsided with the temperature. On the 55th day the temperature remained up for five days, returning to normal on the 62nd day. There was some swelling in front of the right hip at this time. On the 72nd day the temperature again rose, reaching 101,8°, and remaining up for five days before it returned to normal. This febrile attack was unaccompanied by any great increase of pain in the hip, but was followed by a most troublesome symptom, attacks of vomiting. In front of the outer part of the hip a swelling appeared, over which the superficial veins were enlarged and an indefinite feeling of fluctuation was obtained. There was marked tenderness over the great trochanter. The next day the swelling was rather less marked and obviously less tender. From this time the tenderness and swelling gradually subsided. But on the 90th day of illness the patient had pain in the *left* side, which hurt him when he coughed and kept him awake at night with throbbing pain. On examination, the abdomen did not move so well on respiration. There was a swelling over the left hip which extended on to the abdomen where it caused dulness. The next day the swelling was less, but the temperature remained between 100.4° and 101.2° for ten days. As the swelling in front of the left hip subsided, the abdomen became resonant again and the glands in the groin were felt to be enlarged and hard. On the 94th day he complained of pain along the back and inner part of the left thigh, extending as far as the popliteal space. On the 96th day this area was less tender but there was marked tenderness and swelling in the popliteal space, accompanied by flexion of the knee. On the 101st day the temperature was normal and there was marked improvement in appetite and general condition. But a tender swelling had appeared at the junction of the upper and middle thirds of the left calf, followed by some swelling of the left foot. On the 115th day samples of blood were examined by Dr. Klein and found to be absolutely sterile. Since this date all the signs have disappeared, and the boy has improved much in appearance, but his pulse rate is rarely under 100, and he has developed starting pains at night in the right hip.

This boy presented three distinct features which lead to great difficulty in his treatment; attacks of vomiting, desquamation of the skin, and easy formation of sores on the skin. The sickness was undoubtedly in part functional, being excited in particular by being pressed to take food, being offered food he disliked, or by visitors talking about food. Pain, such as was caused in putting on the Thomas' splint always brought on sickness; as, also, would an enema at times. It constituted a very great difficulty in feeding the boy, and was undoubtedly the cause of much of his wasting. In the middle of his illness it was associated with some headache, when the possibility of tuberculous meningitis was discussed. The symptom has at last been overcome by constant care and patience.

A very curious feature about the illness is the desquamation of the skin which was noticed throughout his illness and was present when the temperature was raised or normal. Indeed, variations of the temperature were not noticed to have any effect on the desquamation. It is most marked on the right leg, whose hip-joint is affected, and which has peeled completely several times. On occasions very tender places have been left on the toes, and sometimes on the face, where the epithelium has been shed.

Associated with the desquamation has been a great liability to the formation of sores. Any point of even the mildest pressure from the splint or extension apparatus will produce them. The ulceration commences insidiously beneath a crust of desquamated epithelium, which when shed or removed displayed a very painful shallow ulcer with shelving edges. In consequence of these sores, the extension apparatus was disused which is now felt to have been unfortunate, though it is very difficult to see how its use could have been continued.

These two cases when compared show many similarities. In both of them the trouble began in the right hip-joint, the onset of the disease being obscure and rather acute. Both children were perfectly healthy before they were attacked. In both cases the temperature rose to 103° in the early part of the disease. And what is of still greater importance although the temperature became normal, in neither did the disease come to an end or, to all appearances, cease to progress. Thus there were some features of acute disease,

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(*a*) By mistake other organs were not looked for.

such as acute epiphysitis, and others of chronic disease, such as tuberculous epiphysitis. The clinical picture of such a pathological mixture was very poor in physical signs. In fact, in both cases the paucity of signs was so great as to cause doubt as to the actual site of the disease. This rendered it difficult to decide upon both the diagnosis and the treatment. In both cases, the acute character and onset would seem to exclude tuberculosis. And the supposition was justified by the pathological findings in the first case.

A point of clinical interest is, that in both cases a skiagraph was taken by a skilled and competent radiographer in the early stages of the disease. In both cases the bones showed no sign of disease. Whilst in the later stages of the first case, the X-rays revealed the presence of disease in the bone; the decision being confirmed by the operation.

In the second case the occurrence of starting pains shows clearly and clinically that there is some disease of the bone. Hence it is clear that the X-rays are of no use at the commencement of the disease, but are only of value in its later stages when the clinical signs become sufficiently obvious for their use to be dispensed with.

There can be no doubt that the treatment of these cases is best palliative at first because the exact site of the disease is uncertain, and, being the result of an infection through the blood stream, it is impossible to be sure that the present lesion is the only one which will be formed. Under such circumstances it is undoubtedly better to wait and watch the case, not running the risk of proceeding quickly and unwisely. Moreover, there is no need for operative interference in every case. It is undoubtedly a subacute infective condition. Acute infective conditions require operation in every or nearly every case. Chronic infective conditions require operation only in the minority of their numbers. As subacute cases are intermediate between the acute and the chronic, it is obvious that far less cases will require operation than with the acute disease, and far more will require operation than with the chronic disease. A guessing estimate is that about 66 per cent. of subacute cases will require operation.

In these days of surgery, the question of the advisability of early operation must be discussed. The great difficulties in the way of early operation are the uncertainty of the exact nature and site of the disease, and the uncertainty that there will be only one focus when the origin of the disease is undoubtedly from organisms conveyed to the part by the blood, a true septicæmia. Organisms can equally well be conveyed to other parts. Until a definite and favourable answer can be given on these two questions about a case under observation, the advisability of early operation is beyond the pale of discussion. In very favourable cases the course of the disease may be cut short by early and timely operation. But there can be few cases in which it is possible to attain so desirable a result.

The first of the two cases reported came to operation, whilst the second looks rather as though it would not escape. Still, although starting pains have commenced it is possible that operation can be avoided.

At present it is difficult to account for the disease except upon the suggestion that it is caused by organisms conveyed to the part by the blood stream, a true septicæmia. There is no direct evidence as to the nature of the organisms but similar septicæmic or pyæmic conditions are well known; typhoid abscesses, gonorrhœal rheumatism, tuberculous joints, pyæmic foci, and so forth. (a)

Note.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by William Alexander, M.D., F.R.C.S., Senior Surgeon to the Liverpool Royal Southern and Workhouse Hospitals. Subject: "Three Cases of Inoperable Cancer of the Rectum."***

LUMLEIAN LECTURES.

POINTS OF PRACTICE IN MALADIES OF THE HEART. (b)

By Sir JAMES SAWYER, M.D., F.R.C.P.Lond.

Senior Consulting Physician, Queen's Hospital, Birmingham, &c.

LECTURE I.

Mr. President, Fellows, and Gentlemen,—There is nothing which pathology touches which does not adorn a physician's understanding of the heart. No therapeutics can ignore that organ's weal. Those of us whose memories of cardiac pathology and therapeutics extend over, say, forty years—those practising physicians whose clinical experiences cover a participation in the views and work of our profession which were current at any particular time within those four decades, in our views concerning the several blended subjects of the diagnosis, prognosis, and treatment of maladies of the heart, will be likely to agree that certain shiftings of our points of view in these important matters have been evolved from our joint and several work. Such movements of thought are largely subconscious, and sometimes it is well to note their existence and to take stock of their effects. While several very distinct additions, and some of them enduring ones, have been made to our knowledge of the origins, of the courses and of the treatment of diseases and disorders of the human heart, and whilst amongst those additions to our science and to the resources of our art are to be counted no less signal gains than the invention and the use of Marey's sphygmograph and of his cardiograph, the portentous discovery of a new and a microbic pathology, and Lauder Brunton's great gift of the potent therapeutics of the nitrites, while these epoch-making advances, and many other improvements, perhaps less notable and of less momentum, have been achieved, our physicians' view, while it has broadened and brightened, does not appear to have spread and cleared quite symmetrically. Perhaps it is always so with an art which is perpetually indispensable to humanity, and which rests upon an ever widening and ever deepening science. Forty years ago, the stethoscope of Laennec was biassing us towards a reliance upon its enthralling revelations. That "gift of science to a favoured son," as Stokes called it, dazzled us, perhaps, and not a little. We might sometimes not recollect that physical signs, how plain and positive soever they may be, are not a diagnosis, but only a help to it; at the most, only one of its foundations, and, great and reliable as they are, nothing more. I understand it is a maxim of criminal law that direct evidence is not so reliable as complete circumstantial evidence. So is it in medicine as to diagnosis, even in physical diagnosis. Of the great value of the physical signs of disease, as they are brought out by the stethoscope and other similar aids to their manifestation, we have all been long agreed.

(a) An organism was grown from the head of the femur in the second case, after this lecture had been delivered.

(b) Abstract of First Lecture delivered before the Royal College of Physicians, London, March 26th, 1908.

As Stokes soon pointed out, "it is on the discovery, explanation, and connection of those signs with organic changes, and with the symptoms and history of the case, that Laennec's imperishable fame is founded." (*a*) "With the symptoms and history of the case," of *the* case, be it noted, "case" in the singular, each one by itself, with its own unique individuality. But, forty years ago, physicians, it would seem, had not then quite "got over" the appearance of the stethoscope, and the comparative perfection of the science of auscultation. About twenty-five years ago, and many years after this great advance in auscultation, certain advances in microscopic and in comparative pathology, and in bedside research, turned us, perhaps a little too far for a just balance, turned us from our auscultatory refinements as to defects of valves, and of orifices, and from our explanations, perhaps too mechanical, of physical defects and their consequences, to a fuller and truer examination and appreciation of the part which we had to give in our cardiac pathology and therapeutics to many vital changes in the shape and structure of the heart's flesh and in the form and texture of the blood-vessels. And, now, of later times, with a maturer mind, we find the just mean between these two views; each point of view is taking its right place in a better understanding of the maladies of one of the chief of the central organs of our lives. Amongst those of our leaders who have pointed out such a justly balanced view are two of my distinguished predecessors in this chair, the late Sir William Broadbent (*b*) and you, yourself, Sir, (*c*) each of whom has addressed the College with much illumination upon the principles and practice of physic in regard to diseases and disorders of the heart.

Of much interest would it be to practising physicians to trace the growth of knowledge of the nature and treatment of maladies of the heart, not from the beginning of such a history, for that would be a long account remounting to the remotest records of our art, but during the last hundred years, or, as approximately that time, in the nineteenth century. In ailments of the heart, in that hundred years, a surely grounded hope, and our powers for the patient's good, have grown apace. At the beginning of that century Baron Corvisart, the learned head of the imperial medical service of France, opened his classic book on diseases of the heart with a line of well nigh hopeless sound: "*Hœret lateri lethilis arundo.*" (*d*) True was this sombre superscription in his time, when even Withering's immortal revelation of the curative uses of digitalis, of a decade or two earlier, did not appear to have passed into current professional knowledge. But such was the advance of medicine that Walshe, soon after the middle of the century, was able to declare that the gloomy metres of Corvisart's Virgilian quotation had lost much of their fitness to his subject, and to ask us to rejoice with him, as he did in the last edition of his great book, in 1873, that our knowledge of non-organic affections of the heart had found a wide extension, as to their nature and as to their successful treatment, while he was able to declare too, as he did in his precise and cautious way, that medical means of controlling the progress of structural diseases of the heart had continued to improve, and that their hygienic management had made marked advancement. (*e*) Another distinguished Fellow of the College, Peter Mere Latham, told us that, when he came up to St. Bartholomew's from Oxford, in 1810, the treatise of Corvisart was in the hands of all the students, and that it deserved to be, for in it there was full knowledge of the best kind given in the best way; and he pointed out that Corvisart was the first to bring the whole subject of the pathology and diagnosis of diseases of the heart out of obscurity, that it seemed impossible that the diagnosis of these diseases could have been carried further than Corvisart brought it by anything less than some new discovery in clinical observation, and such discovery was made by Laennec in his momentous invention of mediate auscultation. (*a*) Since Walshe's time the progress he helped so much has been kept up. Our diagnosis has gained in precision, our therapeutics have grown in range and in exactness, in the use of new drugs and in estimation of older ones, while what Walshe called the hygienic management of cardiac maladies has been helped by knowledge of how to live in physiological obedience, and by the reasoned use of physical exercises, such exercises being selected upon a skilled appreciation of the possibilities of each patient. In ailments of the heart it has been as true as it ever is in our practice, that the proportions of our power take measure from the extent and precision of our knowledge. During the later three-quarters of the nineteenth century, and until to-day, the clinical study of maladies of the heart has been carried forward with untiring industry and with much success. In no other part of the science and practice of medicine has more brilliant advancement been won, in practical knowledge and especially in remedial opportunities. It is beyond question that this great progress has been due in a large part to the use of various methods of physical examination, in the investigation and treatment of these affections. These methods have been multiplied, their applications refined; and the results of their employment have been differentiated more and more. Especially has the discrimination of cardiac maladies by the objective signs yielded by percussion and by auscultation been advanced to much precision, and all this by continued and by multiplied toil, by the bright contrivings and long researches of many minds and by the patient labours of many hands. The older physical methods of inspection and of palpation have not been superseded; rather have our later elaborations of auricular methods, in auscultation and in percussion, strengthened the indications and pointed the value of those signs which the watchful eye can see and the erudite hand can feel.

Still limiting this brief retrospect to the hundred years last past, one may note two other important details in which our notions as to maladies of the heart have found significant development. One of these points concerns the frequency of these affections; the other springs in part from a recognition of that frequency, and is that wider view of cardiac diseases and disorders which is giving us a more efficient grasp of their treatment, of their treatment not by drugs alone, but also by hygienics, and by every agency we can bring into use for the help of their therapeutics. The frequency of heart affections, relatively to that of other human maladies, does not appear to have increased of later times.

From the recognition of the abiding frequency of organic diseases and of functional disorders of the heart, and from a truer appreciation of the causes of that frequency, has arisen a great and far-reaching qualification in our view of how far the structural and functional changes which form the maladies of the heart may be dealt with as things somewhat apart, of how far such changes should be regarded as portentous matters with an impress and intrinsic characters of their own, as matters which have a peculiar clinical and vital detachment, as it were, of their own kind. Modern physiology, modern pathology, and physical diagnosis have each widened our view. Our later physiological knowledge has given us proofs to demonstration of how manifold, how intricate, and how widely spread throughout the human body are the influences which govern and affect the circulation of the blood. Physiology has shown us that, at the centre of the human circulatory system, of heart, arteries, capillaries and veins, there lies and works the cardiac

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(*a*) "Treatise on Diseases of the Chest." Dr. Stokes.

(*b*) Dr. (afterwards Sir) William H. Broadbent was the Lumleian Lecturer in 1891, and the subject of his lectures was:—"Structural Diseases of the Heart from the Point of view of Prognosis."

(*c*) Sir Richard Douglas Powell was the Lumleian Lecturer in 1898, and the subject of his lectures was:—"On the Principles which govern Treatment in Diseases and Disorders of the Heart."

(*d*) "A Treatise on the Diseases and Organic Lesions of the Heart and Great Vessels." By J. N. Corvisart, M.D. Translated from the French by C. H. Hebb, M.R.C.S. London. 1813.

(*e*) "A Practical Treatise on Diseases of the Heart, &c." By W. H. Walshe, M.D., F.R.C.P., &c. London. 1873.

(*a*) "Collected works of Dr. P. M. Latham." Vol. I. New Sydenham Society. 1876.

musculature, and near the periphery the musculature of the minuter arteries, and that on these two instruments of power many influences are constantly acting and reacting, according to the needs of the body. More and more have morbid cardiac changes become to be seen as what they are, as incidents, though prominent and often vital ones, in many pathological abnormalities. It is seen that the heart, in its complex functions in health and in their manifold derangements in disease, is the main-spring and active centre, the "prince in the commonwealth," as Harvey called it, (*a*) in a vascular system which comprises, besides itself, and the arteries, capillaries, and veins of the systemic and pulmonary circuits, the lymphatic vessels and the lymphatic glands, together with certain ductless glands, and the blood also, and the various fluids which may be its tributaries. We remember how inseparable are the lymphatic and the sanguineous circulations, how intimate is their connection in structure and in function. The circulating lymph is slowly moving, from the blood and into the blood, exuding from the blood through the walls of capillaries, and flowing back to the blood, with what it may bring with it, through the lymphatic vessels, which vessels come from all parts of the body, and at last form the greater and smaller thoracic ducts, which are always pouring their contents into the blood in the left and in the right subclavian veins. We know how important is this lymphatic circulation, to the blood and to the heart. We know how large is the whole amount of lymph in the healthy living body; it is measured at twenty-five to thirty per cent. of the body weight, that is, at three or four times the amount of the blood. (*b*) As to the place of certain ductless glands in the scheme of the vascular system, we may recall that the fruits of some recent researches show the relationship of the functions of those glands with the beats of the heart. Cyon, who is distinguished as one of the discoverers of the accelerator nerve of the heart, has recently developed his hypotheses that the thyroid, adrenals, and pituitary are glands which have the especial function of regulating the nerves of the heart, and even that the proper action of the pneumogastrics is maintained by a secretion of the thyroid. (*c*)

But our wider view in every case of disease or of disturbance of the heart must be far wider still. Extended and complex as is the vascular system, it is only one of many so-called systems of the human body which are in living co-operation with it. Not one of such systems is there but what is "in touch," so to speak, more or less directly, with each function and with every derangement of the heart, through nervous impulses of excitation, of depression, of inhibition, and these sometimes of thought, of volition, or of feeling, through the conveyance of secretion or of excretion, through rest or unrest, through warmth or cold. We know, with knowledge which is especially particular, how manifold and how close are the connections of the heart, through its innervation, with the brain, with the spinal cord, with the sympathetic system of nerves and ganglia, and through these, with all the parts which they animate and govern. In our view of each case of cardiac affection the complete grasp of the whole case must go with the narrow observation of the disturbed part. While each distinct change in cardiac structure or in cardiac function must be observed separately, must be separately recognised and described, and sometimes traced separately to its pathological origin, while our progress in practice in maladies of the heart cannot add to our knowledge of them without such minute and distinct consideration, yet the whole of each case must be grasped, in its living combinations and in its working relations, if the therapeutics and all other management of the case are to be understood, if they are to be conducted aright. For no detail must the whole be neglected.

In this greater grasp our therapeutics has its own place, and this not only for its own usual, direct, and essential usefulness, but also because of its reflex illumination of our diagnosis, and of our prognosis. The very treatment of diseases, rightly considered, is, as we all know, and as Latham wrote when there loomed largely in his mind the treatment of the very maladies we are now regarding—the very treatment of diseases is truly a part of their pathology. "What they need," as he put it, "and what they can bear, the kind and strength of the remedy, and the changes which follow its application, are amongst the surest tests of their nature and tendency." (*a*) We know that this dictum of a great physician is very true as to cardiac affections. The treatment of diseases of the heart is among the tests of the nature and tendencies of those maladies. In any particular instance of disease the therapeutic response to a remedy is a basis of judgment as to the nature of the case, both in diagnosis and in prognosis.

And, further, a heart case is never only a heart case. A heart case is never a heart case, be it either a functional one or be it an organic one, as so a case may be called. If some neurosis or if some temperamental neurotisms be causes in a heart case, then the whole of such neurosis or all of such neurotism, even to their remotest causation, is in question. If structural change in the heart be the proximate basis of the case, putting aside for the moment the general and local changes of metabolism, or of infection from without, or of degenerative metamorphosis, or of these variously combined, which may be the remoter basis of it—if structural change in the heart be the basis of the case, that change has either begun in the heart and is extending to the arteries, or it has begun in the arteries and is extending to the heart, or it has begun coincidently both in the heart and in the arteries, of which last case we have instances in the more fatty forms of degeneration. For the understanding of a heart malady all its accompaniments must be appreciated.

In the last few years many advances have been won in the histology and physiology of the heart and of the blood vessels. Especially has our knowledge grown as to the government of the heart and of the arteries through their nervous supply. Through this supply it is that the force and frequency of the heart's beats are ruled, that the tone of the arteries is kept up, so far as it depends upon arterial muscularity, and the peripheral resistance is controlled, so far as that complex factor in the blood-flow depends upon the tightening or upon the slackening of the muscularity of the lesser arteries. The paths of innervation through which the heart's beats are roused and hastened, through which they are checked and slowed, through which the arteries, and especially the smaller and smallest ones, are braced or unbraced; the efferent depressor path from the heart, through which, by exact mutual adjustment, the force and rate of the heart's beats and the tone and bore of the arteries are balanced; and, lastly, "the band of His," a singular fibro-muscular fillet, found, with its knot-like thickening, with its branches in the ventricular walls, and forming a union between auricle and ventricle through which systolic impulses spread from the one to the other—all these paths of power have been found. A working scheme of cardiac and cardio-vascular innervation has been made out, and this, in the main, from proven and evident facts, and with small mixture of hypothesis, so that much in cardiac pathology has found explanation therein, and so that our understanding of maladies of the heart has grown, to the advancement of our practice in diagnosis, in prognosis, and in treatment. We all know how an intimate knowledge of this innervation interprets to us in practice many points in the courses of certain affections of the heart. It is sometimes said that we have long relied upon an explanation of the action of the heart which may be called the neurogenic theory. But the heart's innervation and musculature are inseparable in the action of the organ. Our theory of yesterday was a neuro-myogenic theory, with an allowance for contractile spontaneity in the heart's musculature, resting on metabolism. Recent researches give fuller knowledge of the play of this musculature,

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(*a*) "The Anatomical Exercises of Dr. William Harvey, &c." London. 1653. Harvey was the Lumleian Lecturer in 1615.

(*b*) "Human Physiology." By Augustus D. Waller, M.D., F.R.S. London. 1893.

(*c*) Review in the *British Medical Journal* of Die Nerven des Herzen, ihre Anatomie and Physiologie. By Dr. E. von Cyon, August 10th, 1907

(*a*) "Collected Works of Dr. P. M. Latham." New Sydenham Society. Vol. I. 1876.

of a kind suggestive of therapeutic consequences. The functioning of the heart seems to depend upon several separable qualities in the cardiac muscular tissue. Amongst these are the power of originating its own stimulus to contraction and of distributing it from part to part of the heart, its excitability or sensitiveness to such stimulus, its contractility and its tone. It appears, further, that the function of tone, which is a characteristic of every living muscular fibre of the heart, is most marked in the fibres which encircle the valved orifices and the openings of the veins into the auricles, that the contraction and the tone of the fibres in these situations help in closing the valved apertures, and are wholly effectual in closing the non-valvular orifices when such orifices need to be closed in particular parts of each cardiac cycle. All this later knowledge is full of suggestion in our practice, diagnostic and therapeutic. Such a statement of the action of the heart may be called a myogenic theory. It is, in truth, a myo-neurogenic one. It gives prominence and leads to the functioning of the heart's musculature, in the combined results of the action and interaction of that musculature and the cardiac innervation. Clinically this later teaching increases the significance of changes in the myocardium. From this recent knowledge we may draw a new and a momentous conclusion. It is this. Now that we know that the initiation of the heart's beating is inherent in the musculature of the organ, we see in such a fact a remarkable safeguard for the continuance of the beating of the heart, and for the recovery of that beating after a momentary suspension, in the presence of the paralysing effect of some shock to the heart, of such a cardio-inhibitory shock as may arise from a great somatic muscular effort or struggle, or from violent and profound emotion, or from some traumatism, or from some anæsthetic inhalation. That the cardiac musculature, of its own intrinsic spontaneity, leads, leads under nervous sustenance and regulation, it is true, but that the musculature does lead in the heart's action, can save the beating of the heart from final stoppage, under stresses which, but for this defence, might close its career for ever.

As, then, to the heart in disease, in disorder, and in health, the indebtedness of medicine to her own physiology is enormous indeed. Recent physiology has discovered much concerning the circulation of the blood in our species, and all that it has discovered in that regard bears, or will bear, upon our practice. Our understanding of affections of that circulation in the sick, whether their seat be in the heart, or in the blood-vessels, or in the blood, or wherever elsewhere, or in these in ever-varying combinations—our understanding of these maladies has been cleared, if not finally illuminated, and to the illustration of our practice in every cardiac malady. With regard to the systemic circulation, we now know that, in the midst and at the core of the currency of the blood lies the musculature of the heart, with the musculous arterioles near the periphery. Upon these two living, contractile, and expansile elements the central nervous system, directed and governed by this or that impulse reaching it along afferent nerve fibres, or affected by this or that influence, is continually playing; is playing in balanced, in harmonised, in reciprocal, and in compensatory actions, now in augmentation of contraction, now in inhibition of it, and so, by help of the elasticity of the arteries and the mechanism of the valves of the heart and of the veins, directing the blood flow according to the needs of the body. (*a*) From this newer knowledge, not a little of it the produce of our own time, we may be sure that our future progress as to the care and cure of maladies of the heart will depend largely upon whatever further help physiology may be able to furnish. After the manner of Harvey, and of others of the old time before him, physiology, as a part of medicine, and medicine in her pathology and in her practice, have gone forwards in interdependence; and so it will be, while clinicians make our science more practical, and physiologists our practice more scientific.

(*a*) The abridged account of the circulation of the blood given in this sentence has been expanded and amended from Sir Michael Foster's summary, as given in his "Text-Book of Physiology."

ORIGINAL PAPERS.

OPEN WINDOWS AND ADENOIDS.

By J. SIM WALLACE, M.D., D.Sc.,
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THE simplest, most definite, and most important truth which preventive medicine has been teaching during the last few decades has been the value of fresh air. This fact has justified many a monograph dealing with the general amelioration in health which has resulted. Curiously enough, the historical or evolutionary justification of the doctrine has not received the attention that such an important principle demands. I do not intend to attempt to supply this want. At the same time I must allude to it, for it was, paradoxical as it may seem, the consideration of this subject which led me to believe that we are not justified under all circumstances in advocating fresh air without any reserve. Moreover, a consideration of the evolutionary justification gives also a rough guide to the limitations, or rather safeguards, which have to be observed under special circumstances. If we look back at the evolution of man, we see that he is undoubtedly and essentially a fresh air animal. Our relations, the monkeys and the anthropoid apes, are animals which specially indicate an urgent need for fresh air if they are to be kept in perfect health. Their arboreal *habitat* has from all time fitted them for fresh air, and when brought to confinement, as in zoological gardens, the absolute necessity for thorough ventilation in their houses is now recognised. Moreover, like ourselves, the monkey tribe is specially susceptible to succumb to certain diseases which are almost innocuous to such animals as rats and mice, which may be taken as types of animals not requiring perfect ventilation to keep them in good health. There appears to be one thing, however, in which we differ from our anthropoid relations in respect to *habitat*. Man is not solely a tropical or sub-tropical animal. To him almost all regions of the globe are habitable, while anthropoid apes, at least, seem quite incapable of living for any time, even in temperate regions, except when most carefully protected from the inclemency of the weather. So, too, perhaps, it was with man before he became more highly differentiated from these animals, until, indeed, his intelligence, his clothing and housing, such as it originally was, allowed him gradually to live in countries less and less tropical. And although at the present day man is adapted to live in northern climates, yet the essential similarity to our anthropoid ancestors is still to be seen in a heavy mortality from the very disease to which monkeys are susceptible when they are brought to live in these climates. It does not need any argument, indeed, to show that man without house and clothing is not fully adapted for all the climates in which he lives. This applies even more strongly in the case of infants and children, who are unable to stand exposure so well as adults. We are certainly justified in saying that ever since man commenced to depart from his tropical *habitat* he must always have had some protection, especially for his children, against the less congenial climates. In other words, a house and clothing become necessities of life. At present I intend to refer only to the house. It was until recently a primitive protection, perhaps, but it had this merit—it was always, with the help of the other primitive comforts obtainable, enough to allow for the continuity of the race. It may have had its faults, it may have been insanitary, it may have been ill-ventilated, especially among cave-dwellers, but, on the whole, its utility justified its existence. Probably many millions have perished on account of the faults of hygiene referred to, and perhaps during the same period man may have become better adapted to his climatic surroundings, although infants and children which were necessarily kept more strictly under the protection of the house may not have become so fully adapted.

What is of special importance to note, however, is that the house existed as a protection against certain extremes or kinds of climatic conditions which are inimical to the well-being of the human body. It may here be said that these kinds of climatic conditions to which I refer do not exist in tropical or sub-tropical regions, so that we as animals had not in our primitive state become adapted to these climatic conditions. It would appear that cold and damp are in general never associated in the tropics. In many tropical localities where the atmosphere is clear, dry, and still at night, radiation is rapid, and very considerable cold may be experienced; but during rainy and damp weather the temperature does not fall to anything like the same extent. When we consider cold and damp, however, such as, let us say, are exemplified in our fogs from November till March, we begin to see something differing from tropical climatic variations, and are justified in doubting if man is altogether adapted for them.

Now let us consider what habit and instinct appear to show. It is hardly necessary to refer to the fact that fires are universally used in cold weather, and this in spite of the fact that it is a more expensive method of maintaining heat than by shutting out the air and heaping on clothes. Now the fire has three attributes to which I would refer. First, it provides warmth; secondly, it ventilates; thirdly, it reduces the humidity of the air. Thus fires are beneficial from all these three points of view. It has not required the advances of science to induce people to put on fires. They instinctively do so. The advances of science have, however, been necessary to induce people to appreciate as thoroughly as they should the benefits of fresh air. But the fresh air doctrine has during the last thirty years been taught with effect, and among the educated classes there are few who do not appreciate it. In fact, it seems to have become a sort of cult, and, notwithstanding the fact that there is an instinctive tendency to shut windows on cold and damp nights, the doctrine of fresh air winter and summer has now become part of the educated man's faith. But here is where a protest must be made, not because of the insistence on fresh air, winter and summer, and night and day, but because of the method most commonly employed to secure it. The neglect to prevent the cold and damp from accompanying the fresh air must be regarded as a serious error. In other words, it is not right to attempt to ventilate a room by simply keeping the windows open if the weather is cold and damp. There are several diseases which the medical profession recognises to be in some way associated with cold and damp, such as catarrhs and rheumatism, but I only wish to refer to one at present—namely, "adenoids." This disease has apparently increased in frequency with prodigious rapidity in recent years, and, what is certainly very suggestive, its increase seems to have been concomitant with the cult of open windows night and day, summer and winter. Moreover, my observations would appear to indicate that the proportion of children affected with adenoids is distinctly greater among the more educated classes who are most scrupulously insistent on keeping their windows open at night throughout the year. Children brought up with open windows appear, indeed, to be about fifteen times more likely to contract adenoids than those who sleep with the windows shut on cold and damp nights, or at least than those who sleep with closed windows throughout the greater part of the year. The few figures which I have so far been able to obtain are as follows:—Of 69 who slept with closed windows, two cases of adenoids were found, while of 49 who slept with open windows at night, winter and summer, 22 cases of adenoids were found. *It will be seen from the above that adenoids appear to be confined almost entirely to those children who sleep with open windows;* but, notwithstanding this, it must not be thought that there are no other contributory causes, or that I abandon altogether the other factors connected with clothing, perspiration, digestion, and the development of the palatal arch which I have previously referred to elsewhere. It would probably be more satisfactory, therefore, if in the collection of further statistics the relative frequency of adenoids were considered class for class and not one class against another, where the other conditions, such as housing, fires, clothing, etc., may be essentially different.

When we consider the question from the point of view of physiology and pathology, and what is already known with regard to the etiology of adenoids, we find that the same conclusion must be arrived at. The first point we have to note is that cold air, especially when damp, causes a certain amount of congestion and catarrh of the mucous membrane of the nose and nasopharynx, and although it may be foggy, and on that account specially objectionable to breathe the air directly into the lungs, we tend more than usually to breathe through the mouth. If the stream of cold air is made greater—as, for example, during considerable muscular exertion, then the congestion and simple catarrh is augmented. Those who skate need hardly be reminded of this. Now, if it is conceded that cold and damp air induce congestion and catarrh, then, if continued sufficiently long, it will tend to produce thickening or hypertrophy also. But, in addition to this, it seems undeniable that the specific catarrhal inflammations are more readily contracted when the mucous membrane is congested from irritation by cold and damp air, and therefore tend to increase the hypertrophy.

Referring to acute catarrhal pharyngitis, De Schweinitz and Randal say, "Exposure to cold really means lessened resistance of the tissue to germ vitality and germ entrance into the substance of the membrane." And, referring to acute naso-pharyngitis, they say:—"Exposure to cold and damp plays the chief exciting *rôle*. Here also should be borne in mind what has already been said regarding such exposure as related to temporary impairment of tissue vitality. As occurring in very young patients, we generally find acute naso-pharyngitis associated with more or less enlargement of the pharyngeal tonsil, which in turn may have resulted from repeated attacks of acute rhinitis."

Whether the above considerations are considered valid or not, it is a fact that cold and damp localities are usually recognised as at least a predisposing cause of adenoids, and if the above explanation is correct, then, instead of cold and damp localities rendering the individual susceptible to adenoids in some vague constitutional way, we see that cold and damp localities cause adenoids, from the simple fact that the cold and damp air is the primary exciting cause itself.

Next, when we consider heredity, we read, for example, in Mr. McLeod Yearsley's book on adenoids, that, "although it cannot be positively said to be hereditary, hypertrophy of the pharyngeal tonsil often shows a distinct tendency to affect several members of the same family." This is a significant fact, and indicates, in my opinion, that the mal-environments of certain families tends to produce the disease in each member of the family. If then, "it is by no means uncommon experience for the surgeon to have to operate upon two, three, or even four or more in the same family for adenoids," and since "this fact has been referred to by nearly every writer of any consequence upon the subject," then it surely is evident that there must be a something in the nature of a very definite and direct cause of adenoids in some families, and that this definite and direct cause is absent in other families. That the definite and direct cause is cold and damp night air seems probable. If we consider treatment, a similar conclusion is enforced. Surgical treatment is recognised as being very satisfactory, although recurrence sometimes happens, but medical treatment—notwithstanding the tendency for the hypertrophied tissue to shrink—seems to be attended with very unsatisfactory results. If medical treatment does not recognise the cause, and if such directions are given as "especially should it be insisted upon that the child shall sleep in a room directly open to the outside," then, in a climate such as ours in winter, medical treatment will probably be unsatisfactory.

It was a consideration of several of the above facts that led me to doubt the advisability of open windows at night in cold and damp weather, and it did not surprise me to find that a direct investigation into the relation between open windows at night and adenoids resulted in the figures which I have already given. Although the relationship seems to be unquestionable, yet, having regard for the other conditions and predisposing causes, I am of opinion that a more extended investigation will not reveal such a startlingly close relationship, especially in those localities which are (unlike the Thames Valley, to which my figures specially refer) relatively free from cold and damp night air.

SEASIDE TREATMENT FOR SICK CHILDREN. (a)

By GEORGE CARPENTER, M.D. Lond.,
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More general attention on the part of the medical profession should be given to the pressing needs for sunlight and pure fresh air, on the rearing and treatment of children by reason of the rapidly increasing expansion of the towns and the growth of the population. The effect of exposure to sunlight on animal life is exceedingly invigorating, while the combination with the inhalation of salt-impregnated ozone-laden winds straight from the ocean, and redolent of the odour of the sea, is a most potent tonic for the sick. The seaside provides for the invalid and the growing child all that is manifestly so wanting in the habitations of the town dwellers, to whom change of air was not merely a luxury, but a vital necessity. A brief review of the various ailments for which seaside treatment is beneficial would include chiefly tuberculous disease of the bones, the joints, the lymph glands, and peritoneum and early phthisis. As a tonic after surgical operation and after recovery from exanthemata, sea air is most valuable. Cases well-nigh moribund from summer diarrhœa and entero-colitis derive the greatest benefit, and for rickets it is a most helpful adjunct. As regards the different seaside climates within a moderate train journey of London, there is, fortunately, a good choice. On the East Coast, in the counties of Essex, Suffolk, Norfolk—there are the towns of Clacton, Frinton, Walton, Dovercourt, Felixstowe, Aldburgh, Southwold, Lowestoft, Yarmouth, Happisburgh, Mundesley, Cromer, with its adjacent villages, Wells and Hunstanton, north of the Thames. South of of the Thames and in Kent there are Tankerton, Herne Bay, Birchington, Westgate, Margate, Broadstairs and Ramsgate. All of these are bracing, and eminently suited for the treatment of delicate children. In the winter and spring months these localities are rather too keen and east windswept for the safe treatment of lung and kidney affections.

Those for whom a bracing air is necessary can also find on the South Coast a suitable climate at Dover, Folkestone, Eastbourne and Brighton. But where a mild climate is indicated for those recovering from acute bronchitis, for those suffering from chronic bronchitis, and for convalescents from acute renal disease, rheumatic fever and heart disease, the choice should fall on Hastings, St. Leonards, Worthing, Littlehampton, or Bognor.

In the Isle of Wight, Sandown and Shanklin, on the East Coast, are bracing, while Ventnor, having a southern aspect, should be chosen for those who require a mild atmosphere. Owing to the latter town being built on terraces, cases of heart disease, with imperfect compensation, should not be sent there. On the other hand, cases of asthma may find a suitable climate at one of the different levels the town occupies. In the present remarks it is possible only to generalise, and it is out of the question, owing to the shortness of time at disposal, to review all the towns included in this definition, or to point out in detail any minor distinctions of climate between them.

The author was impressed by the fact that the physicians practising at the seaside do not make the best use of the natural advantages of their towns—viz., the sea water. In this respect they are behind their Continental brethren, and a trip to Biarritz, for instance, would make this abundantly clear to them. It is well known that hot and cold baths increase metabolism, while tepid baths produce no such effect. That metabolism is further increased by mechanical stimulation of the skin, such as by rubbing and by the addition of chemical substances, such as CO_2. In sea water the chemical stimulant resides in the various salts held in solution. Cold baths produce greater metabolic effects, because they lead to more muscular movements.

A further study is needed of the effects of hot and cold sea water baths and douches on the secretions and metabolic processes of children, and of the therapeutic effects of such remedies on their complaints, such as tuberculous adenitis, arthritis, tuberculous and rheumatoid, abdominal tuberculosis, and on various functional gastro-intestinal and liver complaints. The present custom is for the family doctor to send the sick child, with a relative or a nurse, to the seaside to recuperate as best it may, and the seaside physician never sees the patient unless it unfortunately happens to develop some acute ailment requiring the attention of a local medical man.

That arrangement can hardly be considered a satisfactory one. Would it not clearly be better that the seaside physician and the town physician should be brought more intimately into contact, and that a society, such as the British Balneological, should be the flux whereby the two could be brazed together? The former would thereby be afforded opportunity of teaching their town brethren what the seaside towns in which they resided were most suitable for, and what complaints should not be sent to them. At present it was left to the town physicians to find out for themselves what seaside climates are best suited to their juvenile patients. It is to be hoped that before many years have elapsed this will be remedied, and that in the future there will be found a little band of children's specialists well versed in sea-water practice at our important seaside towns, available, not only in the summer, but all the year round.

CLINICAL RECORDS.

CASE OF CHRONIC PHTHISIS: CALMETTE'S TEST.

By DAVID WALSH, M.D.Ed.,
Physician, Kensington General Hospital, &c.

E. H., female, æt. 38, domestic servant, came to hospital January 25th, 1908, complaining of chronic indigestion, which had become worse during the previous three weeks. Pain came on at once after food, and was associated with nausea, but seldom vomiting. There had been no hæmatemesis or melæna. Bowels regular. No cough.

Family History.—Father died at the age of 70 of "bronchitis," mother, at 43, cancer. Five brothers and sisters in good health; two died in infancy. An uncle on mother's side died of phthisis.

Previous History.—Was treated at Brompton Hospital for consumption five years ago. At the time she had grown thin, suffered from cough, and spat blood. After two years' treatment she "recovered," and was well for a time until an attack of pleurisy two years ago. Has had occasional attacks since of asthma and bronchitis.

Present Condition.—Is dyspeptic (as above noted); has got thinner of late; no cough; no hæmoptysis, but suffers from night sweats. Bronchial breathing was found over right apex; heart sounds feeble. No other marked physical signs in chest. Temperature at time of first visit, 98.4° F.; weight, 9st. 6lbs. A few weeks later patient complained of fleeting pain in right leg (so-called "tubercular rheumatism"). She was given a mixture of cod-liver oil and iron, and ordered a diet composed chiefly of fish and milk, with careful atention to exercise, clothing, and ventilation of bed-room.

(a) Abstract of paper read before the British Balneological and Climatological Society, March 5th, 1908.

Patient improved rapidly under treatment, and as there seemed to be some reasonable doubt about the activity of the tubercular process, a drop of .1 per cent. Calmette's suspension was introduced into the conjunctival sac of the right eye. A slight and delayed but positive reaction followed 13 hours later. This result may be regarded as indicating the activity of the tubercular process in some part of the lungs. The case was one in which it was not easy to form any definite opinion one way or the other. The patient's appearance certainly did not suggest chronic tuberculosis, nor was the diagnosis by any means so easy to arrive at as might perhaps be inferred from the foregoing history. Cough being absent, there was no sputum to examine for tubercle bacilli. Any additional evidence, therefore, as regards the activity of the tuberculous process has its value, even if we cannot accept such evidence as final in all cases.

The writer has to thank Dr. G. H. Jacob, House Surgeon, for careful notes of the case.

OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Syphilitic Ulceration of the Nasal Septum and Around the Anus.

BY PEYTON T. B. BEALE, F.R.C.S., F.R.C.P.LOND.,
Surgeon to King's College Hospital.

AMONGST Mr. Peyton Beale's out-patients was a man, æt. about 40, suffering from tertiary syphilis. When he presented himself it was observed that the septum between the two exterior nares, together with portions of the alæ nasi, were absent, and that the edges of the skin and mucous membrane were ulcerated. The appearance was like that which would have been formed by removing the portions with a large punching machine, the edges being sharp cut. The patient said he had difficulty in passing his motions, complaining of dragging pain when expelling fæces. He also said that he noticed discharge on his shirt. On examining the anal region, the anal aperture was found very deeply placed, the whole of the tissues for about two inches around it being lost, so that, on separating the nates, one saw a large cavernous circular opening about four inches in diameter, and about two inches deep, with a small, puckered ring of mucous membrane in the centre, this being the orifice of the rectum. He did not know how long the trouble had been going on; he did not even know that there was any ulceration present, the part being quite devoid of pain. Mr. Beale said that this was a condition brought about by gummatous infiltration; subcutaneous gummata arose in fibrous tissues such as fasciæ and intermuscular planes; also in connection with cartilages of the nose and muscular aponeuroses. They occurred in parts of the body which were not, as a rule, exposed to injury—for example, in the back between the scapulæ, the inner aspect of the nates and around the anus, the lower portion of the anterior abdominal wall over the symphysis pubis, below the inner head of the tibia. At the commencement there were one or more subcutaneous nodules, then later these coalesced, and the skin over them, as a rule, broke down fairly suddenly, the process being a sort of local necrosis, so that there was very extensive loss of tissue and of the skin covering it. It was fairly clear that there were two factors at work in causing the destruction of tissue—one an affection of the sensory and trophic nerves supplying the part, and the other an obliterative endarteritis of arterioles of the part. The process was devoid of pain and of hæmorrhage. He looked upon the condition as being the result of untreated or imperfectly treated syphilis. By that he meant that the patient's tissues had not received a sufficient amount of mercury or mercury in a form suitable for the tissues to destroy the syphilitic virus in them. He believed that in many cases of primary and secondary syphilis, in which large doses of mercury had been administered for a long period, the greater part of the drug in certain cases became deposited in some of the tissues either as an insoluble organic salt or in the metallic form. If in these cases iodide of potassium was freely administered, it produced iodide of mercury, and this was set free, rapidly causing symptoms of mercurialism to appear; in fact, many of the symptoms commonly ascribed to overdosage by potassium iodide were in reality due to the soluble mercury salt formed from the mercury stored up in the tissues.

The patient under observation was treated by subcutaneous injections of mercury, and locally with lotio nigra.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

OPERATION FOR SEPARATED LOWER EPIPHYSIS OF THE FEMUR—Mr. CARLESS operated on a boy, æt. 7, who had sustained a separation of the lower epiphysis of the femur a fortnight previously. The accident was the result of the practice so common among street urchins of running after a four-wheeled cab, jumping on to and sitting on the back springs. The patient's leg was caught between the spokes of the revolving wheel and wrenched forcibly forwards. The displacement of the epiphysis was, as is usual in these cases, in a forward direction. The limb was much swollen, and evidently a large hæmorrhagic extravasation had occurred, but there was no sign of pressure on the popliteal vessels. Attempts had been made then, under an anæsthetic, to reduce the displaced fragment; on one occasion, under the control of the X-rays, it was hoped that this had been satisfactorily accomplished, and the limb was put up in a flexed position, but the swelling of the leg was so great and the child was so restless that each time the fragment was found to have slipped forward after a day or two. It was therefore determined to fix the fragment by operation. A longitudinal incision was made on each side of the limb a little above the patella and carried down through the aponeurosis of the vastus on each side to the bone, the synovial membrane of the knee-joint being encroached on on the inner side; the margins of the fragment were then discovered and the periosteum divided—a raspatory was introduced under the fragment, which was levered up and loosened from the position in which it was becoming fixed. It was found, however, that the adhesions were so firm that its replacement was not to be easily accomplished without more space being obtained. The upper ends of the incision were therefore joined together by a curved out, and the body of the quadriceps entirely divided along this line. It was now possible to detach the fragments completely, and by means of traction on the lower part of the limb, combined with flexion of the knee, to bring the epiphysis into exact apposition with the lower end of the shaft. As soon, however, as the traction was relaxed the epiphysis slipped back into its old position, and therefore its fixation became a matter of necessity. This was accomplished by driving two steel round-headed nails, about two inches in length, through the epiphysis in an oblique direction into the lower end of the shaft, a sufficient length of these nails were left to protrude through the skin, one nail emerging through one of the incisions and a special opening being made in the base of the flap for the other. The joint was then closed, the quadriceps muscle sutured up with iodised catgut, and the skin incision closed without drainage. The limb was put up in a somewhat flexed position and kept at rest with a starch bandage. Mr. Carless commented on the difficulty he had experienced in the treatment of this case owing to the large amount of hæmorrhage extravasation. These cases, he said, were usually treated without much difficulty by putting the limb into a position of acute flexion, but in this case the smallness of the boy, his restlessness, and the impossibility of flexing the limb to any great extent owing to the swelling, rendered such treatment unsatisfactory, and therefore open operation had to be resorted to. If another similar case came under his observation he would not hesitate in the future to cut down at an earlier stage through the periosteum and let out the effused blood so as to facilitate the re-position of the fragment. The nails which had been introduced would be removed in ten days or a fortnight, and by that time, in all probability, the epiphysis would be secured in place.

The after history of this case has been satisfactory: the nails were removed in about ten days; the wound healed by first intention, and the epiphysis remained in good position. There was some difficulty in obtaining complete extension at first, but this is gradually being overcome by the use of a weight and pulley and massage.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

Meeting held Friday, March 13th, 1908.

The President, E. H. Tweedy, in the Chair.

AN ABNORMAL PLACENTA.

Dr. Spencer Sheill exhibited an abnormal placenta which showed a raised ring forming a complete circle about half-way between the margin and the insertion of the cord, about 2 cm. in depth and half that in thickness. The membranes were adherent to the margin of the placenta. On cutting into the placenta —at the suggestion of the President—he found that the membranes below the ridge met, but did not cause a complete folding of the layers. He would, however, submit the specimen for a closer examination to a pathologist.

A NEW TABLE FOR ESTIMATING THE DATE OF DELIVERY FROM THE SIZE OF THE UTERUS.

Dr. **Henry Jellett** exhibited the above. It was not, he said, intended for perfect accuracy, nor was it new. It was simply an arrangement of ordinary data to save time in calculating the date of delivery, as estimated by the size of the uterus, in cases in which the patient could not give a definite menstrual history.

Sir A. V. Macan, Professor Alfred Smith, Dr. Purefoy, and the President spoke.

TUBERCULOUS SALPINGITIS.

Dr. R. D. **Purefoy** read a paper entitled: "Some Remarks on Tuberculous Salpingitis," with specimen illustrating the condition. We hope to publish this paper in our next issue. In the discussion that followed:—

Sir A. V. **Macan** said there was a great difficulty as to the origin of primary tubercle of the tubes. If it did not ascend or descend they could only suppose that it filtered out from the blood. Sterility was one of the earliest effects of tubercle of the tubes, and he was not sure whether it would be much use to leave a small portion of the tube in such cases. He had at one time held the view that if they could not see their way to extirpate completely such affection of the tubes they had better leave them alone, but now he thought they ought to remove as much as was possible, and trust to general strength to get rid of what was left behind.

Professor **Alfred Smith** said they were struck, in operation, with the fact that it was of little use to leave even a small portion of a Fallopian tube behind; the tube became so thickened that the lumen was practically useless, and seemed to be another starting focus of disease. But, when the tubes were removed, it did not follow that the uterus should be removed also. If it was curetted, it would probably be found to contain no tuberculous disease. While, however, no necessity might arise for the removal of the uterus in tubercular salpingitis, it might be good practice to remove it in staphylococcic or streptococcic infection. As regards drainage, he was of opinion that it was not necessary to leave in a tube or gauze-drain; by leaving them in they courted the tendency to a hernia in the track left by the drainage tube.

Dr. **Spencer Sheill** said he had under his care a case of suspected tubercular salpingitis in which intermittent diarrhœa was a marked symptom, and without, so far as he knew, any disease of the intestines. He asked if Dr. Purefoy had found this to be a usual symptom of tuberculous disease of the tubes.

Dr. **Jellett** said that, a few years ago, Dr. Bond, of Leicester, had brought to the notice of the annual meeting of the British Medical Association the existence of what he called "ascending mucous currents," and showed how methyl blue, deposited in the region of the vagina, was found afterwards in the tubes. This suggested one mode of origin of primary tubal tuberculosis. The infection had to pass through the uterus, the periodical sweep out of which probably prevented it from takng root there. He was strongly against the wholesale removal of the uterus and ovaries in these cases. Tuberculosis of the ovaries was a very rare condition, and he thought that, even if there were adhesions round the ovary connecting it with the tube, where at all possible, one or both ovaries should be spared; and the same thing applied to the uterus. Drainage might be very necessary in some cases, but he would drain through the vagina, and in cases in which there was no intestinal infection of the tube contents he would not drain at all.

Dr. **Holmes** said he had lately seen several cases where tubercle was suspected, where the Calmette reaction was tried, and three out of four reacted, and evidently the condition was very early.

The **President** said it was very rare that tuberculous tubes were diagnosed until they had opened the abdomen, and they did not always recognise it even then. He agreed with the wisdom of draining in Dr. Purefoy's case, and he considered the best plan to be a wick of iodoform gauze through the abdomen rather than through the vagina. He drained more with the hope of exciting a localised peritonitis than getting septic matter away. The cause being walled off would prevent the infected area spreading, and they had an outlet for any infected matter. He did not think there was anything in the fear of a hernia forming. His experience as regards leaving the ovaries and tubes was not at all that of Professor Smith's. Dr. Jellett had pointed out that it was very rare to see tubercular tubes affecting the uterus; but they sometimes saw, just at the cornua, an isolated tubercle which they could cut out, and leave a healthy tube behind. If, however, the tubes were removed, he did not see the use of the uterus, if for no other reason than that women were more subject to cancer than men, and that the uterus was the organ most prone to that disease.

Dr. **Purefoy**, in reply, said he agreed as to the wisdom of avoiding drainage, except for some good reason, such as he thought he had in the case before them. He was also in accord with regard to the retention of the ovaries where possible. He thought it was quite possible that diarrhœa was a sign of tuberculosis, but he had not had the condition under observation.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, March 12th, 1908.

On opening the meeting, the **President** alluded to the loss the Institution had sustained by the deaths of Mr. Edward R. Bickersteth and Mr. Reginald Harrison. Mr. Bickersteth was the oldest existing member, having joined in 1853. In 1870 he was elected President. He was a member of the distinguished family of that name, and, in addition to his eminent surgical skill, which has been so well described elsewhere, he possessed the true medical instinct in dealing with his patients. His manner and address were models for younger men, for he possessed in the highest degree the power of acquiring the confidence of his patients. Mr. Reginald Harrison was one of our oldest surviving members, and was President in 1880-1881. To his genius in his management of the Liverpool Medical School is to be attributed the revival and progress which have led to its present status. Mr. Harrison established for himself a reputation in the treatment of urinary affections, and when he removed to London the profession in Liverpool felt that they had lost one of their most capable members.

A PURE MILK SUPPLY.

Dr. H. **Clarke** moved the following resolution:—"That a committee of five members, with power to add to their number, be appointed to consider whether the Liverpool voluntary hospitals should be advised to take action to ensure the greater purity of their milk supply, with special reference to tubercular infection, and to report thereon to the Medical Institution." He pointed out the extent of the danger, about 5 per cent. of all milk sold in Liverpool being tuberculous. This danger could be removed by sterilising all milk used. This method, however, was unsatisfactory. The milk of a diseased cow should not be used for food if it could be avoided. The efforts of the public health authorities had resulted in a marked improvement in the milk produced in the Liverpool area, but their powers over outside dairies which supplied most of the hospitals were inadequate, and, in consequence, no improvement had taken place in the quality of the milk from the country during the last ten years. He pointed out that there was no adequate body of public opinion to support the authorities against the strong opposition drastic measures were sure to arouse, and he considered it was the duty of the medical profession of Liverpool to give a clear and authoritative statement of the present state of our knowledge of this subject, and to show by a practical demonstration how this danger could be avoided. In this way public opinion could be educated, and the efforts of the authorities rendered easier.

The resolution was seconded by Dr. C. Hill, supported by Drs. P. Marsh and Logan, and carried.

The following gentlemen were selected to serve on the Committee:—Mr. T. H. Bickerton (President), Sir Rubert Boyce, Drs. H. Clarke, P. Marsh, E. E. Glynn, E. Hope, C. Hill, W. B. Warrington, and R. J. M. Buchanan.

OPHTHALMIA NEONATORUM.

Dr. **Nimmo Walker** read a note on ophthalmia neonatorum based upon an experiment in its treatment which he believed to be new—at any rate in Britain. A small ward had been allotted in St. Paul's Hospital, and, with the help of the City Health Department, acting under the "Notification of Births" and "Registration of Midwives" Acts, infant and mother were admitted at the beginning of the disease. He hopes to publish fuller details and particulars later.

Dr. **Stookes** pointed out that the midwives trained during the last ten years had been thoroughly impressed with the importance of cleansing the child's eyes. At the Liverpool school the midwives were taught the details of asepsis, but he did not think it would be wise to allow midwives to use antiseptics on their own initiative. He recommended Dr. Walker to notify every case he met with of neglected ophthalmia to the supervising authority appointed by the Central Midwives Board.

Dr. **Grossmann** was heartily in sympathy with Mr. Walker's suggestions. The movement was one which required a good deal of perseverance to produce tangible results. In a paper which he had read at the British Medical Association at Leeds twenty years ago, Dr. Grossmann had emphasised the fact that the disease was one which came almost invariably under the range of the obstetrician; when it came to the ophthalmic surgeon the mischief had nearly always been done. Inasmuch as it was a thoroughly preventible disease, there was no excuse for its occurrence at all, and the fact that about one-third of the inmates of the blind asylums owe their blindness to this ophthalmia is a crying disgrace to existing conditions, as we have absolutely reliable methods for its prevention.

The subject was further discussed by the President, Drs. Logan, Stockdale, Harcourt, E. Stevenson; and Mr. Walker replied.

A discussion then took place on the

PATHOLOGY AND TREATMENT OF EXOPHTHALMIC GOITRE.

The discussion was opened by Dr. W. B. **Warrington**, who said that, owing to the general advance that had taken place in our knowledge of thyroid pathology, the present was an appropriate time to reconsider the treatment of Graves' disease. He briefly reviewed the views held as to the functions of the thyroid and parathyroid bodies. He stated the necessity for greater knowledge of the history of the whole course of the disease, and said that, in his opinion, it was a very serious condition, only rarely terminating in real and permanent recovery. He described the principles underlying the serum and general treatment of the disease, and alluded to the remarkable successes obtained on the Continent and America from operative procedure.

Dr. A. **Gordon Gullan** discussed the etiology of Graves' disease, and showed that it was more prevalent in women, being rare before puberty and after the menopause, and mentioned instances of family history in this disease. He then dealt with the pathology of the disease, and claimed that it was due to excessive activity of the thyroid gland—thyroidism—as proved by experiments on animals and over-dosage with thyroid extract in man. He also discussed the *rationale* of the action of anti-thyroidin (mœbius), radogen and thyroidectin. He quoted several cases which he had treated during the last few years with these substances, and in most instances the results were most satisfactory, and in many cases the result was quite definite. In conclusion, he urged a more extended use of anti-thyroid treatment rather than operative treatment, and advocated that larger doses of the antithyroid substance should be used in some cases.

Dr. T. R. **Glynn** pointed out that Graves' disease was hereditary. He had met with an instance where two sisters and the only daughter of one of them suffered from this affection. In the case of the latter the typical symptoms appeared at the age of six. The majority of these cases improved under rest and treatment in hospital, and occasionally recovered perfectly. The mortality of thyroidectomy had diminished greatly in late years, but thyroidectomy and other operative measures were only moderately successful. In a recent paper by Dr. Garre, of Bonn, he stated that he had operated on 35 cases of Graves' disease chiefly by removal of the more hypertrophied part of the gland. Absolute cure had followed in 16 per cent. only, amelioration in 85, and no improvement in 15 per cent., deaths in 12 per cent. He also referred to the fact that in fatal cases the thymus was enlarged in about 80 per cent., indicating that there was some relation between this gland and the thyroid.

Mr. C. **Thurstan Holland** discussed the X-ray treatment. Twenty cases had been treated in private, and at the Royal Infirmary, during the last five years, but some of these only attended a few times. In most of the cases following immediately on the first exposure a noticeable drop in the pulse rate occurred, and muscular tremors and general nervous symptoms abated. Several mild cases after a course of this treatment were symptomatically cured. The X-ray treatment seemed to be of undoubted value, and in bad cases might be valuable as a preliminary to operative interference. In making the exposure the skin should be protected by two or three layers of thick boiler felt.

Dr. R. J. M. **Buchanan**, while agreeing that the symptoms of Graves' disease were due to an increased or perverted activity of the thyroid gland, did not consider that much light had been thrown on the cause of this. He pointed out that as the other organs of different people varied in the range and character of their activity, so it is with the thyroid, and that the condition is a congenital anomaly in certain individuals. During his investigations into the clinical side of the disease, he had been led to conclude that the condition is one largely governed by heredity. He considered that people in whom Graves' disease showed itself in later life were of a separate and distinctive class, and whom he believed had the affection in a certain degree from early childhood. A condition which might be regarded as simple goître if closely watched will be found to develop some sign of the graver form at some period of life. He showed lantern slide photographs of families of the type to which he referred, and in which some members had simple goître, others in the same family the symptoms of Graves' disease. In one family the father had a large thyroid, and the condition had been transmitted to his three daughters by two separate mothers, two of the daughters had large quiescent thyroids, and the third a large thyroid with signs of Graves' disease. In one case he had watched the development of the disease in a lady over a period of 18 years, and also in her daughter from early childhood for the same period of time. He considered the thyroid functionated intermittently as all other organs of the body must do, and in this way they account for the exacerbations which are so common. Dr. Buchanan drew attention to a clinical sign which he had found present in cases of Graves' disease, and which he had not seen described, that before moving the eyes from one fixed object to another blinking of the eyelids always took place.

The President, Drs. Abram and Johnson, and Messrs. F. T. Paul and Damer Harrisson also took part in the discussion.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday, March 26th.

The President, Dr. John McCaw, in the Chair.

A very large number of specimens of various sorts were on exhibition before the meeting, and various demonstrations were given.

Prof. Symington gave a lantern demonstration of (*a*) a reconstruction to illustrate the relation of the deeper parts of the brain to the lateral aspect of the skull; (*b*) specimens illustrating dental anatomy with X-ray photographs of developing teeth, by Dr. Rankin. These radiographs, shown on the lantern screen, showed in a most beautiful manner the position of the teeth, both milk and permanent, at various ages from birth onwards.

Dr. **Crumble** gave a lantern deuonstration of the variations of the central or Rolandic fissure of the cerebrum, as noted in a large number of specimens in the anatomical rooms.

Drs. **Killen** and **Maguire** showed specimens of spinal cord and hind-brain to illustrate the order of medullation of the fibres.

Professor **Milroy** read a short communication on Colour Fatigue, and showed apparatus used in testing it.

Professor **Summers** and Dr. **Wilson** presented notes on four subjects:—

(*a*) Agglutination of organisms of the typhoid, colon and alkaligenes groups by the blood-serum of cerebro-spinal fever cases.

(*b*) Cerebro-spinal meningitis, due to infection with the typhoid bacillus, Gartner's bacillus, and the anthrax bacillus.

(*c*) Fermentative powers of the meningococcus and gonococcus.

(*d*) Certain differences between young and old cultures of meningococci.

These notes were of too technical a nature to lend themselves to condensed reporting, but will, no doubt, be published in full later.

Drs. D. P. **Gaussen** and **Houston** gave an account of a case of streptococcic septicæmia treated by a vaccine. The patient, a lady, was ill for many weeks, with frequent rigors, and temperature running up to 104°. A bacteriological examination by Dr. Houston showed that a streptococcus was present, and a vaccine prepared from cultures of this was administered six times, at intervals of a few days, with most satisfactory results.

Sir John **Byers** showed a number of specimens of gynæcological interest, including a molluscum fibrosum tumour removed from the clitoris, and a large tumour of rapid growth, the size of a full-term fœtus, which was removed from the abdomen without any vessels having to be tied, and which showed no trace of connection with uterus, ovaries, or any other structures. Its structure was doubtful—seemingly muscular, but with some signs of malignancy.

Dr. **Cecil Shaw** showed (*a*) a water-colour drawing of a peculiar congenital condition, melaena of the conjunctiva, and a microscopic section of a piece of the same. (*b*) A series of sections illustrating different forms of nasal neoplasms. In reference to the former specimen, Dr. Shaw said that he had been unable to find any description of a similar condition in ophthalmic literature. The patient, a man, æt. 40, had six or eight small sessile tumours, nearly as large as a split pea, scattered over the conjunctiva of the lid and globe in one eye only, and a good deal of pigment diffused through the surrounding conjunctiva. The eye was otherwise normal.

Mr. **Craig** showed an eye removed for melanotic sarcoma of the choroid.

Mr. **Fullerton** showed several specimens and instruments illustrating recent advances in the surgery of the bladder.

Specimens were also shown by Drs. St. George, Darling, Dempsey, O'Doherty, and Messrs. Mitchell, Kirk and R. J. Johnstone.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, March 29th, 1908.

Cardiac Pleurisy.

Leaving aside pleural effusions due to tuberculosis, cancer, and certain acute infectious maladies, it is common practice to find pleurisy in patients suffering from cardiac and renal disease as well as from arteriosclerosis. To these effusions are given the names of pleurisy or hydrothorax, according as they are unilateral or bilateral. The former were particularly studied by Huchard, Merklen, Renon, etc., who proved their frequency on the right side and insisted on the importance of thoracentesis as treatment.

The inflammation of the pleura is unilateral, says M. Renon, and is accompanied by a fibrous exudation and false membranes. The liquid is either purulent, hæmorrhagic, or sero-fibrinous. It depends entirely on pulmonary infarctus and frequently lobular apoplexy is evident; pain, more or less intense, with sanguinolent expectoration, precedes by one or several days the development of the effusion. Sometimes, however, the symptoms are less acute, the pain is insignificant, but dyspnœa is very pronounced.

Cardiac pleurisy varies considerably as to its situation. It can occupy the whole cavity of the pleura, or it can be supra-diaphragmatic, mediastinal, or encysted. The commencement is slow and insidious. The physical signs present the usual characters. The exciting causes are generally pericarditis, hepatic congestion, acute œdema of the lung.

As soon as the existence of the effusion is diagnosed, it should be evacuated without delay, and this repeated frequently if necessary. The operation should be done low down (tenth intercostal space). Immediately the liquid is evacuated improvement takes place, the dyspnœa diminishes, sleep returns, and polyuria takes place.

Nucleinate of Soda.

Nucleinate of soda administered in major abdominal operations seems to have a double action, a preventive local action on peritoneal infection, and a general action by which the defences of the organism are increased, phagocytosis in particular.

When injections of 10 grains in an ounce and a half of serum are made in the external portion of the thigh one or two days before the operation, no inflammatory reaction follows the operation. The same amount abandoned in the abdominal cavity produces similar effects. Thus, nucleinate of soda can be injected beneath the skin the day before the operation, or poured directly into the peritoneal cavity before closing the wound at the dose of 10 grains, and under its influence the normal temperature returns on the third or fourth day.

Thiosinamine and Deafness.

Deafness, as a rule, is due to three great causes—disease of the labyrinth (ischæmia followed by arterial sclerosis), oto-sclerosis, and adhesive otitis.

The first-named is observed in persons over fifty suffering from arterio-sclerosis generally, and in whom local treatment is useless.

The second is found in the young—young women principally. The deafness comes on insidiously, progresses at each pregnancy, and is complete towards forty-five.

The lesion is deep-seated. On the confines of the labyrinth hyperostosis accumulates in the labyrinth, obstructing the foramen, and paralysing the terminal filaments of the facial nerve. No therapeutic treatment, local or general, has any effect on the development of the malady.

The third or adhesive otitis is of purely local origin. The infection ascends the nose and the naso-pharynx by the Eustachian tube, attacks the middle ear, either suddenly in the form of suppurative otitis or insidiously by repeated catarrh. Otorrhœa leaves behind cicatrices of the tympanum, while catarrh provokes progressive hyperplastic otitis which deforms the drum and welds together the small bones. Here local treatment succeeds.

Besides the complicated and varied interventions of aurists, who endeavour to remove the fibrous obstacles to audition, a new treatment has been proposed and practised by M. Lermoyez, which, he maintains, is as simple as effective: thiosinamine.

Von Hebra introduced thiosinamine into therapeutics, and its indications extended rapidly. Unna used it with advantage in cheloids. Latzko employed it in pelvi-peritonitis, while Teleky obtained very good results in applying it methodically in the treatment of fibrous stricture of the œsophagas.

The cases published by Teleky gave to M. Lermoyez the idea of employing thiosinamine in cicatricial or catarrhal otitis. The treatment is simple enough and can be employed by any practitioner. The patient bathes his ear every evening with a warm solution of thiosinamine and antipyrine for five minutes, and twice a week he goes to see his medical attendant, who practises pneumatic massage of the tympanum. In general, at the end of a fortnight, the hearing is much improved. This improvement is very remarkable where a large perforation of the tympanum permits the penetration of the liquid into the internal ear.

Ichthyosis.

Ichthyosis should be considered more in the light of an infirmity than of a malady. If no treatment has any curative effect, considerable improvement may be obtained by simple means.

Three or four times a week, the patient suffering from ichthyosis, takes a prolonged bath, during which he rubs himself with ordinary soap; after this he applies a small quantity of glycerine.

The skin is thus modified very rapidly, especially if the cutaneous secretion—perspiration—is stimulated. The general treatment includes cod-liver oil and arsenical preparations.

GERMANY.

Berlin, March 29th, 1908.

At the Verein für Innere Medizin, Geheimrat Prof. Bumm spoke on

Pulmonary Tuberculosis and Gravidity.

He said that the indications to interrupt pregnancy in women suffering from pulmonary phthisis had become very frequent of late. Numerous tuberculous women were sent from curative institutions, and the Charité for this purpose. That pregnancy reduced the resisting power of tuberculous women, that the disease advanced rapidly in that condition, and first showed itself then when it had before been latent was already known. For that reason it had been demanded that tuberculous girls, and those of tuberculous parentage should not marry, they should not at least have children, or not suckle them. Whilst the latter requirement was easy of fulfilment, we were powerless as regarded the others. The question therefore frequently came up: Shall we interrupt the pregnancies of tuberculous females? No general principles could be laid down, we must individualise, and decide each case by itself. In thus judging, however, we must lay down some guiding principles:—1. Our hopes from the operation must not be too great. 2. We must undertake the interruption only when objective signs of the disease are actually present, not from fear or because of hereditary tendency—there we lost the ground under our feet. Sometimes the interruption was wished for on other grounds—for that we could not be responsible. 3. The operation should never be undertaken in advanced cases, for here there was no hope of improving the patient's condition, but it was almost always made worse rapidly from the loss of blood and other fluids. An exception was formed as an *indicatio vitalis*, by sudden excessive œdema of the lungs, the speaker had seen instances of such rare cases several times. 4. The interruption should not be made in advanced pregnancy, as then the loss of blood and fluids was greater, and the disease was made rapidly worse by it. The operation was not indicated therefore in half the cases of pregnancy, and only in pronounced, but not too far advanced cases of tuberculosis.

His experiences with the ophthalmic reaction had been very good, if the result was negative the progress was almost always rapid. It also happened sometimes that after the interruption the reaction again became positive, a certain sign that the tuberculosis was improved. (A case of this kind was shown.) The operation was to be performed at one sitting under lumbar anæsthesia. The doing of it in stages after preparation and dilatation was objectionable, on account of the greater losses of fluid and the depressing mental effects of the prolonged course of procedures.

Sometimes no advance was made with a simple interruption as a second pregnancy immediately followed, in such cases it was sometimes advisable to sterilise at the same time the abortion was induced, by removing the ovaries along with the pregnant uterus. The consideration that a change for the good might be brought about by arrest of the menstrual flow, might lead to a favourable view of the proposal for sterilisation. Naturally this could only be done in the cases of women who already had children, and who gave their consent. Naturally also the cases must be carefully selected.

Geheimrat Prof. Hildebrand related a case of

Œsophageal Bodies with Gangrene of the Lung —Operation and Recovery.

In January, 1907, the patient, a female, swallowed a plate with artificial teeth in the night. She had sought relief from many medical men without obtaining any. In November, *i.e.*, 10 months after the accident she was admitted into Kraus's Klinik, and here the position of the plate was ascertained by means of the X-rays to be just above the cardiac opening. The patient was then transferred to the speaker's wards in a most reduced condition. From the situation it was not possible to extract the foreign body through the mouth. He performed laparotomy, and made a small opening into the stomach; he could now feel the body with the tip of his finger but not grasp it, nor could he do so even by passing the whole hand into the stomach. Neither could he grasp it with a pair of forceps, as it lay embedded in a cavity, near to the heart, and only separated from it by a thin wall. He now made an incision into the œsophagus from the neck, and even then he did not succeed. It was only after breaking up the foreign body with a powerful pair of forceps that he was able to extract it, piece by piece. After the removal gastrotomy was performed for the purpose of giving nourishment. At first all went well, and then fever set in, with fœtid expectoration, from an encapsuled empyæma and pulmonary gangrene. All went well in the end, however, and the patient had gained 24 lbs. in weight in three months.

The wound of the œsophagus healed *per primam* as it was not used for feeding. The gangrene of the lung recovered after draining.

The *Therapeutische Monats. XXI.* contains a paper by Dr. A. Lübbert, of Hamburg, on

The Treatment of Hyperæmia.

After speaking of the usual methods in vogue, Preissnitz bandages, mud and peat baths, poultices, etc., he refers to the more recently introduced method of Bier, which as every one now knows consists in the production of an artificial hyperæmia by means of elastic bandages, cupping glasses, or exhausts made of indiarubber. "Realising" some of the difficulties met with in the employment of the Bier method, and endeavouring to find out one by which they could be overcome he thought that some hygroscopic application would answer the purpose. When a friend suggested the American preparation called "antiphlogistine," and after he had satisfied himself from its composition that it would be likely to be useful he gave it a trial. To his great satisfaction it seemed to answer all the requirements exactly. It extracted a large quantity of fluid without leaving the skin in the sodden condition so regularly seen after poultices. It relieved pain promptly, and it possessed the distinct advantages that it was easily applied, did not require frequent renewals, and gave notice itself when it had done its work by turning up at the edges and becoming loose. The paper concludes with reports of a number of cases in which it gave satisfaction.

AUSTRIA.

Vienna, March 29th, 1908.

Polyarticular Arthritis Deformans.

Wick treated the Gesellschaft to an exhaustive exposition of Heberden's nodules, or what others have termed polyarticular arthritis deformans. These nodules usually begin to form about the last phalangeal articulation in advanced years, or about the age of 40 in females and 60 in males. As time rolls on the interphalangeal joints become involved. They appear without pain or inflammation and are evidently excrescences of bone. Their etiology seems closely connected with the climacteric period, sterility, or senility. Such patients exhibit general and local nervous phenomena, which he considers factors in their production. He is quite convinced the nodules are not gouty in nature, nor are they connected with arthritis deformans of the large joints, although they may have some connection with chronic rheumatic arthritis.

Noorden is of the same opinion that this morbid condition is not gouty, but thinks the disease might be designated arthrosis deformans. He is also of opinion that there is some connection between the malady and the sexual organs.

The treatment can only be symptomatic from our present knowledge; hence hot baths, sand electric baths, or Biers' congestive treatment are found to be the best. Paraffin injections have proved successful in many cases where the joint is implicated.

Weichselbaum thinks that the name Heberden's nodules should be retained for the disease, as it is a specific one and worthy of further investigation.

Pineles said he had often seen Heberden's disease appear after castration of both women and men; in the latter he thought the connection was well established.

Gara thought Noorden's treatment with vaseline injections was a very temporary remedy and hardly worth the effort, as the injections were absorbed within a week.

Pyocyanase.

Winkler gave a biological demonstration of the above, which acts on the polynuclear leucocytes, dissolving the plasma, leaving nothing but the nucleolus and granula. With the condenser these active granulæ are observed to become quiet when pyocyanase is presented, and the amœboid movement of the cell ceased at once. Spirilla and bacteria shared the same fate as the leucocyte, which became quite stiff. The spirochæta pallida and spirillum volutans were acted on in the same manner and with the same result. The spermatozoa were the principal object of research; they were acted on in a dark field and not, as is usually done, with the microscope. A very brief period was necessary to check the action of the spermatozoon. In the gonorrhœal discharge the granulæ and the gonococci stood out boldly on the slide when examined in the ordinary way; and after an hour the whole became solvent. If this pus be coloured with neutral red methylen blue and the pyocyanase be applied for five minutes, the gonococci will be found to be dead. A strong feature of the experiments was the absence of any action on the epithelial cells. Unna tells us he dialysed and washed out the granula with sodium chloride, but Winkler never obtained this result with the drug.

Weinberger gave a report of his results obtained from pyocyanase on the coli and typhus bacterium, which were much the same as Winkler's.

Fellner rose and extolled the clinical effects of pyocyanase, which he has used in cases of gonorrhœa with wonderful success. The gonococci disappear from the secretions of uterus and urethra in a very short time, while the subjective symptoms are instantly relieved.

Fibrolysin.

Gara followed with a history of seven cases of ankylosis which he had treated with success. The pathological fibrous tissue becomes softened under the influence of intra-muscular injections of 2 gr. of fibrolysin daily. Gonorrhœic and rheumatic cases yield readily to this treatment. Manual or machine extension commences shortly after beginning the injections, and if they be troublesome a little aspirin relieves the difficulty. Two of his cases which had both knees and hips bent, could after 17 injections move them through 90°. In others the elbows were movable to the same extent after 17 injections.

Teleky related how he had succeeded, eight years ago, with thiosinamine in relieving a stricture in the œsophagus which was the result of a cicatrix. Since that time he had administered the same drug for other forms of ankylosis in joints with equal success. Parts long stiffened with bandages, instruments, etc., are rapidly relieved. He had not yet tried it in rheumatic joints.

Wick has also used fibrolysin in rheumatic ankylosis without success, but would not condemn the drug with such scant knowledge.

Ullmann had used both fibrolysin and thiosinamine in a hundred cases of cicatrices, leucoma, scleroderma, etc., etc., with decided improvement of the patient. Thiosinamine first and fibrolysin afterwards act very well.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Retirement of Professor Crum Brown.—Professor Crum Brown, who for forty years has occupied the Chair of Chemistry in the University of Edinburgh, is about to retire from his position. He comes of a well-known Edinburgh family, and to his brother, the late Dr. John Brown, the world owes "Rab and his Friends." Professor Crum Brown received his M.D. degree in 1861. He studied chemistry under Gregory and Lyon Playfair, and then under Bunsen and Kolbe, and in 1863 began the career of an extramural lecturer. On the election of Sir Lyon Playfair as member of Parliament for Edinburgh and St. Andrews Universities, Crum Brown became Professor of Chemistry in the year 1869, and since then has occupied a leading place in the scientific life of Edinburgh. It has been said of him that he is capable of examining in almost any of the subjects of the scientific curricula in the University, and certain it is that few of the members of the Senatus Academicus are more versatile than Crum Brown. His thesis of 1861 anticipated many of the later discoveries on structural chemistry, but as it was not published until 1878, he never, perhaps, has received full credit for his investigations. The system of graphic formulæ described in it is that now universally followed. The researches by which Crum Brown is best known encroach upon the domain of physiology and pharmacology. In 1868, in conjunction with Sir Thomas Fraser, he made an important investigation into the chemical constitution of the alkaloids, and the now well-known fact established then—namely, the effect of the introduction of the methyl group—was the first serious advance in our knowledge of the relation of chemical constitution and pharmacological action. For this the authors were awarded the Macdougall-Brisbane medal of the Royal Society of Edinburgh, while in 1875 Professor Crum Brown received the Keith prize for his researches on the functions of the semi-circular canals, in which he demonstrated the nature of the stimulus to which they respond—namely, stresses in the endolymph. Professor Crum Brown is also a mathematician and a linguist. His knowledge of languages extends to Russian and Chinese. In his public capacity Crum Brown has not shirked such duties as have naturally presented themselves to one in his position, but he has never put himself prominently forward in such matters. He has been a manager of the Royal Infirmary, and a member of the School Board. He has devoted himself almost exclusively to science, and has for many years been Secretary of the Royal Society of Edinburgh, in the debates of which body he takes an active part. He is a Fellow of the Royal Society, and LL.D. Glasgow, and was Boyle Lecturer at Oxford in 1895. Coming, as he does, of an ecclesiastical stock, it is not to be wondered at that Professor Crum Brown takes an ardent interest in Church matters, both on the historical side and in the everyday affairs of Church life, and many are the stories of his kindliness and charity in connection with congregational work. He is hale and alert, and his clear eye and vivacious gesture belie his seventy years. He retires from the University with his faculties undimmed, respected and beloved by colleagues and students.

GLASGOW INFIRMARY.—FINANCIAL IRREGULARITIES.—Mr. Henry Lamond, who was for forty years secretary to the Infirmary, having resigned that office a month ago, and his partner, Mr. J. S. Lang, were arrested last week on a charge of embezzlement. Messrs. Lamond and Lang were lawyers in Glasgow, and the charge on which they were arrested arises in connection with a sum of £10,000 of trust funds, the life rent of which was payable to certain beneficiaries, and on their death the capital sum was to be paid to the Infirmary. Bail was fixed at £2,000 in each case, and as the sum was not forthcoming, the accused were conveyed to prison. Mr. Henry Lamond is over 70 years of age, and had been a member of the Partick Town Council and served as a magistrate. The alleged irregularities have been going on, it is stated, for the past fifteen years.

LIEUT.-COL. W. B. BANNERMAN, M.D., ON PLAGUE.—An address on recent researches into the etiology of plague in India was delivered by Col. Bannerman, of the Indian Medical Service, at a special meeting of the Medico-Chirurgical Society in Edinburgh last week. He described the appointment and *personnel* of the Commission, which began work in 1905 at the Bombay bacteriological laboratory at Parel and in the Punjaub. In that year the existing knowledge of plague was confined to two types of the disease—pneumonic, which is very contagious from one person to another, and bubonic, which is not communicable. In fact, it used to be said that the safest place in a plague epidemic was the ward of a plague hospital among bubonic cases. It was further known that there was a marked seasonal prevalence of plague, which differed in different towns, each locality having its own epidemic season. It had also been observed that houses, not inhabitants, were infective, and there was some evidence that rats played a part in carrying the disease. If curves of mortality were made, it was found that the discovery of dead rats always preceded the rise in the human death-rate. It had also been shown that the transmission of infected clothes to distant localities might give rise to fresh outbreaks. In the opinion of the First Plague Commission, infection is almost always conveyed through the skin, but "suctorial insects do not come under consideration in connection with the spread of plague." Captain Liston, however, had made an elaborate series of researches showing that plague was actually communicated to man from rats by fleas. There were three species of rats in India, the two most common being the black and the brown rat. Liston showed that the fleas of rats and men belonged to different species, and that the former would attack other animals and man himself in the absence of their natural host. He also said that guinea-pigs could be used to trap rat fleas in a plague-infected place, and that these rat fleas sometimes had plague germs in their stomachs. Guinea-pigs, in places that were not plague-infected, had no fleas on them, and did not die of plague, as did some of those exposed to the bites of rat fleas. Finally, he showed that in plague-infected houses a large proportion of the fleas taken on men were rat fleas, not human ones. Three possibilities presented themselves to the 1905 Commission:—(*a*) Rats might soil food by their excreta; (*b*) rats might similarly contaminate the floors; (*c*) some insect on the rat might convey the bacillus. The last of these was finally accepted as fully accounting for the epidemiology of plague. The general conclusions arrived at were:—(1) Pneumonic plague is highly contagious, but, being rare (less than 3 per cent. of all cases), plays a very small part in spreading the disease; (2) bubonic plague in man is not infectious, and is entirely dependent on the disease in the rat; (3) the infection is conveyed from rat to rat, and from rat to man, solely by the rat flea; (4) a large majority of plague cases occur singly in houses, but when more than one case takes place in a room, the attacks are usually nearly simultaneous; (5) plague is usually conveyed from place to place by rat fleas brought by people in their baggage or on their person. Colonel Bannerman's interesting address was illustrated by many lantern slides showing the conditions under which the Indians are housed and the facilities they offer for invasion by rats, as well as photographs of the experimental station and the researches in progress. It was fully appreciated by the members, as was shown by the large attendance.

BELFAST.

ROYAL VICTORIA HOSPITAL.—The annual meeting of this hospital was held last week, the Bishop of Down, Connor and Dromore presiding. The report showed that the intern patients last year numbered 3,281, and the extern 29,433. The average number of beds occupied was 223. Dr. McKisack moved the adoption of the medical report, and referred to the great loss the hospital had sustained in the retirement from active duty of Dr. Nelson, so long the senior ophthalmic surgeon to the hospital.

SAMARITAN HOSPITAL.—The Lord Mayor presided over the annual meeting of this hospital last week, when Dr. Hicks read the medical report. This showed that 200 intern and 683 extern patients had been treated during the year, and 149 operations had been performed, with four deaths. Hitherto there has been a minimum fee of 10s. per week for intern patients, but the medical staff have now suggested that this is a prohibitive charge to many women of the working classes, and have asked the Board to arrange for a varying charge, to be fixed by the Ladies' Committee after inquiry into the circumstances of the case.

PUBLIC HEALTH.—The death-rate for the city still remains abnormally high, having been 26.9 last week. No less than 12.6 of this was due to chest affections, a figure 5.6 in excess of the normal. The zymotic rate was 2.6, chiefly from measles and whooping-cough. There are nine cases of typhus in Purdysburn Fever Hospital, and 30 contact cases in isolation at the Twin Islands. There are still 20 cases of cerebro-spinal meningitis in hospital.

LETTERS TO THE EDITOR.

THE REFERENDUM OF THE BRITISH MEDICAL ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of your correspondent who signs himself "An Obscure Practitioner" scarcely supports the claim for obscurity which he makes. His letter on the contrary indicates that he must be freely accustomed to ventilate his opinions upon the above subject. That being evidently the case he should therefore have had the courage of his convictions, and have appended his ordinary signature. Meanwhile I think that he is mistaken in the conclusions at which he has arrived. He points out that barely 2,000 members, out of a total of 20,000, took the trouble to record their votes upon the referendum; "it is amazing, it is deplorable, it is to me inexplicable," he says, "that this astonishing indifference should have been displayed." But the whole matter of the referendum had been thrashed out by the representative body, and agreed upon by the branches, and all that was wanted was to secure its official passing by the branches. This was easily accomplished as the voting has shown. To my mind the non-voters, by not taking part in the final act, merely showed their confidence in the promotion of the referendum. When it is common knowledge in the Association that Sir Victor Horsley was at the head of the reform movement ample reason exists for the apparent lethargy in voting, which has caused your correspondent so much surprise and regret. The smallness of the members voting does not indicate a want of interest in the matter concerned; it is only a proof that the great bulk of the Association was satisfied with the reforms which the referendum proposed to introduce. As a matter of fact this referendum will create a new era in the history of the Association—a new era which was badly needed. Among other things it will dispose of the family circle arrangement upon which the Council has for too many years been organised. Of course, the "old-timers" on the Council resent this effort to infuse new blood into the governing body of the Association. Many of them have doubtless come to regard the Council as a desirable club at which they can conveniently meet their friends, at the expense of the Association, for a chat. This may have been in Sir Victor Horsley's mind when he described the meetings of the *Journal* and *Finance* Committee as a "farce"—a statement so condemnatory as this could scarcely have been publicly made without ample proof to support it. The members of the Association, outside the majority of the Council, owe a debt of gratitude to Sir Victor Horsley and his coadjutors for having made so strenuous an effort to introduce reforms into the Association, on the lines of the referendum. Hitherto the members, not in office, have been regarded as mere cyphers, units without power or influence, puppets unworthy of notice—all this will now be changed—to the great benefit of the Association generally. I will follow your correspondent's lead, and sign myself,

Sir, yours truly,
Nil Desperandum.

SCIENCE, THE PEOPLE AND THE STATE.

To the Editor of The Medical Press and Circular.

Sir,—The study of your interesting paper by the non-medical scientific reader affords food for thought of many varieties; and to me nothing is more striking than the evidence you present almost weekly of the loss, and the danger to the State to which the present national neglect of science is giving rise. To minds below a certain standard science is, and must remain, a sealed book. Vast numbers of the common people—and by these I by no means imply the poor alone—have not the intellectual capacity to understand the meaning of a single scientific fact much less to follow, and appreciate a logical chain of reasoning composed of such facts. They are swayed entirely by transient emotions, or by the sufficiently long continued reiteration of any plausible statement. Placard the walls sufficiently with the statement that Dr. Bogus's pills will cure all diseases, or cry out with enough persistence that Free Trade, or Tariff Reform, or Socialism is the remedy for all disorders of the body politic, and the unreasoning crowd will adopt one or other of these panaceas, and swallow them in perfect faith. This is the frame of mind of the masses of the people, hence the dangers of democracy. Everything depends upon the leaders—upon their moral fibre and their mental training. If they are as ignorant of science as the crowd they sway, Heaven help the nation. At present probably more than one half of the men undergoing education for leading positions in the professional and political world are receiving no instruction whatever in science. There are, it is true, scientific "sides" at our public schools, but these are largely looked down upon by politicians and lawyers, and all save those destined for a scientific career. To many of these men when boys science was known under the designation of "stinks," and "stinks" it remains to them in after life, with a corresponding scorn of its professors. It is a fact to make one think when one sees in your pages an exposure of the attitude, say, of a distinguished lawyer towards medical science. Not infrequently you have shown us such a man who does not know, and scorns to learn what is meant by a disease; refuses to see that the true malady is not the superficial symptom by which it manifests itself, and cannot understand that suppression or mitigation of a nervous symptom by local narcosis or anæsthesia is no cure for concrete pathological tissue changes. This ignorance of physical science in general and of the bases of medical science in particular on the part of those who make, and those who administer, our laws lies at the bottom of the enormous development of the blatant quackery of the day—an atrocious evil, and by no means the least among the hurts inflicted upon the simple people through the incompetence of those to whom alone they can look for leadership and protection.

I am, Sir, yours truly,
A Science Teacher.

Birmingham, March 20th, 1908.

LAW FOR TRADERS AND LAW FOR QUACKS.

To the Editor of The Medical Press and Circular.

Sir,—In the *Times* of to-day is published the report of a case in which a London shopkeeper was summoned for selling a blouse as "Irish lace" which was, in fact, manufactured in France. The magistrate fined the defendant £20, with five guineas costs, and remarked that "if the defendant could not sell an article without telling falsehoods about it, he must drop its sale." Such is the law that regulates trade, and prevents false pretences of comparatively harmless kinds. On the other hand, there exists no law to interfere in any way with the traffic in quack medicines—a system of cruel and murderous fraud entirely founded on falsehood and deception. A tradesman may not sell French lace for Irish, but he may sell coloured lard as a cure for cancer, or coloured water as a cure for epilepsy, and in cunningly-worded advertisements may persuade ignorant and simple sufferers to put their trust in his worthless wares. That this state of things continues is entirely the fault of the profession. The case for medical law reform is overwhelming. It needs only to be stated authoritatively to compel the attention of statesmen and Parliament to make them recognise its urgency and devise without delay the legislation demanded.

I am, Sir, yours truly,
An Obscure Practitioner.

March 28th, 1908.

SANATORIA FOR PHTHISIS AMONG THE POORER CLASSES.

To the Editor of The Medical Press and Circular.

Sir,—In your issue of March 25th a report is given of the last meeting of the Edinburgh Medico-Chirurgical Society, and a large space is allowed to my paper on sanatoria. Whilst conscious that my paper was unworthy of such distinction as compared with the very able and original contributions of Mr. Alexis Thomson and Dr. Peel Ritchie, I was pleased that the subject which I was trying to bring before the profession thus received some prominence. You will excuse me if, in the interests of truth and my own credit, I ask permission to make a few corrections. I am reported to have said that the bacillus was "readily destroyed by air and sunlight," whereas it was only the latter which could be claimed as bactericidal. Again, I am reported to have stated that there were 10,000 beds available in Great Britain. I wish there were so many, for it would be an approach to the requirements of the case. At the time of my investigation there were only 1,084 as far as I could ascertain. Then I am reported to have said that in some sanatoria the cost per bed worked out at £300. The average cost of all the sanatoria open to the poor was about £350 per bed, and in some cases the capital expenditure reached the outrageous figure of £1,000 a bed. On the other hand some of the best institutions were built at or under £100 a bed, the test being (as it ought to be) the efficiency of the treatment. Lastly, the cost of the model sanatorium I showed the designs of was £100 a bed, and not £50, as stated by your reporter.

Permit me to say that there is no question more important than the financial one, if there is an appeal to be made on a national scale for the sanatorium treatment of early cases among the poorer classes. It is hopeless to expect either the charitable public, or the rating authorities, to build palatial structures where the poor would be ruined for the humble homes and faring of ordinary life. Efficiency is perfectly compatible with simplicity and economy.

I am, Sir, yours truly,
A. Walker.

Edinburgh, March 26th, 1908.

OBITUARY.

JOHN GABB, M.R.C.S., L.S.A.

We regret to record the death, which took place on March 26th, at Bewdley, of Dr. John Gabb, one of the oldest and best-known medical practitioners in Worcestershire, at the advanced age of 86. Dr. Gabb, who belonged to a Worcestershire family, was born in 1821 in the neighbourhood of Worcester. He had a distinguished medical course, being a gold medalist. He went to Bewdley in 1836, and was, subsequent to passing his final examination, in partnership for some years with his uncle, the late Dr. Cole. Since 1863 he practised alone, but for some years prior to his death he had retired from active work. He was a man of striking personality, and filled many public offices in Bewdley. He was by far the oldest magistrate, and till quite recently was a regular attendant at the police court. As a member of the Town Council for a prolonged period he rendered valuable services to the town; was several times elected an alderman; and filled the mayoral chair in 1863, and again in 1885-6 and 1886-7.

REVIEWS OF BOOKS.

TRANSACTIONS OF THE CLINICAL SOCIETY OF LONDON. (a)

It is with feelings of considerable regret that we start the review of this volume of the Clinical Society's Transactions, regret due to the fact that it is the last of the numbers to appear in its present guise. The Clinical Society, like most of the other London medical associations, has thought wise to merge its individuality in the Royal Medical Society, and henceforward it will consist of a section of that society, and its proceedings will be published along with the other records of the society. We trust that this change will in no way alter the character of the work that they have been doing, but will rather increase the usefulness and extend the limits of the association. We have long been accustomed to look upon their transactions as the most interesting of all the yearly publications which are especially devoted to internal medicine, containing, as they do, crisp accounts of the best clinical cases met with at the London hospitals during the year, and we would regard any great change in their character as a distinct loss to the medical profession. The volume now before us contains 34 papers, and 44 brief accounts of cases shown at the various meetings. Almost all of the records are of special interest, and well merit careful perusal, so that it is with difficulty that we can single out any of the papers for special notice. The Presidential Address by Dr. Clutton is devoted to an account of three cases of late rickets, followed by a brief discussion concerning the causes of and the treatment of the condition. The paper is illustrated by X-ray photographs, and is succeeded by a short paper on the same subject by Dr. Muirhead Little. Forsyth contributes an account of a fatal case of myxœdema, in which the parathyroid glands were found to contain an abundance of colloid material, due, the author believes, to a compensatory functional activity on their part. This paper adds further weight to the gradual store of evidence which is accumulating in favour of the parathyroids being merely accessory thyroids, instead of independent glands, with an independent function. Another interesting paper, from the pathological point of view, is the sequel to one on a case of "Juvenile General Paralysis of the Insane," reported by Dr. Lunn a year previously. The post-mortem examination by Dr. Gordon Holmes showed the existence of a chronic inflammatory process, and other changes which amply confirmed the diagnosis. Havilland Hall writes an interesting article on "Prolonged Pyrexia," and Langmead records four cases in children of tetany associated with dilatation of the large intestine. Numerous papers of surgical interest are included, amongst which the most striking is, perhaps, that of Moynihan on "Mimicry of Malignant Disease in the Large Intestine." On the whole, the present volume is as interesting and useful as its predecessors, and we advise all interested in clinical work to obtain it.

LABORATORY NOTES.

THE EUSTACE MILES FOODS.

We have received specimens of foods prepared by the Eustace Miles Restaurant Company, Limited, and have submitted the same to a careful examination. These foods purport to be both rich in nourishing constituents and easily digestible, and our experiments show that these claims are amply justified. We find the "Emprote" Proteid Food to contain a large amount of proteid matter (30 per cent.), and generally to be a most satisfactory preparation. The Eustace Miles Nourishing Cocoa likewise contains a much larger amount of protein matter than is to be found in ordinary cocoas—the actual percentage of protein as found by us being 27.9 per cent. This cocoa contains a satisfactorily small amount of moisture (4.7 per cent.) and 6.8 per cent. of mineral matter. The amount of matter soluble in water is very high, viz., 47.3 per cent., which is about 30 per cent. more than is normally found in cocoas. We feel sure that these foods will be very much appreciated by patients and also by those whose digestive faculties are below the normal.

Many of the Infants' Foods on the market are absolutely unsuitable for use owing to a deficiency of fat. The Eustace Miles Nourishing Food for Infants is very satisfactory in respect of this constituent, which it contains to the extent of 21 per cent.

GRAY'S GLYCERINE TONIC COMP.

Our analysis shows that this preparation contains 11.42 per cent. of alcohol (by volume) and about 45 per cent. of extractives. It is a judicious combination of glycerine, gentian, taraxacum, phosphoric acid, sherry and carminatives, which form a palatable and readily taken tonic. So far as we have tried it, it has no constipating action on the patient, while it stimulates the appetite and removes depression. It is said to have proved valuable in the treatment of pulmonary consumption, diabetes, marasmus, and other diseases associated with defective nutrition, but of this we have no knowledge. It has been found to give good results in nervous exhaustion, neurasthenia, general debility and bronchitis.

The tonic is made by the Purdue Frederick Company, of New York, and is to be obtained from Messrs. E. J. Reid and Co., of Dunedin House, London.

The Asylums Committee of the London County Council are recommending the Council to accept the offer made by Dr. Henry Maudsley to contribute £30,000 towards the cost of the erection and equipment in London of a hospital of 100 beds for the treatment of cases of recent and acute mental disorder.

(a) "Clinical Society's Transactions." Vol. XL. London: Longmans, Green and Co.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

Some Observations on the Use of Tobacco in Surgical Practice.—Bangs (*Med. Record,* March 14th, 1908) believes, and reports some surgical cases in support of the fact that the withdrawal of tobacco is sometimes followed by irritability and restlessness, and not infrequently by a vital depression not to be accounted for by the surgical state. In one case internal urethrotomy was performed on an otherwise healthy young man, æt. 26, who was an inveterate cigarette smoker. Everything went on well for six days. He was then persuaded by his mother to give up smoking. He spent a restless night. About 2 p.m. next day he became collapsed. His face was ashy and covered with clammy sweat. His respirations were shallow and laboured. His pulse was feeble and fluctuating. He had the appearance of someone suffering from extreme shock. There was no apparent reason for the condition. There was no hæmorrhage from the urethra, chill, nor rise of temperature. He had eaten a good breakfast. The author noticed the absence of the stumps of innumerable cigarettes which he had been accustomed to smoke all through his illness, and found he had not smoked since the previous morning. Brandy and water had little effect. A cigarette was placed in the patient's mouth and lit for him. He took a few feeble whiffs, inhaling each time, and then, as his respiration became stronger, he inhaled the smoke vigorously. In a few seconds his usual colour came back to his face, the sweating stopped, and his heart-beats became stronger and regular. This is all that was done for him, and his return to his normal condition was rapid. The author gives an account of two other similar experiences in highly neurotic patients who had suddenly stopped smoking after operations for hæmorrhoids and appendicitis. S

The Unbalanced Foot.—McKenzie (*Canada Journal of Med. and Surg.,* March, 1908) says that a lack of balance, so that the foot is not maintained directly under the body weight, is an important, if not the chief cause of discomfort and disability in walking. In the slighter cases balance may be restored by the use of properly constructed boots and braces. In young persons especially, education and development of the muscles is an important factor in treatment. Tendon transplantation to restore balance is indicated in infantile paralysis, as little can be done by art in the way of improving the condition of the muscles disabled This treatment is fairly satisfactory in its results. Excision of the ankle-joint in "flail foot" has proved itself a highly satisfactory method of treatment. Osteotomy is frequently necessary, especially after injuries of the leg near the ankle. The author also points out that a properly designed night brace is important to prevent deformity. In all cases the great essential is to place and maintain the foot evenly and directly under the body weight. S.

Modern Treatment of Surgical Tuberculosis.—Low (*Brit. Med. Journ.,* March 7th, 1908) summarises the treatment of surgical tuberculosis thus:—(1) In all cases open-air treatment should be organised to meet the circumstances and requirements of the case. (2) The patients' powers of resistance to the disease should be periodically measured by suitable blood examination. (3) When the resistance is found to be low, and there is no evidence of excessive auto-inoculation, use should be made of inoculation of Koch's new tuberculin, in doses that are accurately controlled, both as regards their amount and repetitions, by examination of the blood. (4) In patients in whom there is evidence of excessive auto-inoculation, absolute rest, with, in the case of a limb, absolute fixity of the diseased part, should be prescribed. (5) In cases of circumscribed tuberculosis, efforts should be directed to increase the circulation through the diseased area. (6) Operative procedures should be directed to the removal of the inert materials, whether caseous glands, carious bone, or collections of pus, and allowing the access to the infected area of healthy lymph. The necessary operations should be conducted with the most scrupulous asepsis. S.

Production of Pseudo-Arthrosis of the Hip without Disarticulation of the Head.—Jones (*Brit. Med. Journ.,* February 29th, 1908) points out that it is inexpedient to disarticulate the head of the femur in osteoarthritis with deformity, and also in ankylosis, on account of shock. After osteotomy to correct flexion, it is difficult to avoid union. Having tried osteotomy with interposing gold-foil and soft structure between the fragments to prevent re-union, the author finds that the following operation gives the best results. This consists in removing a slice of the great trochanter, chiselling through the neck, and sewing the separated portion of the great trochanter to the proximal end of the neck to ensure non-union of the fragments. The neck may be chiselled close to the head, or at a little distance from it, or the neck may be completely removed. The operation is not admissible in the case of children. It is performed as follows:—A longitudinal incision is made about 6 in. in length from the upper part of the trochanter to its centre. An incision is made across the base of the trochanter just below the insertion of the gluteal muscles. A slice of the trochanter from this point to its junction with the neck above is sawn or separated by a very wide osteotome and retracted upwards. The capsule is now opened, and the head separated from the neck with an osteotome. Extension is next put on the femur, and the trochanter, with its muscles attached, is screwed on to the head of the femur, which remains in the acetabulum. Deep and superficial sutures complete the operation. This operation is very suitable to those advancing in years. In bony ankylosis the femur is well supplied with muscles for useful movement, and no stitching of the capsule is necessary for the prevention of displacement upwards. S.

Report of a Case of Intussusception.—Hooper (*Canada Lancet,* February, 1908) reports the following case:—A child, 8 months old, had passed only a little blood and mucus per rectum for three days. The patient seemed to experience little pain, but was somewhat fretful. Its general appearance was fairly good. The abdomen was not tense, and palpation did not reveal any unusual condition. On examination per rectum a tube-like structure was felt in the sigmoid region. The abdomen was opened in the middle line. A crescentic-shaped tumour was found, with its lower extremity near the sigmoid flexure. The intussusception was of enteric type, and involved the jejunum in its upper part. The sheath slipped easily from its intussuscepted portion. The surfaces, though deeply congested, were free from adhesions. On reduction the distal portion of the bowel became immediately inflated with air. In spite of the easy reduction of the intussusception, the short time of the operation, and the good quality of the pulse after it, vomiting, which had commenced before the operation, continued, and became more frequent. General paresis of the bowel resulted in this case, and every effort failed to restore peristaltic activity. The child died in a few hours. S.

Finsen Light Treatment.—J. H. Sequeira (*Lancet,* March 7th) gives his experience of Finsen light work at the London Hospital for seven years. 791 cases of lupus vulgaris were treated. Of these, 71.6 per cent., or 429 cases, were cured. Some have been now

for nearly six years without treatment, and the disease shows no sign of recurrence. In cases where the lupus was very extensive and advanced, cures were not always obtainable. 107 cases were improved by this treatment; that is to say, while the disease is not cured, it has been stopped from spreading, if not considerably diminished in amount. In 23 cases the treatment failed entirely to do any good. In the remainder of the cases the treatment was abandoned for some other cause than failure. Lupus erythematosus did not yield so readily to this form of treatment. Of 68 patients treated, only 26 derived definite benefit from the action of the Finsen light; 14 cases of rodent ulcer were treated; some were improved, but the results were not very definite, and the author now treats all such cases by means of the X-rays, as this gives more certain results. Five cases of cutaneous nævi were treated; all showed improvement, but the treatment is so slow and tedious that it cannot be recommended except in the case of small nævi. A few cases of pigmented moles were treated, but all without success. One case of leucoderma was treated, but without any benefit. Several cases of alopecia areata were treated, but the benefit derived from the light reaction appeared to be no greater than that following treatment by the usual stimulants, cantharides, etc. Several cases of keloid were treated with considerable benefit. The results were not more striking than those seen after X-ray work, which has the advantages that there is no inflammatory reaction, and a much greater area of disease can be treated at the one time. Some X-ray scars were much improved by the Finsen light; the results seem to be better than those obtained by any other method of treatment.
G.

Carbolic Acid Gangrene.—J. Murphy (*Intercolonial Journ.*, January, 1908) records the case of a healthy man, æt. 25, who had crushed his fingers while at work seven days before. The fingers were very sensitive. A solution of carbolic acid, strength not known, was applied on lint, and the finger bandaged up. Soon after the fingers became somewhat numb. About 17 hours later the dressing was removed. The fingers then looked well, but were pale, and without sensation. Six days later, when the patient came under Mr. Murphy's care, the fingers were normal in size, cold, yellowish white and anæsthetic; they could move freely. Ten days later the colour became brown, and a definite line of demarcation began to appear, and a week later both gangrenous fingers were amputated. The digital arteries were normal in size, and spurted vigorously when cut across, showing that the blood supply of the fingers originally was very good. Gangrene of the extremities following the application of carbolic acid is not a very uncommon occurrence. Many cases are recorded of gangrene following the continued use of a 1 per cent. solution for 24 hours, a 2 per cent. solution of the acid in 12 hours, and stronger solutions in from three to four hours. The danger is not recognised by the patient, as the carbolic renders the part anæsthetic. Carbolic acid, even in weak solutions, must be looked on as a distinctly dangerous continuous local application to the extremities, more especially where their vitality has been previously lowered by injury or disease. G.

A Symptom of Movable Kidney.—J. Brena (*Lancet*, January 4th, 1908) calls attention to the following symptom, which he has found useful in the diagnosis of movable kidney. Persons habitually constipated, or who have to make great exertion on defæcation, when emptying or beginning to empty the bladder feel a sudden sharp pain, which stops the flow of urine and runs through the urinary passage with all the characteristics of a urinary colic. Instinctively the patient changes his position, rises from his seat, and puts his hand on the lower abdomen, pressing or rubbing the side affected, and the pain disappears as suddenly as it came on, micturition goes on, and everything proceeds in due course. The phenomenon appears to be due either to compression of the kidney, caused by the effort to evacuate the fæces, or to sudden obstruction of the ureter by excessive twisting or distension. G.

Migraine and Errors of Refraction.—A. R. Baker publishes, in the *Ophthalmic Record*, January, 1907, the results of having sent a circular letter to 100 patients who had suffered from migraine, and for whom he had ordered glasses. He asked three questions:—"How frequently did you have attacks of sick headache before you were fitted with glasses?" "How frequently have you had such attacks since you were fitted with glasses?" "Do you have a return of the headaches if you leave off the glasses?" The refraction of these patients had been estimated under a cycloplegic. In most cases the total error of refraction had been corrected. The answers received to the above questions went to show that 55 patients were cured and 31 much improved. The glasses had no effect on the remaining 14, but 5 were cured by tenotomy, 1 by wearing a pessary, and 8 were unrelieved. In answer to the third question, 89 patients said "Yes"; 85 of the hundred patients had astigmatism in one or both eyes. Of the 200 eyes examined, 134 were hypermetropic, 21 myopic, and 25 mixed. Astigmatism occurred in 85 of the 100 patients, and an oblique axis in 42. Baker was prompted to ascertain these facts on account of Posey and Spiller, in their "The Eye and Nervous System," having denied that the refraction of the eye played an important part in causing migraine. On the contrary, Baker maintains that the most frequent cause of migraine is eye-strain, due, as a rule, to astigmatism; that migraine need not necessarily disappear at 40 or 50 years of age, when accommodation commences to be limited; and that some cases of eye-strain which cause migraine may be of emmetropic refraction.
M.

MEDICAL NEWS IN BRIEF

The Royal College of Surgeons of Ireland and the Proposed New University.

The President and Council of the Royal College of Surgeons of Ireland have addressed a letter to the Chief Secretary for Ireland in which they point out the disastrous results which the establishment of a new and endowed medical school will have on the Medical School which is at present so successfully conducted by the College. The letter points out that if such a school is established "there will be in Ireland six schools, five of whch will be substantially endowed with public money, and one, our College School, will be without endowment. It is obvious that such hopelessly unfair competition must inevitably cause our School to close its doors, and the destruction of the School will at an early date entail the destruction of the College."

The letter then continues:—

"We seek no monopoly of medical education. We do not desire to hinder or delay educational proposals wished for by any body of our countrymen. We ask only that when such proposals are being carried into effect provision will be made to prevent the destruction of an ancient and distinguished College, the closing of a large and increasing school, and incidentally the beggaring of such of its professors as rely solely upon the income of their chairs for their livelihood.

"The most simple and effective safeguard would be an annual grant of an amount sufficient to permit us to maintain our College and its school in a state of efficiency. This sum we estimate at £5,000 per annum. But we have reason to believe that a direct grant may be withheld.

"We have, therefore, after anxious consideration, come to the conclusion that as an alternative solution, we would be willing that the precedent of London University should be adopted, and that our school should be made a 'constituent school' of the new University. Provision would then be made in the Bill that our school be placed *cæteris paribus* in the same position as the proposed School of Medicine with regard to equipment, endowment, scholarships, privileges, representation on Senate Examining Board, and the like.

"Our school would continue to educate candidates for our diplomas, as well as for degrees of the new University. It would remain under our management, but in so far as it was concerned with the education of University students, it would be subject to the supervision of the medical faculty and Senate of the new University."

We refer to this important subject again in our editorial columns.

Liverpool and Tuberculosis.

THE annual meeting of subscribers, donors, and friends of the Liverpool Hospital for Consumption and Diseases of the Chest, Mount Pleasant, and the Liverpool Sanatorium, Kingswood, Delamere Forest, was held on March 24th, in the Liverpool Town Hall, the Lord Mayor presiding.

Mr. Alfred Shawfield submitted the 44th annual report of the committee. A large measure of success has resulted from the sanatorium treatment where it has been undertaken for those in the primary stage of the disease. Preference in admission is given to applicants in that stage, and it is gratifying to have a late statement from the resident medical officer at Delamere that they have recently had an increased percentage of these primary cases. An important extension there during the past year has been the erection and equipment within the hospital grounds of a laboratory designed to undertake the most modern research. In their report for 1906 the hon. medical staff at Mount Pleasant referred to the measure of pathological work which they were already undertaking in an improvised laboratory which was then existing, and particularly in connection with what is known as the "Opsonic treatment for consumption." The laboratory is under the hon. superintendence of Dr. Henry Clarke, having under him a qualified assistant, Dr. C. E. P. Forsyth, who likewise fills the post of stipendiary to the hospital. In the main the committee are once more indebted to the liberality of their president, Mr. W. P. Hartley, for the pecuniary means of maintaining a qualified assistant in the laboratory, he having increased his annual subscription by £100 towards that specific end. The whole cost of the laboratory and equipment will be met out of special donations for that purpose, amounting to about £1,260, contributed by a few friends of the charity, so that no part of the cost will fall on its own capital funds. The year ended with a debit balance in maintenance account of £679 5s. 3d., and a credit balance in capital account of £68 6s. 11d.

Earlier in the day the Lord Mayor, accompanied by the Lady Mayoress, visited the Consumption Hospital in Mount Pleasant and opened the new laboratory which has been provided for research work and other very valuable purposes. The new premises are at the rear of the hospital.

Infant Life Protection.

THE report of the Select Committee appointed to inquire "and report as to the desirability of extending the provisions of the Infant Life Protection Act, 1897, to homes in which not more than one infant is kept in consideration of periodical payment," expresses the opinion that the body of facts laid before the committee by those who urge the extension of the Act was not displaced by any contrary evidence. Having regard to the serious amount of evil thus brought under their notice, the committee recommend that the provisions of the Infant Life Protection Act, 1897, should be extended to homes in which not more than one infant is kept in consideration of periodical payment. They are, however, of opinion that some of the objections urged by the witnesses against extension deserve serious consideration. The committee believes there are a large number of these one-child cases where the infant is received from motives of a real affection for children in general, or for some child or parent in particular. On a careful review of this aspect of the case the committee are of opinion that some power should be given to the local authority to exempt, on such terms and conditions as it may think fit, any particular home in their district from inspection, or to make arrangements for any such inspection to be made by a properly-constituted benevolent society, if the local authority are satisfied that the interests of the child will be safeguarded.

Prosecution of an Alleged Bogus Doctor.

At Dungannon last week a charge was preferred against a man named James Maguire, under the Medical Acts, 1858 and 1886, of having unlawfully pretended to be, and used the title of, Doctor of Medicine, thereby implying that he was a registered medical practitioner under those Acts. Mr. Meglaughlin, solicitor, prosecuted on behalf of the Medical Defence Union, and Mr. W. J. Reynolds, solicitor, represented the defendant. On the case being called, Mr. Reynolds raised the preliminary objection that the prosecution had been brought in the name of a solicitor's clerk, who had made a deposition in the matter, instead of by the General Medical Council. Mr. Meglaughlin contended that any person who had the necessary knowledge of the facts could bring the prosecution, and he quoted decisions in the English Court of Appeal in support of his argument. The magistrates, however, by nine votes to seven, decided in favour of Mr. Reynolds, and dismissed the charge without prejudice.

Medical Graduates' College and Polyclinic.

THE annual general meeting of the Medical Graduates' College and Polyclinic was held on Friday evening at 22, Chenies Street, Bloomsbury, Dr. C. Theodore Williams presiding. The ninth annual report, the adoption of which with the balance-sheet was moved by the chairman, stated that a large amount of work had been done during the year, and there was gratifying evidence of the fact that the polyclinic filled a very real want in the later education of the medical practitioner. As many as 1,127 cases of disease, many of them of extreme rarity and interest, had been shown, and the attendance of medical practitioners at the cliniques and lectures made a grand total of 13,862 for the year.

University College Hospital Needs.

AT the annual general meeting of University College Hospital, on March 27th, it was announced that an available ward, containing 24 beds, could not be opened for lack of means. This means that about 350 of the sick poor each year, many requiring immediate treatment, have to be refused admission. An additional annual expenditure of about £1,200 would be required to keep the ward open, and the committee have not felt justified, owing to the financial state of the charity, in incurring this further liability. The upkeep of the hospital involves £28,000, there being the charge of nearly 3,300 poor sick people in the wards and treatment of over 50,000 out-patients to be provided for. The committee again appeal to the benevolent for the endowment of cots and beds.

Trinity College, Dublin.

THE following candidates passed the Final Medical Examination (Surgery), Part II., during Hilary term, 1908:—William S. Thacker and John L. Phibbs (passed on high marks), Thomas P. Dowley, Alfred H. Smith.

The following passed the Intermediate Medical Examination, Part I.:—Herbert de L. Crawford, Douglas M. Moffat, Hugh R. M. Ferguson (Sch.), Arnold K. Henry, George F. C. Healy, Thomas A. Watson, John B. Burgess, Ernest W. G. Young, Thomas M. Crawford, Richard P. Pollard, Charles H. Denham, James Beckett, Cecil Grene.

The following passed the Final Examination in Medicine, Part II.:—Midwifery: James P. S. Dunn, Charles W. Laird, passed on high marks; David J. Miller, David G. Madill, Arthur H. Laird, Alexander K. Cosgrave, James F. Clarke, Norman P. Jewell, Edward J. H. Garstin, Richard J. Attridge, Frederick R. Sayers, John C. Baker, William H. L. M'Carthy, Alexander S. M. Winder.

Catholic University School of Medicine.

AT a meeting of the Board of Governors of the above institution, held on Friday, the 27th ult., the Chair of Medical Jurisprudence and Hygiene, vacated by the death of the late Professor Antony Roche, was filled by the appointment of Professor E. J. M'Weeney, M.D., D.P.H., F.R.C.P.I.

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial,* and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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The following reductions are made for a series:—Whole Page, 13 insertions, at £3 10s.; 26 at £3 3s.; 52 insertions at £3. Half Page, 13 insertions, at 35s.; 26 at 32s.; 52 at 30s. Quarter Page, 13, at 18s.; 26 at 16s.; 52 at 15s. Eighth Page, 13, at 9s.; 26 at 8s.; 52 at 7s. 6d.

Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Dr. R. S. (Birmingham).—A copy of this journal of the date referred to has been sent to Paris, as desired.

Mr. T. C. J. (Liverpool).—From your description of the case, we fear the result was unavoidable, but no useful purpose would be served by publication

Dr. B. H. S.—The law regarding medical practitioners in Queensland is pretty much the same as in other parts of Australia and in Great Britain. Registration is conducted by a duly appointed Medical Board. Dentists, however, are not affected by the Act in force. Fraudulent registration is punishable by imprisonment, and any person falsely pretending to be a medical practitioner is subject to a heavy penalty.

Meetings of the Societies, Lectures, &c.

Tuesday, March 31st.

Royal College of Physicians (Pall Mall East).—5 p.m.: Sir James Sawyer: Points of Practice in Maladies of the Heart. (Lumleian Lecture.)

Wednesday, April 1st.

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. C. O. Hawthorne: The Clinical Anatomy and Physiology of the Nervous System.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipman); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks).

Thursday, April 2nd.

North-East London Clinical Society (Prince of Wales's General Hospital, Tottenham, N.).—4.15 p.m.: Discussion: (1) Does Chloroform Administration tend to the Production of Post-partum Hæmorrhage (opened by Dr. Bowie); (2) Anæsthetics in General Practice (opened by Mr. H. Wallace).

Royal College of Physicians (Pall Mall East).—5 p.m.: Sir James Sawyer: Points of Practice in Maladies of the Heart. (Lumleian Lecture.)

Medical Graduates' College and Polyclinic (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. G. Barling (Birmingham): The Diagnosis and Treatment of Renal Mobility.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). 4.30 p.m.: Throat Operations (Mr. H. W. Carson).

Friday, April 3rd.

Royal Society of Medicine (Laryngological Section) (20, Hanover Square, W.).—5 p.m.: Cases and Specimens:—Dr. Jas. Donelan: (1) Case of marked Nasal Obstruction resulting from Neglected Adenoids; (2) Case of Nasal Obstruction with Deflected Septum. Dr. StClair Thomson: Two Radiographs illustrating Value of X-Rays in Sounding and Washing-out the Frontal Sinus. Dr. Scanes Spicer: Case of Intrinsic Neoplasm of Left Vocal Cord. Dr. Dundas Grant: (1) Case of Thyro-lingual Fistula treated by Electrolysis and Excision; (2) Case of Chronic Frontal Sinusitis treated by Irrigation.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8 p.m.: Clinical Meeting.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. W. Dodd: Clinique. (Eye.)

Appointments.

Cope, V. Zachary, M.D., B.S.Lond., Surgical Registrar to the London Temperance Hospital.

Edwards, Albert Davies, M.B., B.S.Lond., D.P.H.Edin., Assistant Medical Officer and Assistant Schools Medical Officer by the Newport (Mon.) Education Committee.

Giles, James A., M.B., B.S.Durh., Assistant Medical Officer of Health of the County Borough of Devonport.

Howard, Russell, M.S.Lond., F.R.C.S.Eng., Curator of the Museum of the London Hospital Medical College.

Lanyon, George Edward, M.B., C.M.Edin., Medical Officer of Health for the Falmouth and Truro Port Sanitary Authority.

Mill, G. Robertson, M.D.Edin., Honorary Anæsthetist to the Liverpool Dental Hospital.

Richmond, D. S., M.B., Ch.B.Glasg., Medical Officer and Vaccinator to the Parish of Dalry, Kirkcudbrightshire.

Vacancies.

Ayr District Asylum.—Junior Assistant Medical Officer. Salary, £120 per annum, with lodging and laundry. Applications to Dr. McRae, Glengall, Ayr.

Canterbury Borough Asylum, Canterbury.—Assistant Medical Officer. Salary, £140 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

Edinburgh District Asylum, Bangour Village.—Second Assistant Physician. Salary, £120 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Bangour Village, Uphall.

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, 18, Emmanuel Street, Cambridge.

York Dispensary.—Resident Medical Officer. Salary, £120 a year, with board, lodging, and attendance. Applications to W. Draper, Esq., De Grey House, York.

County Borough of Warrington.—Assistant Medical Officer of Health. Salary, £125 per annum, with board and residence. Applications to J. Lyon Whittle, Town Clerk.

London Fever Hospital, Liverpool Road, N.—Assistant Resident Medical Officer. Salary, £150 per annum, with residence and board. Applications to the Secretary, at the Hospital.

Borough of Cambridge.—Medical Officer of Health. Salary, £500 per annum. Applications to J. E. L. Whitehead, Town Clerk, Guildhall, Cambridge.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

Births.

Brown.—On March 26th, at 1, Bartholomew Road, London, the wife of Alexander Brown, M.B.Lond., M.R.C.S., of a daughter.

Marriages.

Dickson—McLaggan.—On March 25th, at St. John's Church, Buxton, Francis Henry Dickson, M.B., Ch.B.(Edin.), of Oxford, youngest son of the late Francis Kennedy Dickson, F.R.C.P. and F.R.C.S., J.P., to Margaret Sophia McLaggan, eldest daughter of the late Alexander McLaggan, of Bombay.

Taylor—Henderson.—On March 27th, at the Church of St. Edward, Lugano, William Macrae Taylor, M.B., C.M., F.R.C.S.E., of Edinburgh, eldest son of William Taylor, M.D., F.R.C.P.E., to Hermina Janet, only daughter of Robert Charles Henderson, Gentilino, Lugano, formerly of Leghorn, Italy.

Worthington—Peacock.—On March 24th, at St. James's Church, Muswell Hill, Oscar Clayton, M.R.C.S., L.R.C.P., second son of the late George Finch Jennings Worthington, M.R.C.S., M.R.C.P.I., to Lousia Jane, daughter of the late Joseph Charles Peacock.

Deaths.

Attfield.—On March 23rd, at San Remo, Italy, in his 42nd year, after suffering for five years from consumption and recently influenza, Donald Harvey Attfield, M.A., M.B., formerly Medical Officer of Health at Watford, and afterwards for several years Chief Maritime Medical Officer of Health for the Egyptian Government at Suez, son of Professor Attfield, F.R.S., of Watford. Friends please accept this the only intimation.

Chamberlain.—On March 22nd, at his residence, Twynham, Park Road, Bournemouth, Charles Basham d'Eyncourt Chamberlain, Surgeon, R.N., retired.

Emerson.—On March 22nd, at 21, Goldington Road, Bedford, David North Bomford Emerson, Esq., B.A., M.B., T.C.D., youngest son of the late John Emerson, of Deer Park, King's County, aged 43.

Gabb.—On March 26th, at Bewdley, John Gabb, J.P., M.R.C.S. Lond., L.R.C.P., etc., in his 87th year.

Lorimer.—On March 25th, at Nelson House, Nelson Street, Oxford Road, Manchester, George Lorimer, M.A., M.D.(Edin.), of Buxton, only son of the late Rev. Archibald Lorimer, of Cockenzie, N.B.

Worthington.—On March 25th, at 95, Beaconsfield Villas, Brighton, Thomas B. Worthington, M.D., late Medical Superintendent of the Hants County Asylum, eldest son of the late Thomas Worthington, Esq., Dublin.

MODERN THERAPY

Bacterial Vaccines

prepared in the Vaccine Laboratory of the Department for Therapeutical Inoculation, St. Mary's Hospital, London, W., under the supervision of the Director, Sir A. E. Wright, M.D., F.R.S., etc.

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Prepared from cultures of various strains of staphylococcus.

Applicable to the treatment of ordinary furunculosis, suppurating acne, staphylococcic sycosis and all other forms of staphylococcus infection.

Supplied in three dilutions, respectively containing 100, 200 and 500 millions of staphylococcus *per c.c.*

GONOCOCCUS VACCINE

Prepared from cultures of gonococcus.

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Supplied in a dilution containing 5 millions of gonococci *per c.c.*

STREPTOCOCCUS VACCINE

Prepared from cultures of streptococcus isolated from cases of erysipelas.

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Prepared from cultures of the typhoid bacillus.

Applicable only for preventive inoculation.

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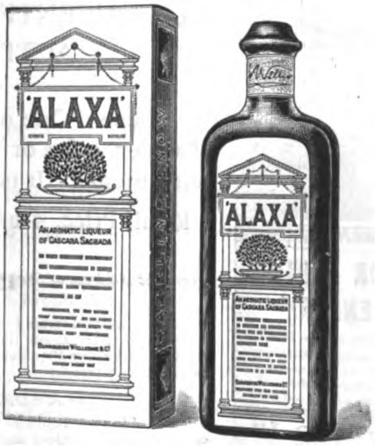

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, APRIL 8, 1908. No. 15.

NOTES AND COMMENTS.

The Casualties of Science. THE humane treatment of the wounded in industrial warfare has developed very rapidly in the last fifteen years, and the sweeping measure of compensation passed the year before last marks in a very practical way the growing sense of responsibility felt by the community towards those wounded in its peaceful service. Indeed, looking at the provisions of that Act, it is hardly possible to resist the conclusion that compensation for disability incurred by labour can stop short where it is at present left, and that the future will see the benefits it awards extended till sickness of every kind is included. However that may be, the person chiefly handicapped by having to provide for others is the small employer, who is struggling to make an honest living for himself and to lay aside something against his own misfortune and old age. The medical practitioner, who has no regular employer but is the servant of many, has no one to whom to look for help when laid aside by the casualties of his calling, and provision, if provision there is to be, has to be made out of his own scanty earnings. It certainly is encouraging, however, to see that the claims of scientific workers disabled by the accidents of their occupation, are receiving some public recognition. In the case of Dr. Hall-Edwards, who is suffering so grievously as the result of his ardour, not only has a sum of £1,000 been publicly subscribed, but a Civil List pension of £120 a year been granted to him by the Government. These sums are miserably small, doubtless, and they will, we hope, be substantially increased, but the very fact that public sympathy is aroused and is taking practical shape is a matter for great thankfulness.

American Recognition. A SIMILAR, and equally cogent, case for like consideration is put forward by the London Hospital authorities in the person of their own X-ray operator, Mr. Ernest Harnack, who, though not actually a medical man, has by his skill and knowledge brought his department to a very high state of efficiency. Mr. Harnack has undergone three serious operations in the last six months, two fingers and all the lymphatic glands of the left arm having been removed, as well as three fingers and part of the dorsum of the right hand. How far, if at all, the patient will ever be able to follow his occupation is doubtful, but his case is worthy of the most generous consideration at the hands of the public whom he has served so enthusiastically and with so much tangible benefit. It is worthy of note in this connection that the American Government granted a pension of £300 a year to the widow of Dr. Walter Reed, the organiser of the researches which demonstrated the part played by the mosquito in yellow fever, although Dr. Reed's death was not caused by his scientific work, and Bills are now before the United States Congress for conferring like pensions on the widows of Dr. J. W. Lazear and Dr. J. Carroll, who both lost their lives in experiments on the same subject. Inadequate, indeed, these sums seem compared with the pensions granted to ministers, judges, and civil servants, but we hope we are not mistaken in regarding them as the thin edge of the wedge. Scientific workers whose researches confer inestimable benefits on their fellow-creatures ought to be able to rely on their uncovenanted services being as handsomely rewarded as those of the hum-drum officials who enjoy large salaries during their active life.

Instructive Railway Accidents. A HIGHLY significant report has been issued by Colonel Yorke, the Board of Trade Inspector, on the railway accident which happened last January near Atherton, on the London and North-Western Railway. It appears from what is there set forth that a train containing passengers was being helped up an incline by an extra engine behind, the plan adopted being for this second engine to propel the train in front by a series of bumps. One of the bumps was carried out with such force that the train was partly derailed and one passenger and six company servants travelling as passengers were injured. The driver of the second engine died three weeks later of diabetes, and it came out on inquiry that the unfortunate man had suffered from the disease for a long time; in fact, that he was in a condition of debility and ill-health at the time of the accident, and in Colonel Yorke's opinion quite unfit to be in charge of an engine. "This case," adds the Inspector, "points to the desirability of more frequent medical examination of engine-drivers, especially after a man has been absent from duty for some months owing to a serious illness."

Their Prevention. WITH these wise words we fancy few will be found to disagree. We do not know what system of medical inspection the London and North-Western Railway imposes on their staff, but it is clear that it is not without loop-holes. The responsibilities of railway servants, especially engine-drivers, guards, and signalmen, are so great that only men in the pink of health and the pick of condition should be employed, and the only system by which the *desideratum* can be attained is by frequent and thorough medical examination. It is wonderful how few railway accidents do occur on British railways, but we cannot forget the terrible disasters which occur from time to time for which no cause can be found, and which can only be explained on the hypothesis that an engine-driver or signalman of many years' service suddenly forgot all that experience had taught him and behaved like a lunatic. Instances will occur to every reader. The only rational explanation for these occurrences is that the servant was ill, perhaps only temporarily, but sufficiently so to be unable to handle his lever, and not sufficiently to leave any post-mortem indications. In the case under notice the cause was abundantly apparent, and we have no doubt that disasters have over and over again been due to physical disability. It is the urgent duty to all railway companies not only to examine their employees systematically at short intervals, but to make it plain to the men that there will be no loss of wages for those on the sick-list through the orders of the Company's medical officers.

Tube Air.

Correspondence and comment has been going on of late with regard to a man who fainted in one of the "Tubes" the other day, and the purity of the air in these systems has been called in question, whilst statements showing the low percentage of carbon dioxide have been put forward triumphantly in refutation. One of the disputants has failed to be properly convinced by this demonstration, and he complains that he always has a sense of asphyxiation when travelling by tube, but modestly attributes his discomfort to "an over-active, and possibly morbid, imagination." We think he is laying undue blame on his mental endowment. While quite prepared to accept the statements made as to the low proportion of carbon dioxide, it is pertinent to point out that that constituent is only an indication of the quality of the air. It was a favourite argument in the days of steam-traction on the Metropolitan Railway that analysis of the air in the underground tunnels showed it to be as pure as that in the middle of Hyde Park, but the only result of such reasoning was to show people how very inadequate is chemical investigation for the purpose of gauging the purity of air. Tube air is, it may thankfully be admitted, an immense advance on the old Underground air, but that it is exceedingly vile is equally beyond question. Chemists and bacteriologists, and, let it be added, medical men, have yet to learn how to ventilate closed systems of rooms or tunnels, and even the plenum method seems so far to present but little attractions. Whatever analysis may show, the air on the front at Brighton is radically different from the air in a tube or any underground railway, and the problem before science is not to persuade people that they are the same, but to devise a method for making them so.

LEADING ARTICLES.

THE TITLE OF CHEMIST.

Now that the Poisons and Pharmacy Bill is again before Parliament, the question of the right of a limited company to use the word "chemists" as a designation of their business has been raised once more, and as the point is one involving important public issues, we make no apology for reverting to it. The matter has almost resolved itself into a duel between the Pharmaceutical Society and "Boots, Cash Chemists," but as we wish to discuss the principle involved, we hope to keep as clear of individual references as possible. The root of the discussion, from the point of view of medical men, is whether the public are as well served and as well protected by dealing with limited companies trading as chemists as if the business were conducted by a pharmacist himself. In the case of so-called "medical" and "dental" companies there can be, and never has been, any question. Both these methods of trading have proved to be of the most undesirable character, and when they have not been purely quack concerns, they have only engaged the services of men who have subordinated the professional to the trade element. The necessity, or the irresistible impulse, to act thus when a company's interest is concerned is universally recognised in medical circles, and the General Medical Council have very naturally ruled that it is infamous conduct in a professional respect for medical or dental practitioners to ally themselves with, or serve, such bodies. The calling of a medical man, if it is to be in the best and highest degree applied to the public benefit, compels individual and personal attendance on and attention to a patient, not with the primary idea of how large an account can be safely run up, but with the intention of restoring the patient to health with the greatest possible safety and ease. If it be argued that a company employing only qualified medical men would serve the public as well as, say, two or three medical men in partnership, the reply is, that the question is one of ideal and consequent method, and that whereas each of the medical men in a partnership is responsible solely and totally for his own acts, and that each is guided by professional opinion, in the case of a company medical treatment would inevitably degenerate rapidly into a method of money-making from which the spirit of Hippocrates would rapidly vanish. The profession would cease to be governed by high motives and generous feelings, and would be the instrument for earning money for a body of shareholders who sat at a distance and were guided only by a desire for dividends. It should thus be abundantly clear to legislators and to people generally that company-trading in medical services is obviously against the public interest, and we believe it is generally so accepted. How, then, does the chemist stand? Is he in the same position in this matter as the medical man? And must his calling equally deteriorate if he is "run" by a company? We are not prepared to say that the two callings stand on a precisely similar footing, but we have no hesitation in saying that the same argument does apply, perhaps not with the same undeniable force, but with little less cogency. A chemist, that is to say, of course, a retail pharmaceutical chemist, is, or should be, a great deal more than a mere purveyor of drugs. He is designed by his education, and by all the machinery to that end, to be the expert adviser of the medical man in matters affecting the dispensing of prescriptions, and there are few practitioners who have not had to thank pharmacists at some time or another for having saved them from committing inelegancies, or worse, in their mixtures. By virtue of his knowledge of drugs and dispensing the chemist acts as an extra check on the medical man, and is thus an additional safeguard to the public. The relationship—we had almost said the old-fashioned relationship—between the medical man and pharmacist is frequently of a co-operative character, each in his sphere working for the patient's good, and each adjusting his charges to the patient's financial position. Moreover, a chemist is himself personally responsible for the mixtures he prepares, and his error may be visited on him even by the criminal law; in fact, his own good conduct of his business is a matter of life and death to him. We are not now speaking of the abuses of their position which some chemists indulge in, but rather of the relationship to the public and to the profession which should exist, and, happily, does frequently exist, under a system of personal effort and personal responsibility; the relationship which the legislature would do well to foster by every means in its power. In the case of a trading company, even employing qualified chemists, no such relations are possible. The inducement to a company is to sell as many boxes of its own pills or as many bottles of its own "liver" mixture, and its own tooth-powders as possible, and to let the dispensing part of its business become ancillary to the quicker and more profitable trade. Indeed, the natural inducements to trade become so great that it is common knowledge that company "chemists" seek to extend their businesses by means of selling trinkets of all kinds, silver goods, Christmas presents, and even of establishing circulating libraries. In other words, it has been proved in practice what is on the face of it inevitable, that the lower, or trading, instinct is exalted, and the higher, or professional, instinct debased. The tendency of company-trading in the chemist's business is inevitably demoralising, and may, if extended, prove the ruin of good pharmacy.

CURRENT TOPICS.

Sir Henry Campbell-Bannerman.

Although it is not strictly our business, we cannot refrain from adding our voice to those of our contemporaries in rendering homage and sympathy to the distinguished sufferer who has just laid down the highest office a subject in this land can hold. We have used the word distinguished advisedly, for though Sir Henry Campbell-Bannerman himself would be the first to repudiate a comparison between himself and men of such brilliant parts as some of his immediate predecessors, it is not denied by political friends or political foes that he has been distinguished for having introduced into public life a new spirit in a new method. That spirit and that method are typical of all that is best in modern civilisation, the spirit of consideration for the feelings and opinions of others, and the method of ruling without cajolery or bullying. In no single person have these high and noble qualities been combined with such grace and in such pre-eminence as in Sir Henry, and the nation is proud to have been governed by a man who so clearly or emphatically sought not his own. In his sick-chamber it may be some comfort to him to know that what he has done for others is not forgotten, and that the warmest wishes go up from every corner of the land that his life may be spared and his health restored, so that he can enjoy the rest and leisure he has earned so faithfully and so well.

The Admission of Women to the Examinations of the Royal College of Surgeons.

The Council of the Royal College of Surgeons, England, have issued to each Fellow and member of the College, a reply post-card, requiring an answer, "yes" or no," to each of the two following questions:—"(1) In your opinion, is it desirable that women should be admitted by examination, as members of the College? (2) In your opinion, is it desirable that women, after admission to the membership, should be admitted, by examination, as Fellows of the College?" In conveying their request for replies to these queries, the Council point out that, although they have decided that it is desirable to admit women to examination for the diploma of member, and although they have power to act upon this opinion, they are nevertheless anxious, in accordance with a resolution passed at a meeting of the Council on May 9th, 1907, to obtain the views of the body corporate upon the subject Of course, it will first be conceded that the Council, in arriving at their decision, have only fallen into line with the other examining corporations in regard to the admission of women. There is, therefore, nothing very extraordinary in the step which it is proposed to take, nor can it be regarded as in any sense iconoclastic, so far as the College is concerned. Indeed, the wonder is, amid the glorious emancipation of women to which recent years have accustomed us, that the Council should only now have agreed to admit women to the examination for the diplomas which the College is empowered to confer. The fact that so far apparently women have been able to do without them, is rather an indication that the portals already available for women are sufficient to meet their requirements. It remains to be seen, therefore, what use they will make of this new accession to their avenues for qualification. Meanwhile there is little reason to doubt that the Fellows and members of the College will support the Council's decision—at all events, so far as the membership is concerned. With regard to the fellowship, some difference of opinion may possibly be expressed. Presumably, to a certain number of the body corporate it may seem rather a "large order," to use a hackneyed expression, to throw open to women the fellowship as well. And yet, after carefully considering the matter, we fail to see that any legitimate objection can be urged against this proposal if the membership be agreed to. On the contrary, there are substantial reasons why no restrictions should be placed upon women desirous of proceeding to the fellowship. For example, it would be very invidious to make any such distinction between the male and female diplomates, a distinction which neither common-sense, justice, nor fair dealing could endorse. We submit, therefore, that the examinational facilities of each should be the same, whether for the membership or the fellowship diploma. In this regard we are reminded of the old saying, "What man has done, man can do." It would, we believe, be only a short-sighted policy which would convert this saying into, "What man has done, woman is not allowed to do." This view of the matter, then, being self-evident, we shall be surprised if the *plébiscite* of the body corporate does not show an almost unanimous affirmation of the principle of the admission of women to the examinations for both the diplomas.

Consumption Treated on the Correspondence System.

The penny post is responsible for many things, some of them desirable, while others are of an obnoxious nature. It would be difficult for the wit of man to devise any more baneful system than that of medical consultation by post. The method, however, is clearly of advantage to the advertiser whose one dominating aim is to secure his patient's money at any cost. Some of these gentlemen go so far as to print a list of questions to be filled in by their victims and transmitted by post. As an illustration of the risks of such a proceeding, a more cogent example than that of consumption could hardly be taken. As every experienced medical man knows, it is often a matter demanding close and prolonged personal investigation and the exercise of the highest skill to determine the presence, the extent, and the progress of the tuberculous processes in any given case. To attempt to do so by post would be to undertake a task absolutely impossible to any human being with any due sense of moral responsibility. From an inquest held by Dr. Wynn Westcott at Poplar, on April 1st, it appears that "Dr. Alabone," who was struck off the *Register* some years ago, engages to treat consumption by correspondence. It was stated in evidence that a clergyman's wife wrote Alabone, who sent a form to be filled up by deceased, and subsequently sent medicine and pills. The fee for a month's treatment was one guinea. The Coroner pointed out that under the circumstances no valid death certificate could be procured. As a person who has had a medical training, Alabone must have known the impossibility of doing justice to the malady in question, even if its existence were ascertainable under the peculiar conditions in question, which is more than doubtful. It constitutes a standing reproach to our social system that any unregistered person should be entitled to play fast and loose with serious issues of life and death with the sole aim of acquiring money, regardless of the injury that may be thereby inflicted upon our weaker brethren. It is not a little curious, by the way, how often "a clergyman's wife" has a hand in the mischief.

Payments by Hospital Patients.

The evergreen subject of part payment by hospital patients was discussed last week at the United Kingdom Hospitals' Conference. It was introduced by the Hon Sydney Holland, who has always warmly advocated the principle involved, and has established it at the London Hospital. The motion brought forward by him and adopted by the Conference was to the effect that "where they can afford to do so, hospitial patients ought to be asked to pay for the food, medicines, and bandages supplied to them." There is, of course, something to be said on both sides of the question, and so far the balance of opinion amongst medical men has certainly not been in favour of the pay system. From the point of view of hospital boards, it is easy to understand how they would welcome what might be regarded as a legitimate source of revenue. The main question for the medical profession to decide is whether the interests of the general practitioner are likely to suffer by the creation of a form of commercial competition. So long as the payments exacted from patients are small and practically nominal probably no great hardship would be inflicted. It is only when fees approximating those payable to outside practitioners are demanded that the element of unfair competition is imported into the situation. There is some significance in the fact that although Mr. Sydney Holland's motion in favour of payment by hospital patients was adopted, it was well nigh unanimously condemned by all the medical speakers. We wonder how a resolution to the effect that, if patients pay, the medical men attending hospital patients should be paid for their services. At present medical philanthropy is freely exploited by the public and by the philanthropists, while the medical profession, both inside and outside the hospitals, is apt to receive scant consideration.

Viewing the Body.

In the House of Commons, on Friday of last week, the second reading was taken of a private member's Bill designed to do away with the practice of viewing the body by the jury at coroners' inquests. The chief clause runs as follows :—"From and after the passing of this Act it shall not be necessary for either coroner or jury at any inquest to view the body, unless the coroner, or, at the first sitting of the inquest, a majority of the jury, shall deem a view necessary"; so that, if passed, the Bill would only do away with the routine practice of viewing, but it would still leave the coroner and the jury discretion to inspect the body if they wished to do so. The reform designed is a slight one doubtless, but it is one of those constantly-recurring matters which there is a general demand for, like the Deceased Wife's Sister Act, and which should certainly be passed in the interest of the time of the House. The argument for the Bill is really one of sentiment, but it is a sentiment that is worthy of respect, and no person in his senses can consider that the perfunctory viewing which takes place at any inquest is of any value to anyone, provided the body has been identified satisfactorily by the relatives and a post-mortem has been made by a medical man. The opposition to the Bill was weak; in fact, it was only the professional obstructionist type of argument that was used against it, and Mr. Samuel accepted the second reading on behalf of the Government. In the course of his speech the Under-Secretary for Home Affairs stated that his chief had under consideration the advisability of appointing a committee to investigate the law relating to coroners' inquests, and though the points outlined for consideration—namely, the number of jurors, the methods of summons, and the holding of inquests in case of fire—are not of the most important, we may assure the Home Secretary that if his committee is also given power again to investigate the methods of death-certification, they will find ample and necessary work to do. Viewing the body in itself is a small matter, but the questions of death-certification and the conduct of coroners' courts are of grave moment to the community.

Dentists' Fees.

The case of Richardson *v.* Fremlin which created so much public interest and amusement last week is of a type which we fortunately do not hear much of, and which we are thankful to say there is seldom any necessity for. It is doubtless true that a medical man or a dentist is entitled as a private individual to fix his own charges, and equally so that there are certain people who never think they are getting good advice unless they are paying a very high price for it, but it remains the fact that there are certain understood limits to charges. A man who calls on a general practitioner at his house to consult him for indigestion knows that he will not be called upon to pay five guineas, and the same man knows that if he goes to Harley Street he will not be charged ten. Specialists' fees, are generally more fluid than those of physicians', but even the most fashionable specialists have recognised limits, beyond which, apart from special agreement, professional opinion would not support them. The jury in the case referred to seemed to take a middle course between the plaintiff's estimate of the value of his "body, bones, and blood," and the defendant's estimate of what he thought he ought to pay for the work—probably as convenient a solution as could be reached.

Open-Air Schools.

Signs are not wanting that the age of reason has at length dawned effectively upon the field of national education. The general recognition of the fact that to educate bodily defective children is to plough the sand, constitutes in itself a great advance in the science of a difficult social problem. When once that principle is admitted it must necessarily influence the whole trend of administrative education. In its broader issues it must lead sooner or later to a popular apprehension of the value of the child as an asset in the national commonwealth. In various parts of the kingdom this new gospel is being pushed to its logical conclusion in the shape of open-air schools. With the sanction of the Board of Education, Manchester has for some time past sent its poorer invalid children to the seaside in the summer. The Education Committee of the London County Council has recently made an important step in a similar direction. Two years ago a portion of the staff and children of the Homerton residential school for defective and deaf children were transfered for a month to Osen Island, Essex. The experiment was in every way a success, and the Special Sub-committee of the Council recommended that the visit should be applied to the whole of the children, residential and non-residential, and extended to a period of two months. The movement is thoroughly in touch with the humane and scientific modern tendencies, and is calculated to save the ratepayers the burden of supporting a number of broken-down individuals in later life.

The Control of Out-Patients.

Birmingham has made various attempts to deal with hospital abuses. The latest scheme was outlined by the Lord Mayor at the recent annual meeting of the Governors of the General Hospital of that town. It dealt with the reform of the medical administration and the relief of the pressure on the out-patient department of the institution. The Chairman stated that the special committee had decided to authorise the present medical and surgical staff to refer elsewhere trivial cases after giving first aid, and also to refer to general practitioners, clubs, dispensaries, or to the Poor-law authorities, chronic cases which did not require the treatment of the hospital staff. The surgical staff had been rearranged by the appointment of the casualty assistant surgeons as assistant surgeons, and it had been decided to appoint officers to deal with surgical casualty cases. Ultimately they hope to give effect to another arrangement by co-operating with other similar institutions, so as to regulate the treatment of the enormous number of out-patients. Over 60,000 out-patients are treated there annually, and there is no doubt that many are not really hospital cases, and ought to be treated by dispensaries or similar institutions. Mr. Neville Chamberlain reminded them that last year he characterised the out-patient department as the weakest part of the administration. Some definite steps are now being taken to check the inflow of trivial cases to that department. At present the scheme is only in its initial stages; but he believes they are on the eve of an important and far-reaching reform in medical administration. If the people can be induced to make small contributions, enabling them to claim medical relief as a right, and not as at present as a charity, they would, in Mr. Chamberlain's opinion, be making very real headway. The outcome of these efforts will be awaited with interest by the medical profession generally.

PERSONAL.

The Queen and the Empress Marie, on April 2nd, inspected the Alexandra Hospital for Children with Hip Disease, Queen Square, Bloomsbury.

Colonel Valentine Matthews, late R.A.M.C. (Vols.) has been made an honorary officer of the Ambulancia No. 3 (Madrid), Spanish Red Cross.

Professor Chrobak, the well-known Professor of Gynæcology and Obstetrics at Vienna, has resigned his appointment.

Sir Felix Semon, K.C.V.O., has been appointed British Government Representative at the International Laryngo-Rhinological Congress, to be held at Vienna this month.

The bungalow occupied by Dr. A. H. Wylie, Medical Superintendent of the Devon and Cornwall Sanatorium for Consumptives at Didsworthy, was destroyed by fire on March 15th.

Mr. Russell Howard, M.S., F.R.C.S., has been appointed Curator of the Museum at the London Hospital Medical College, in place of Mr. Arthur Keith, F.R.C.S.

Probate of the will of Mr. Edward Robert Bickersteth, F.R.C.S., of Rodney Street, Liverpool, and of Craig-y-Don, Anglesey, late Lecturer on Clinical Surgery to University College, Liverpool, son of the late Dr. Robert Bickersteth, of Liverpool, has been taken at £342,955.

A famous analyst has passed away by the decease of Dr. James Bell, late principal of Somerset House Laboratory, at the age of 82. For years Dr. Bell was chemical referee under the Sale of Food and Drugs Act. His work on "The Chemistry of Foods" has been long and widely known.

To-night the annual debate of the Hunterian Society will take place at the London Institution. Dr. Frederick Taylor will open the discussion, which is on the subject of "Rheumatism." Drs. Poynton, Horder and Luff have promised to take part.

The United Kingdom Hospital Conference took place on Wednesday and Thursday of last week, Mr. Charles Lupton, of the Leeds General Infirmary, presiding. The members of the Conference dined together on Wednesday evening, under the presidency of Mr. Cosmo Bonsor.

Dr. Stafford, Medical Commissioner of the Local Government Board of Ireland, and Mr. C. D. La Touche, have published an important report embodying the result of their researches into the social conditions and domestic economy of the working-class families in Dublin. We understand the report is a most valuable and interesting one, but, so far, no apparent attempt has been made to give it publicity.

A CLINICAL LECTURE
ON
THREE CASES OF "INOPERABLE" CANCER OF THE RECTUM.

By WILLIAM ALEXANDER, M.D., F.R.C.S.,

Senior Surgeon to the Liverpool Royal Southern and Workhouse Hospitals.

GENTLEMEN,—You have seen me operate upon two cases of so-called "inoperable" cancer of the rectum within the past few months, and the specimens removed, with their microscopic sections, are before you. The microscope shows that one is a specimen of adeno-carcinoma so often seen in this region, and the other a colloid carcinoma. Before I proceed with these modern cases with which you are all more or less acquainted, I wish to refer for a few minutes to a third inoperable case, and one that most of you will no doubt regard as a piece of ancient history—viz., the narrative of a case operated on by me on February 2nd, 1887. The case is reported in the *Liverpool Medico-Chirurgical Journal* for 1887, p. 235, from which I quote largely.

John G., æt. 42, a labourer, was admitted to the workhouse hospital on January 26th, 1887. The patient was very cachectic, and had lost flesh. A foul, fungating mass protruded from his rectum, and although the anus had escaped, the patient, on account of the extreme tenderness of the parts had to be anæsthetised before examination. Then it was found that my forefinger, pushed well up into the bowel, could just feel the upper edge of a cancerous mass that surrounded the lower four inches of the rectum. The case had been sent into the workhouse hospital as "inoperable" by the senior surgeon of a local hospital, who considered that colotomy was the only operation justifiable. The desperate plight of the poor fellow set me thinking, and the result was that I devised and performed the following operation on my patient, practising it several times on the dead subject before operating on the living.

Mode of Performing the Operation in 1887.—The patient, being anæsthetised, was placed in the lithotomy position in a good light, with his buttocks well raised and projecting over the edge of a hard pillow. The scrotum was held out of the way by an assistant, who was also prepared to pass a catheter into the bladder should the operator require it during the operation. The perineum was shaved and thoroughly cleansed with a solution of perchloride of mercury. The rectum, that had been well emptied before operation, was now plugged with cotton wool in order to prevent any outpouring of fæces or mucus during operation, and also to render the outline of the bowel more distinct. An incision was made in the middle line from the level of the exit of the fourth sacral nerve along the sacrum and coccyx up to within half an inch of the anal margin. From this point the knife was made to sweep round the anus. The lower two pieces of the sacrum and the entire coccyx were now cleared all round, the knife being applied closely to the bone during the process of denudation, and both the coccyx and the last two pieces of the sacrum were removed by the cutting bone forceps. By means of scissors the rectum was now detached from its surroundings, all bleeding points being promptly compressed. We were just able to reach healthy bowel without entering the peritoneal cavity. The diseased part was cut off after the proximal end of the bowel had been brought down and attached to the skin posteriorly, and afterwards as the sides of the wound were brought together, to the skin all round. The patient was carefully treated after operation by my house surgeon, now Dr. MacMurray, of Bootle, and convalesced satisfactorily.

I showed the patient, as well as the macroscopic and microscopic specimens of the growth removed at the Liverpool Medical Institution two months after operation, and in concluding my narrative of the case at that time I said:—

"I have not met with any case in my reading, as far as I remember, where this procedure is recommended or described. Mr. Cripps mentions removal of the coccyx to facilitate operation for rectal malformations in young children. In the *British Medical Journal*, March 19th, 1897, I read that a German surgeon had, with chisel, removed the left side of the sacrum before removal of the rectum, but this I did not know until some time after the operation. I do not know if the operation has been performed or recommended before, for my time for literary research is small; but whether it is a new operation or a revival, I can strongly recommend it to the profession. It is a formidable operation, and will require preparation on the surgeon's part to ensure its safe performance, but it is a remedy for the most formidable, most painful, and most disgusting disease that flesh is heir to. My first patient is, as yet, a standing testimony to its efficiency. How long he will remain so is a question that the future will settle, but he has already enjoyed two months' happiness and ease, and is almost certain of enjoying many more."

Well, gentlemen, time has completed for us the history of this case. The patient was again shown at the Liverpool Medical Institution ten years after operation. He was then working; the sphincterless rectum did not seem to give him any trouble. At any rate, he complained of none, and appeared to be quite satisfied with his condition. In January, 1908, I searched for him again, and found he had died on September 23rd, 1900, of broncho-pneumonia; duration of illness 14 days; so that he was really cured of his disease, and had his life prolonged for thirteen years, an excellent result of an operation on a case that was then looked upon as inoperable.

Such operations are now called by the name of Kraske, who first, in 1885, I believe, performed the operation of removing one side of the sacrum and all the coccyx and the sacro-sciatic ligaments on the left side so as to obtain access to the rectum. Many modifications of his operation have been made since, but they all, and mine included, are called Kraske's, and are performed in a great variety of ways, the sacrum and coccyx being often cut across but left attached by their ligaments, and then replaced after the operation is over. These modifications you will find in your text-books. I shall now describe to you what modifications I have found by experience to be most useful in my own operative practice.

In my first operation in 1887, I did not perform a preparatory inguinal colotomy. I have done this in both my other inoperable cases, and I generally do it now in all my "Kraske's." In 1887, colotomy, though a much safer operation than it had been, entailed some risks, and was not so absolutely safe as it is at the present time, and its performance was a somewhat serious additional risk. Now it is not so, and its performance is a distinct advantage. A colotomy diverts the fæces from their normal passage over the diseased mass. In consequence the diseased part shrinks in size, becomes less painful and more movable through the absence of irritation and the subsidence of inflammation. The strength, comfort and appearance of the patient consequently improve, often to a remarkable degree. In fact, many patients feel so much better that they prefer not to have any *further* operation. These are the ignorant and stupid patients, who, like the ostrich, hide their heads in the sand to avoid danger, and who will not look the stern facts in the face. In such cases, where the disease is very favourable for removal, I do without a colotomy, as I know I shall only have one opportunity given me; but in dealing with sensible people I always do a preparatory colotomy.

This temporary improvement after colotomy is a grand opportunity for preparing the patient to undergo the removal of the rectum. I generally allow a month or more to elapse between the colotomy and the excision. This gives the artificial anus time to get into good working order, and accustoms the patient to its presence, as well as allows him full opportunities to recuperate his health and strength.

I will now describe the method of removal of the rectum practised by me at the present time, and you will be able to compare it with that of twenty years ago. I only refer to cases where it is advisable to remove the anus with the diseased rectum. The patient is now generally placed on the *left side*, buttocks well elevated, and knees and hips well flexed. The skin covering the scrotum and anus is more thoroughly shaved and cleansed than in 1887, as the aseptic system has now displaced the antiseptic system then in vogue. Soap and water, ethereal soap, perchloride compresses are now more vigorously used. I now stitch up the anal opening closely and firmly with strong silk, leaving a loop of the silk free to enable me to pull upon and manipulate the bowel during the operation. The opening incision is the same, from the middle of the sacrum at the level of where it will be necessary to divide that bone right down to the anus when it sweeps right round the anal opening. The sacral and coccygeal bones are then denuded and removed as before, with the silk controlling the rectum in the left hand and scissors in the right, I snip through the muscles and fascia as they appear. An assistant on each side holds back the edges of the wound by retractors, and catches each vessel immediately it is seen either before or after it is cut. The peritoneum may be opened and the bowel followed up as far as necessary, and owing to the position of the patient the small intestines fall away and can be kept out of sight by sterilised gauze till all the diseased part has been freed all round from the healthy tissues. Then the proximal part of the healthy bowel is clamped, the diseased part cut away, and a Paul's tube tied in the proximal end of the bowel. The healthy bowel is then united high up with the edges of the cut peritoneum by fine silk, so as to shut off the peritoneal cavity from the wound, and the lower end of the bowel just above the tube is sutured to the skin by silk or silkworm-gut sutures. The sides of the enormous wound are allowed to fall together over strips of gauze that drain its depths. Few large wounds shrink so rapidly. A week makes a wonderful difference.

The inoperable case of 1887 would probably be looked upon to-day as quite operable by everyone, but my next two inoperable cases are modern, being operated on last year.

Case II.—F. H., æt. 53, a coachman.

History of Complaint.—In August, 1906, he was seized with violent diarrhœa for about ten days, having as many as 15 or 16 stools a day. This soon became reduced to 6 a day, a rate which continued unaltered for several months. About Christmas, 1906, he began to be troubled, in addition to diarrhœa, with a burning, gnawing pain in the rectum. This alarmed him more than the diarrhœa, and caused him to seek relief at a Liverpool hospital. He was there told that his disease was inoperable. His medical attendant gave him trypsin for about three months without any effect. In March, 1907, he went again to the same hospital, and was again told nothing could be done. In the meantime he was losing flesh and strength, had no appetite, the "diarrhœa" continued, the motions were composed mostly of mucus and blood, and the pain on each motion was now very severe, and at last he was unable to sit down on account of the agony it caused. His weight was now 11 st. 1 lb. instead of 14 st. 7 lb. before he was taken ill.

On July 29th, 1907, I saw the patient at the Royal Southern Hospital, heard his history, and advised his admittance in order to have a colotomy performed. This operation was done on July 30th, and the patient was left to recuperate until I returned from my holidays at the beginning of September. On my return he was much improved, was quite comfortable, the diarrhœa had disappeared, and the growths in the rectum appeared to be smaller and more movable. The operation for removal of the rectum that I have described was performed. The peritoneal cavity was opened, and a chain of affected glands which occupied the hollow of the sacrum behind the rectum had to be followed up to the promontory of the sacrum before I felt that they were all removed. This part of the operation required much patience and many ligatures, but no blood was lost. The peritoneum was now closed round healthy rectum that discharged its contents through the usual glass and rubber tube. The sides of the enormous wound fell together. A considerable amount of shock was experienced, but it soon passed away without any extraordinary remedies.

The patient left the hospital at the end of the year, having regained his normal weight, very happy and grateful, with the colotomy wound in good working order.

Case III.—The last case I will trouble you with just now is one where the prostate was affected and was removed entire, along with the diseased rectum. Such a case is by common consent deemed inoperable.

H. R., æt. 57, was admitted to the Royal Southern Hospital on October 8th, 1907, suffering from bleeding from the rectum and pain. Nine months ago the patient began to be troubled with pain in the rectum and a frequent desire to defæcate. He would be called to stool several times a day without passing anything except blood, and sometimes this passed in very large quantities. Patient sometimes has difficulty in passing water, and has to strain a long time before it comes. He sometimes passes no urine for 12 hours. No hæmaturia. Has been losing weight rapidly, and now feels very weak. On examination a hard, irregular mass encircled the lower three inches of the rectum. The anus, which was not involved, was attached rather firmly to the prostate in front; the prostate was enlarged. The case was considered to be inoperable except for a colotomy, but I reserved my decision until after that operation. Accordingly, on October 10th, 1907, a left inguinal colotomy was performed, and the fæces were completely diverted from their usual course. On December 12th, 1907, the patient had improved in the usual way. The rectum seemed more movable, and altogether the prospects seemed better. He was very anxious for radical cure, and there were no indications showing that the bladder was involved beyond the prostate. Conscious that we were operating upon a veritable inoperable case, but anxious notwithstanding to do something for the patient, we undertook the operation. The rectum was easily separated all round, but when we reached the neighbourhood of the prostate we could not find any line of separation between the rectum and that organ. We therefore snipped through the membranous urethra and removed the prostate along with the diseased rectum. Of course, a hole was made into the bladder, but this we stitched up as accurately as possible with numerous fine silk sutures, and a catheter was inserted into the bladder per urethram. The peritoneum did not require opening in this case. The rectum showed under the microscope colloid carcinoma, and the prostate malignant adenoma limited in extent and intracapsular, so that the adhesions to the rectum were the result of inflammatory action rather than extension of malignant disease from one organ to the other. The catheter, unfortunately, got out of the bladder during the first night after operation, and did not drain the bladder satisfactorily. Hence the formation of a small vesical fistula which partly closed of its own accord and required to be closed by plastic operations afterwards.

Gentlemen, I do not narrate these three cases to press you to operate on hopeless cases, but to impress upon you the seriousness of the decision that the surgeon has to make in declining to operate in any given case. The decision must be made from your knowledge of the extent of the disease, of the anatomical relations of the diseased and healthy structures, and the possibility of the separation of the diseased and healthy without so much hæmorrhage and shock as to threaten too seriously the life of the patient. The tenaciousness of the hold upon life and the vitality of the patient must be taken into account, as well as the healthiness of the system generally, so that it will not do to take shelter under an opinion taken from a text-book. The text-books resemble posts fixed in a stream, which are soon left far behind by the traffic of the river. So the opinions of our text-books are always those of the past, and the past is soon left behind in the rapid progress of surgery. But our books cannot tell us anything about the circumstances in which our individual cases are at the time that we have to decide the question of life and death in regard to them. Every such decision that we make is a new and original one. The first thing that we should try to ascertain is the bearing of the operation on the welfare of the patient. If we may reasonably hope to prolong life by an operation, then no trouble that we can take and nothing that we can do should be grudged to attain that end. The second question is the effect on the surgeon. No doubt the patient described in Case I. was very grateful to me, and all who knew of it congratulated me on the success, and to be the instrument of conferring twelve or thirteen years of life on a fellow-creature is an honour that is not often earned so clearly as in this case; but the results of such an honour are not entirely advantageous, Patients form the opinion that operations on extreme cases are your speciality, and you will be consulted by all the hopeless cases who have neglected themselves, and who are grievously disappointed when you tell them that nothing can be done A colotomy relieves even these, but they are not content with that. They find the supernatural powers they had ascribed to you did not exist, and vent their disappointment upon your character.

In all these serious operations you cannot be too explicit, both to the patient and especially to the friends, as to the prospects of the operation. It should only be undertaken, not only with their complete approval, but at their express desire.

Leaving these ethical matters, which are all-important in regard to your career as operating surgeons, I have one or two remarks to make about the operation.

First, by removal of the sacrum and the coccyx in the way described above, ample room is obtained for removal of the diseased rectum and glands with the least possible disturbance of the contents of the abdomen. The complete removal of the diseased structures should be the primary object of the attention of the surgeon. When this is finished the parts that are left can be attended to.

Second, the simple inguinal colotomy is of great advantage. It prepares the patient both locally and constitutionally for the more serious operation, promotes all important conditions of asepsis during and after operating, and most patients in my practice prefer to utilise the colotomy opening ever after as being more convenient and more controllable than the new sacral opening.

These inoperable cases will probably become less and less frequent in the future. The wider spread of diagnostic acumen will do much. The presence of diarrhœa as a clue to the narrowing of the bowel by cancer should not be forgotten. Piles, it should be remembered, are not the only source of bleeding from the rectum. In all cases digital examination should be made, so that the mistake of treating a cancer of the rectum for a year as troublesome piles should not be made. It will be made again and again unless routine examinations become the rule.

Cancer of the rectum is in my experience the least malignant of all the cancers. Its invasion of the bowel is slow and limited. Its tendency to glandular affection is not great, and is nearly always local.

I have not been able, for want of time, to trace my cases, but I know that the one recorded lived thirteen years after. Only the other day I found the address of a case operated in 1899, and learned that she was free from recurrence after nine years. Another patient died from inter-current disease three years after operation with the rectum quite sound, and all my cases had considerable relief allowed before recurrence took place. So that there is every encouragement to use our efforts in this terrible disease.

Remember that early operation is preferable to heroic operations, but these three cases show what can be done, even in neglected cases.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by J. Teissier, M.D., Professor of Clinical Medicine in the University of Lyons. Subject: "The Clinical Varieties of Chronic Rheumatism."*

LUMLEIAN LECTURES.

POINTS OF PRACTICE IN
MALADIES OF THE HEART. (*a*)

BY SIR JAMES SAWYER, M.D., F.R.C.P.LOND.,

Senior Consulting Physician, Queen's Hospital, Birmingham, &c.

LECTURE II.

MALADIES of the heart illustrate the truth that nothing in Nature is presented to us in an abstract form. While each of the four chief and well-known methods of physical examination is commonly employed by us in our examinations of the heart in practice, it would seem that those methods, in the hands of most of us, stand usually in order as to the time of their use as, first, inspection, then palpation, then auscultation, lastly, percussion. Inspection is a method by which errors of mal-observation are minimised, and errors of non-observation practically excluded. For the full use of inspection in these affections, a good light, as always, is needed, and the surfaces to be examined must be quite bared. In systematic inspection of the front of the chest, comparing the front surfaces of the two sides by sight, point by point, from every aspect, as to their size, shape, and outline, it is found that the two sides are always identically proportional in every part, in chests perfectly normal. As Walshe said, it is found that, "in perfectly normal chests the part of the walls lying to the left of the middle line, and corresponding to the heart, does not differ perceptibly in form from that placed to its right; these two divisions of the thorax are symmetrical." (*b*) In some circumstances, though very rarely, this complete bilateral symmetry may be deviated from, either as a slight præcordial excess of convexity, or even of depression, without there being proof of past or present disease of the heart. In by far the most of persons who are sound and healthy as to the heart, the impulse of the organ in its natural position is to be seen. "This spot, where the impulse is greatest, is," as Dr. Augustus Waller has reminded us, "often termed the 'apex-beat'—a misleading expression, for the true apex of the heart lies much deeper; a needle plunged through the spot of maximum impulse would pierce the left ventricle at the junction of the middle with the lower third. The cardiac impulse is not produced by the heart's tilting itself so as to strike the chest-wall; it is due to the sudden hardening and tension of the contracting ventricles, and the spot of impulse, or so-called 'apex-beat,' is simply the spot where the convex ventricular mass comes in contact with the chest-wall." (*c*) It would be more exact, in our present knowledge, to speak of impulse-beat and impulse-point than of apex-beat, and some such better diction is taking the place of the older words. Undoubtedly the systolic bulging of the ventricles is most manifest a little higher than the true apex of the heart. This bulging, in its pressure towards the anterior wall of the chest, is the main part of the impulse.

Our inspection, in an extended sense of the word, and in one especial to medicine, regards the

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(*a*) Abstract of Second Lecture delivered before the Royal College of Physicians, London, March 31st, 1908.

(*b*) "A Practical Treatise on Diseases of the Heart and Great Vessels." By W. H. Walshe, M.D., F.R.C.P., &c. London. 1873.

(*c*) "Human Physiology." By Augustus Waller, M.D., F.R.S. London. 1893.

physiognomy of disease. It regards the characteristic appearance of the patient in particular maladies, which appearance is made up of various combinations of many constituent factors, such as size, shape, colour, and movement of parts, attitude, aspect, gestures, and so on. In many heart maladies this physiognomy is characteristic. Cardiac distress has its own form of orthopnœa, recognisable at sight, and also its Cheyne-Stokes respiration. The latter, previously noted by Cheyne, was described vividly by Stokes, with the pencil of a master, in a couple of sentences. "It consists," he wrote, "in the occurrence of a series of inspirations, increasing to a maximum, and then declining in force and length, until a state of apparent apnœa is established. In this condition the patient may remain for such a length of time as to make his attendants believe that he is dead, when a low inspiration, followed by one more decided, marks the commencement of a new ascending and then descending series of inspirations." (*a*) This striking and serious disturbance of the respiratory rhythm is found in the later stages of various forms of organic disease of the heart. It is not pathognomonic of any of these forms; certainly not of fatty degeneration, of which it was at one time held to be characteristic. It is found, too, in some cases of renal disease, sometimes of uræmic intoxication, sometimes in cerebral disease, and sometimes in tubercular meningitis. The central characteristic of Cheyne-Stokes breathing is a period of apnœa. Serious, as to the duration of life, as is the prognostic import of the appearance of this kind of disturbance of respiration, there is even an aspect of a compensatory and quasi-conservative kind in the long respiratory pause, in this waiting, as it were, of the breathing, until the feeble beats of a labouring heart can overtake it. The exact pathology of Cheyne-Stokes respiration has not been made out. Whatever may be the pathological explanation of this ominous perversion of breathing in cases other than those of failing hearts, when this respiratory trouble occurs in heart disease it may have an especial pathological basis. Perhaps it may not be too fanciful to think that, in this and in other morbidities of the heart, and in its health, too, the cardiac ganglia, with their "grey matter," may be the local centres of a kind of sub-conscious intelligence, by which some nerve-transmitted power is distributed, by the quasi-intelligent action of these little local brains, according to the circulatory needs of the moment. Perhaps we may think it likely, reasoning by physiological analogy, that, just as the depressor nerve bears from the heart an influence which passes through the medulla oblongata and causes reflex inhibition of vaso-constriction, so that blood pressure falls to suit the action of the left ventricle, so we may surmise that there may be a like communication between the heart and the respiratory centre, through which the breathing may be slowed down upon occasion, in correspondence with failing systoles; and so the apnœa becomes the physiological consequence of a syncopal stasis of the pulmonary circuit.

From a study of Cheyne-Stokes breathing I devised, some years ago, a clinical test which has been useful in practice. If we place a watch upon the front of the chest, over the middle of the sternum, of a healthy adult, who is lying upon his back, and tell him to hold his breath as long as he can easily do so, and if we time the breathing pause he makes by our watch upon his chest, we find that he will hold his breath for a quarter, or, perhaps, for a third of a minute. Sometimes in the case of a sufferer from a chronic disease of the heart in which there is a feebleness of ventricular contraction, and in which the patient is resting in bed, it will be found that the patient can hold his breath for a much longer time than a healthy person can, and that he will hold it for half a minute, a minute, or longer, and this even if his breathing be hurried by cardiac dyspnœa. This clinical fact seems explicable in the same way as was the respiratory pause in Cheyne-Stokes respiration. It appears that weak systoles of the right ventricle lengthen the time during which the breath can be held, because they permit such arrest when the blood tension in the pulmonary circuit is subnormal; such tension as compels inspiration is longer in being reached than when the heart is healthy. In cases of degenerative mural disease this test is useful; its use from time to time gives a valuable prognostic. This is not discoverable in every case of cardiac dyspnœa; but it is found from case to case, especially in cases of fatty heart, and also, perhaps, in chronic valvular disease, when compensation is failing. It seems to be a change which is allied to Cheyne-Stokes respiration, to be a lesser degree of that abnormality, evoked by a voluntary stoppage of breathing. I think it will be found upon further examination of this test in practice that in those cases in which the breath can be held longer than in health there is no blocking, or but little, of the pulmonary circuit.

We recognise a physiognomy of general cardiac suffering, apart from dyspnœa and apart from local pain, as the mark of a late stage of several forms of failure of the heart, when the malady nears a fatal ending. It is a peculiar unrest and distress, of regard, of face, of attitude, and of manner, with painful and frequent shiftings of posture. It is a physiognomy which mutely shows the obsession of a mighty dread, of a cardiac consciousness heaped up to the anguish of

"Impending horrors threatening hideous fall,"

in which there is added to the wakefulness of restlessness an imminent fear of death and even a sense of dying, with a determination to keep awake because going to sleep appears so like going to die. There is the torture of trying to keep awake to keep alive. This is a characteristic pervigilium, always of mortal purport.

By palpation we appreciate palpitation, cardiac thrills, and pericardial rubs, and examine the position, character, and extent of the heart's impulse. The push, the screwing swing, and the drop, which make up the recurring stroke of the impulse beat, are factors of that beat which our tactus eruditus may be unable to separate, for they happen together, in the same part, at the same time. But they are movements which the skilled touch appreciates, without differentiating them, in their various morbid combinations, in the differences of this impulse in disease. They are movements which make up the well-known characteristics of the healthy beat as felt by the hand, its mixed impulsive and gliding qualities, smooth, rather waving, decisive, unhasty, brief. It is impossible to describe the "feel" of the normal impulse beat; that is an experience which can only be learned in medical practice. We accept the systolic synchronism of the impulse; there is no question about it now. Synchronously with the beginning of the first sound of the heart, and synchronously with the systoles of the ventricles, the shock of the heart strikes the side of the chest. In most healthy people the impulse can be felt by palpation in the same place where is seen the visible impulse. In stout, broad-chested people no impulse may be palpable; in such the absence of it is not of itself a morbid sign. Some passions of the mind, chiefly fear, exaggerate the force of the impulse beat and widen the space over which it can be felt, and even give it somewhat of a heaving quality; what is called nervousness does the same, to less degrees. In few words the more usual of the teachings of cardiac palpation may be summed up. In adynamic diseases the impulse is weakened, and it is also weakened, or not palpable at all, when a pad of emphysematous lung covers it. The force and area of the impulse are increased when the heart is hypertrophied, and then the impulse point is variously displaced. Dilatation of one or of both ventricles, fatty change of the heart's walls or fatty loading of them, and pericardial effusions, may each lessen the force of the impulse beat, even to impalpability. Valvular thrill, the *frémissement cataire* of Corvisart and of Laennec, at first thought to mark mitral disease, is now known to be an occasional sign in any of the four valvular diseases of the left side of the heart. It seems to need for its origin a rippling current of blood, in forcible motion. In such conditions, perhaps some degree of spanæmia favours its production; a slighter thrill, but one distinguishable easily from the true valvular thrill, is observable in some cases of spanæmia alone. True

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(*a*) "The Diseases of the Heart and Aorta." By William Stokes, &c. Dublin. 1854. P. 324.

valvular thrill always shows forth structural valvular disease. There are no statistics published as to the proportions of the frequency of valvular thrill with any of the valvular defects which it may accompany; but it seems to occur oftenest with mitral stenosis, next with aortic obstruction, next with mitral insufficiency, and least often in aortic incompetence. Valvular thrill marks valvular disease of old standing. It is one of the signs by which we discover the effects of an endocarditis of some time ago. My experience agrees with that of Walshe, who never found acute endocarditis to be attended with valvular thrill when there was certainty of the absence of old valvular disease. Later experience does not support his conclusion that "it has never been shown that nervous excitement of the heart, pure and uncomplicated, will produce thrill in people whose blood is healthy." (*a*) It is true that valvular thrill never arises as a neurotism, and that it is always a mark of valvular deformity; but there is a thrill of a softer kind which is certainly only a neurotism. A gentle, systolic thrill, somewhat tickling in quality, is palpable in some cases sometimes, when a palm is pressed over the impulse beat in nervous palpitation. Such palpitation has sometimes its own bellows sound, the *bruit de consultation* of some later French writers. One might call this thrill the *frémissement de consultation.* I think it comes and goes with the bruit, and the bruit comes and goes in half a dozen beats, perhaps in fewer: no bruit; no *frémissement.*

The College is fully aware of all the developments and refinements of cardiac auscultation which have been evolved, by the labours of many workers, since the time, now ninety years ago, when Laennec announced his discovery of mediate auscultation to the Académie des Sciences, in Paris, in the year 1818. As to diseases of the heart, Laennec declared, and, as we know, rightly, that he had discovered a "set of new signs," which were, as he called them, "certain, simple, and prominent," and such as would render the diagnosis of those diseases, to quote his words, "as decided and circumstantial as the indications furnished to the surgeon by the introduction of the finger or sound in the complaints wherein these are used." (*b*) Since that time many physicians, amongst the chief of whom have been not a few of this ancient foundation, have worked in medical practice with the stethoscope, and have traced, distinguished, and named every acoustic quality and characteristic, of the various audibilities which the play of the heart can yield in health or in disorder, of every sound which the human ear can appreciate, and of those which make manifest the origin, onset, and course of every variety of cardiac malady. Every sound of all these which our hearing can distinguish has been recognised, and has been traced to its pathological origin, to its diagnostic significance, and to its remedial indications. No other area of work within the science and art of medicine can show a progress more decisive, or knowledge more complete in its fulness, more illuminating in its clearness, in its import in our practice more significant or more helpful. This great mass of achievement, begun by Laennec, and developed by him wonderfully far from the immediate auscultation which was practised before his time, has grown and grows still, by slow experience and by the labours of many workers. Our hearing, and our sight, are our chief senses of inquisition. To our ear the examination of the heart has been opened fully.

We know the numerous modifications of Laennec's stethoscope which have been brought into use since his day, and which have been regarded often as steps in the evolution of his instrument towards perfection. In several particulars, real advances in the structure, shape and form of the stethoscope have been made. Of course, the stethoscope does not magnify cardiac sounds; it only brings them within our ken. It elongates; so to speak, our ears, gives them a medium of distant contact, and circumscribes and concentrates our hearing. For several years last past I have worked with a solid wooden stethoscope, modified in several particulars after many experiments, and I find such a one the best for auscultation, at the least, for cardiac auscultation. Acoustics, as well as practice, supports such a preference. I venture, in a very few words, to recall to my learned auditory the principles of the science of sounds which support my conclusion. The "points" of this stethoscope are: it is made of wood, of cedar wood; it is in one piece; it is about 15 ins. in length; it has an aural end of the usual shape and size; the chest end is accurately rounded to a hemisphere, with the base of the hemisphere three-quarters of an inch in diameter; the stem is tapered evenly from the chest end to a diameter of three-eighths of an inch, where it passes into the flat aural end; it is smooth but unpolished, so that it is relatively soft and warm to touch. (*a*) As to the comparative advantages, as a medium of transmission of sonorous vibrations to the ear, of a stethoscope in which the shaft is a hollow tube and of one in which the shaft is solid, it may be concluded with certainty that the teachings derivable from the principles of acoustics would lead to preference of the solid instrument. Although it has become customary to use a hollow tube in all auscultation, this subject of the comparative values of solid and tubular instruments was one of friendly scientific controversy early in the history of stethoscopy. The merits of this dispute were summed up ably by Peyton Blakiston, a Fellow of this College, in 1848, who found theory and trial alike in favour of a quite solid stethoscope. He described a simple form of such instrument of his own arrangement, and he was able to state, as he did in the remarkable chapter on the practice of auscultation in his book on diseases of the chest, that Dr. Watson, afterwards Sir Thomas Watson, whom some of us are so happy as to remember in the College, "one of the most accomplished and skilful physicians of the age," had "made use of this kind of instrument," namely, the solid stethoscope, "in preference to any other, for some years past." (*b*) Again, to take in testimony the words of a master, C. J. B. Williams, a pupil of Laennec, and himself the greatest and earliest authority on auscultation in England, and an ornament of this College, writing in 1835, in the classic Cyclopædia of Forbes, Tweedie, and Conolly, pronounced that, "it might be well for the attainment of greater accuracy in physical diagnosis . . . if auscultators would use," instead of one stethoscope for every use of the instrument, "a solid cylinder of wood for the auscultation of the heart." The science of acoustics teaches that audible vibrations are conducted farthest and with least loss of intensity, firstly, through solids, next through liquids, and least well through a gas, or through a mixture of gases.

If we compare a solid with a tubular stethoscope in practice, we can hear sounds in auscultation well with the tubular one, there being enough of solidity in its walls for a fairly good conduction of the sounds: but the pitch of the sound is higher, and so more striking to the ear, when heard through the solid one. The solid stethoscope brings out well the soft, short, low-pitched puffs of the systolic bellows sounds which mark one of the kinds of neurotic disturbance of the heart. The chest end of such a stethoscope cleanses well. A long and rigid stethoscope, 15 in. in length, has some administrative advantages in practice; one of that length is not too long for auscultatory percussion, and it is long enough to facilitate the use of that aid to diagnosis. As to the shape of the chest end, it is best rounded to the form of half a sphere. A smooth hemisphere, and one not too small, made of a kind of wood which is not too hard, as cedar, gives the shape and the material which allow of comparatively greater pressure upon the part to which the smaller end of the instrument is applied in its use, without the least discomfort to the patient, and so, one would think, of the transmission to our ear of

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(*a*) "A Practical Treatise on Diseases of the Heart, &c." 1873.

(*b*) "A Treatise on the Diseases of the Chest and on Mediate Auscultation." By R. T H. Laennec, M.D., &c. Translated by John Forbes, M.D., &c. Third Edition. London. 1829.

(*a*) Messrs. Cuxson, Gerrard & Co., medical instrument makers, of Corporation Street, Birmingham, have followed with much care my directions as to the making of a stethoscope of this description, and have produced one which is satisfactory in its use, and which I find yields improved auscultatory results in auscultation of the heart.

(*b*) "Practical Observations on Certain Diseases of the Chest and on the Principles of Auscultation." By Peyton Blakiston, M.D., F.R.S., F.R.C.P. London. 1848.

the sonorous vibrations we seek with the least loss of them in their convection. When a stethoscope is in use, comfort should be found at each end of it. There is another advantage in this half-ball-shaped end. I have wished long for a stethoscope which could be slided over the surface to which I was listening; could be slided without any breach of contact, like a ball castor, so that cardiac sounds could be the more easily traced as to the directions of their propagation. In some degree a solid chest end of a stethoscope of hemispherical shape can give such sliding, and the noise of rubbing between the end of the instrument and the patient's skin can be ended by a little smearing with oil.

ORIGINAL PAPERS.

PELVIC TUBERCULOSIS. (*a*)

By R. D. PUREFOY, M.D., F.R.C.S.I.,

Ex-Master of the Rotunda Hospital.

The Fallopian tubes take an important and indispensable part in the complex processes concerned in the reproduction of our race, and failure in the discharge of their functions, either from malformation or disease, must be reckoned one of the commonest causes of sterility. Consequently, the structure and the diseases of the tubes deserve the careful study of every practical obstetrician and gynæcologist, and though much attention has been of late years bestowed on them, our knowledge on some points remains inadequate. For instance, the condition termed hydrosalpinx appears to arise under many diverse conditions, and, according to one English writer, may even be a late stage in pyosalpinx. Again, it is at least probable that congenital malformation, or disease of the tube, plays an important part in bringing about tubal pregnancy, but writers are by no means agreed on the subject. For many reasons tuberculous salpingitis more than any other affection of the Fallopian tubes deserves careful study. Post-mortem examination shows that the genital organs are affected in 7 per cent. of all cases of tuberculosis, and the tubes in 90 per cent. of all these. The condition is generally bilateral, and in about 18 per cent. is primary, though much discussion has arisen as to how this occurs. Possibly tubal epithelium, damaged by the gonococcus, cannot resist the invasion of the bacillus, a condition homologous to tuberculous disease of the testis following gonorrhœal orchitis. Some hold that the bacillus enters the organism elsewhere, without causing changes at the seat of entrance, and settles in the tube. In most cases, however, tuberculosis of the tubes is secondary to that of other organs, and due to infection from the blood or from the neighbouring organs. Three forms of it have been recognised:—

1. A tubercular perisalpingitis, in which the serosa only is the seat of granulations.
2. A miliary parenchymatous salpingitis, in which the mucosa and musculosa are both affected.
3. A tubercular endosalpingitis, in which the mucosa alone is involved.

If the germ attacks the tubal mucous membrane in the acute miliary or chronic form, irritation and inflammation are set up, free round-celled infiltration and scattered tubercle may be observed; giant cells are scarce, as the tuberculous masses break down quickly, but the tubercle bacillus abounds. Extensive destruction of the mucosa takes place, often with infiltration of the muscular coat. In the chronic form the infiltrated plicæ swell, and through union of their edges, cystlike spaces, lined with epithelium, are formed. The tuberculous growth is often exuberant so as to simulate cancer or sarcoma; giant cells are usually detected in considerable numbers, while the specific bacilli disappear. The ostium does not always close, and sometimes the morbid contents of the tube are discharged, causing local or general tubercular peritonitis. If closure occurs, generally through peritonitic adhesions, the tube dilates, forming a pyosalpinx. It is to be remembered that such a swelling may result from a hydro- or pyosalpinx, secondarily infected with tubercle. In time, such a dilated tube may shrivel up, its cheesy contents becoming infiltrated with earthy salts; its diseased walls undergo a kind of sclerosis, through free development of fibrous tissue, constituting "salpingitis interstitialis." Frequently associated with tubercle of the tubes, though not pathognomonic of it, is the interesting condition described by Chiari as salpingitis isthmica nodosa, due to very irregular hypertrophy of the muscular coat, forming swellings, sometimes as big as a hemp seed, in the walls of the uterine ends of the tubes. They contain cystlike spaces lined with tubal epithelium, probably involutions of the mucosa. In the opinion of some writers these swellings are congenital, originating in Müller's or Wolff's ducts.

In its early stages the diagnosis of tubercular salpingitis is beset with difficulty. The tubercular diathesis and the presence of the disease in other organs constitute presumptive evidence when associated with pelvic pain, frequent, periodical, and localised, along with slight evening rise of temperature. With regard to the last-mentioned sign some important facts have been observed during recent years. In the first place there may be an appreciable degree of menstrual fever, without organic disease, as was shown by a case recorded in one of my Rotunda reports. A well-grown, healthy-looking young woman was admitted to hospital, seeking relief for grievous pain and vomiting every month, without any menstrual flux. Examination disclosed a very imperfectly developed vagina, and the absence of the uterus. During one of these monthly paroxysms her temperature reached 101° F. I removed the ovaries, which were considerably enlarged, and there was no further trouble. Some writers, such as Riebold, explain ovulation fever by the supposition that owing to the more active exchange of the body fluids at this time, resorption takes place from old pathological foci. Further observation has shown that in many, if not most, phthisical women menstruation is attended by elevation of temperature, and often hæmoptysis as well; both may be dependent on changes in the lungs, and not indicative of pelvic disease. Making all due allowance for the clinical facts, we should, in my opinion, regard with suspicion elevation of temperature during menstruation, even though for a time no other evidence of disease may be obtainable. When the disease has lasted for some time local signs of much diagnostic value may be detected by careful vaginal and rectal examination. In Douglas' space and about the utero-sacral ligaments granules and nodules may be found; and one or both tubes may be felt either contorted and thickened, or even already converted into an easily recognised swelling, with or without an adherent ovary. The interesting fact that a pyosalpinx may become twisted on itself, as happens in the case of ovarian cysts, was first pointed out on the Continent by Pozzi, of Paris, in 1897; and a few months later I operated successfully on a similar case, which is figured in my Rotunda Hospital Report for 1898, and is the first instance of this condition recorded in the United Kingdom. Some writers affirm that in tubercular salpingitis the menstrual function is but little affected; my opinion

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(a) Paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, March 13th, 1908.

is that in the majority of cases menstruation becomes either much diminished or much increased in amount, and in either event attended or preceded by much pain. Though many, or most, of the signs and symptoms here enumerated will be present in any given case, the disease under consideration sometimes exists when the general health and good condition point strongly to a different conclusion. In passing, we may direct attention to the fact that after tuberculosis of the tubes, tuberculosis of the fundus uteri is most frequent, and the part of fundus adjacent to the orifices of the tubes is most often affected. This was very well illustrated in a case which I saw lately, through the kindness of the Master of the Rotunda. The woman was middle-aged, in good health, and very good condition; but sterile and much troubled with pelvic pain. Laparotomy revealed the presence of general tubercular peritonitis, obliteration of the lumen of the tubes, and some caseating and calcareous tubercular masses embedded in the fundus uteri.

In August last I was consulted by a young woman living in co. Galway, on account of general delicacy and progressive loss of weight, attended with constipation and much lassitude, and inability for continued exertion. She was pale, thin, troubled with backache, and presented the aspect of one likely to become, if not so already, the subject of some form of tubercular disease. On inquiry I was told that menstruation had begun at 12 years of age, and had become too frequent and profuse; in the intervals leucorrhœa was troublesome. On making a vaginal examination I found the uterus of normal size, but pushed forward and to the right by an irregularly-shaped mass fixed in Douglas' space, nodular on its vaginal aspect, of no great thickness, and rather flattened on its upper surface. The appendages could not be differentiated on either side. I expressed the opinion that some operative procedure alone was likely to effect improvement in her condition, and consent to this was readily granted. On opening the belly the bladder was found spread over the fundus of the uterus, and extensive adhesions in all directions entirely concealed the appendages of both sides. With considerable difficulty, and in some dread of doing harm, I extricated a mass from Douglas' space, consisting of the right ovary and tube enclosing an abscess with very fœtid pus, most of which escaped during the process of removal. Continuing my efforts to loosen adhesions, I brought up the left appendages, the ovary being in a very degenerate condition, and the tube contorted and thickened. The fœtor of the extravasated pus was such that I dreaded some injury to the intestine, and was much relieved when I failed to detect any lesion of it. A gauze drain was brought out through the abdominal wound, and left in for twenty-four hours. The recovery was uneventful, and I have received excellent accounts of the patient's present condition.

On the subject of treatment there is not much to be said of an encouraging nature. It has been observed that when laparotomy is deemed advisable in tubercular peritonitis, the tubes should be carefully examined, as they may be the starting point of the disease, and the prognosis may be favourably affected by their removal; but in such a case this latter step would not be warranted unless a distended state of the organs was apparent. When the disease is only, or chiefly, in the tubes, it may still be possible to leave enough of the uterine ends to secure the continuance of their functions. In more advanced cases, where extensive intestinal adhesions are encountered, much time, skill, and patience are demanded in our efforts to secure a successful result. It is sometimes very difficult to locate the uterus itself, and it is often advisable to have it drawn up by a ligature fixed in the fundus, while we are engaged in extricating the distorted and dislocated appendages. The separation of adhesions is sometimes most easily effected by beginning from below, and it is sometimes a wise precaution to begin by tying the ovarian artery, a step likely to lessen the hæmorrhage attendant on the later stages of the operation.

GALL-STONES REMOVED FROM THE PANCREAS. (*a*)

By P. J. FAGAN, F.R.C.S.,

Surgeon to St. Vincent's Hospital, Dublin.

GENTLEMEN,—The case we have under consideration this morning merits the distinction of indicating in a marked and unusual way the pitfalls that surround our best methods of arriving at a certain diagnosis. This young woman, our patient, had the good luck of being from the very beginning of her illness, now two years ago, under the observation and care of the most skilled physicians. These gentlemen kindly communicated to me the opinions they formed of the origin and course of her present disease, and you will soon be in a position to judge how far and why they diverged from one another.

The Family Physician's View.—I look upon Miss C.'s sickness as due entirely to gastric ulcer. The ulcer is situated on the posterior wall of the pyloric end of the stomach. A good deal of thickening can easily be felt in this neighbourhood, due to adhesions to the pancreas. Local tenderness is well marked. The vomiting, which usually consists of altered food, sometimes blood-tinged, invariably sets in at that time when pyloric activity is most requisite. As the inflammation is creeping into the duodenum, causing paroxysms of pain and transient jaundice, and as I fear the danger of a severe hæmorrhage to be imminent, I recommend operation.

A Second Physician's View.—During her doctor's absence she consulted his friend, a neighbouring practitioner. He examined her on several ocasions, and told her that his deliberate opinion was that she was suffering from colic, due to a gall-stone working its way from her gall-bladder into the bowel. The hard lump in her stomach was due to a cramp of her muscles. But he pointed out that her liver was very big, and recommended an operation, as her gall-bladder he thought contained more stones.

An Expert's View.—I abstract the following from the report of this detailed examination :—"Taking into consideration the rapid and extreme emaciation, the presence of a hard, craggy tumour in the pancreas (not the stomach; the distended stomach was found separable from it), the enlargement of the liver and spleen, the jaundice increasing in intensity, the pain becoming more constant, the vomiting and loss of strength, with the passage of foul-smelling greasy stools, the disease is cancer of the head of the pancreas. The condition of the liver is secondary."

The witnessing of a paroxysm of pain determined me to explore.

Plan of the Operation.—A long cut was made through the outer part of right rectus muscle, and a transverse cut at right angles added above. The large triangular flap was turned downwards and inwards and exposed the liver—much enlarged and deeply congested—with the transverse colon tucked up close to it by a strong ligamentum hepatico-colicum, the stomach empty with remarkably prominent large veins along the curvatures, and some adhesions at the pylorus. On drawing downwards

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(*a*) A Clinical Lecture delivered at St. Vincent's Hospital, Dublin.

the stomach, the pancreas, deep coloured, could be seen through the lesser omentum. In its head could be felt the hard-bossed tumour about the size of a medium orange. The gland was enlarged in every part. The intestinal veins throughout were distended. No peritoneal fluid was noted.

On cutting through the ligamentum hepaticocolicum and drawing the transverse colon downwards out of the field, a shrunken gall-bladder with very thick dark red walls came into view. Associated with the cystic duct, partly embedded in the liver substance and partly projecting into the foramen of Winslow, was a thin-walled swelling which promptly burst and discharged about two ounces of slightly bile-stained fluid. No induration or enlarged glands were present in the ligamentum hepato-duodenale or porta hepatis. On cutting lightly about one-eighth of an inch to the right of the descending part of the duodenum, that structure was lifted off the renal vessels and inferior vena cava, both of which appeared normal, and the whole duodenum turned as on a hinge upwards and inwards.

The common bile duct was now isolated and traced downwards to its termination. The fingers of the left hand were now placed beneath the head of the pancreas, the duodenum being received into the palm; the right hand was placed in front and the tumuor gently palpated. It rose and fell with each throb of the aorta which was resting against the left fingers'-tips. Now, in the posterior part of the tumour where the wall was thinnest the first stone was felt moving; this was pushed upwards as high as possible, cut down upon, and removed, and two others dealt with in a like manner. Thus three good-sized facetted stones were taken away. The fundus of the gall-bladder was opened, and no calculi being found in it, a metallic sound was passed down to the cavity originally filled with the stones, the cut at the end of the common duct was sutured with fine silk, the sound withdrawn, and the opened gall-bladder stitched to the skin. The abdominal wound was then closed. Bile began to flow immediately, and has continued to do so copiously ever since. The patient was able to leave hospital in three weeks. She never had a return of pain or sickness, but wishes the fistula closed, hence her presence here to-day.

I may add that though jaundice was present and the operation extensive, the bleeding was very slight, only one vessel, and that in the abdominal wall needing a ligature, and, notwithstanding that an hour and a quarter was spent in dissecting out these important structures, the patient rallied immediately.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Tuberculous Disease of the Os Calcis.—**Mr. Arthur Edmunds** operated on a girl, æt. 8, who had been suffering for the last two years from a discharging sinus on the outer side of the right os calcis. The case in question had been under treatment mainly at the Paddington Green Children's Hospital for the two years, and it was of interest as showing the value of expectant treatment in these cases. When the child was first seen there was a considerable amount of swelling and tenderness on both sides of the os calcis, and from the very first a question of radical operation had to be considered. The age of the patient and her excellent general health suggested, however, that it would be advisable to postpone operation until it was quite certain that conservative measures were useless. Accordingly, a splint with a foot-piece was applied, with the result that a good deal of the swelling disappeared. An abscess subsequently formed, however, and this was opened and scraped out. A sinus formed, which healed up after several weeks, but afterwards broke down. A second attempt was made to remove the disease by a scraping operation, but this again failed in its object and a second sinus formed on the inner side of the foot. During this time the child's health had been well maintained, and with the assistance of various societies she had spent a good many weeks of the year at the seaside. As the two sinuses still persisted, it was obvious that something would have to be done, and the child was accordingly admitted to the Great Northern Hospital. Both sinuses were freely opened up when it was found that the one on the outer side led into a cavity of the bone, while that on the inner side communicated with the first-named track by passing across the sole of the foot. This was scraped out, and gave no more trouble. With regard to the sinus which led directly into the bone, it was found that there was no evidence of any caries or necrosis of the os calcis, the healing having been delayed simply by the inability of the suppurating cavity to contract. Accordingly, the bone around the suppurating cavity was gouged away so as to leave merely a wide-mouthed depression in the side of the bone, which was then firmly packed and allowed to granulate.

Mr. Edmunds pointed out that although tuberculous disease of the bone could often be quickly and satisfactorily dealt with by a radical operation, such a method of treatment in the present case would have involved the loss of the whole or greater part of the os calcis, leading to a very considerable deformity and disability. For this reason tuberculosis of the os calcis should be dealt with in a different way to disease of the astragalus, a bone which can be excised without impairing the efficiency of the foot to any great extent. Further, there was not the same tendency in tuberculosis of the os calcis for the disease to spread, and cases such as the present often occur in which the disease is limited throughout to the one bone. It is therefore, he thought, quite justifiable to adopt an expectant attitude, to open abscesses and scrape sinuses as they form, and to keep the foot at rest, provided always that the general health of the patient is good, and that efficient antiseptic dressings can be applied over a long period.

In the present case the wound has granulated well, and is nearly healed, without any deformity or impairment of function of the foot

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

Meeting held Friday, March 20th, 1908.

Dr. James Little in the Chair.

A CASE OF PERFORATION OF ŒSOPHAGUS.

Dr. Travers Smith exhibited specimen showing perforation of the œsophagus. The patient was a girl, æt. 18, who was admitted to hospital complaining that for three days she had had a sore throat, and felt very ill. Nothing could be found in the throat, except that the anterior parts were all red and swollen. There was a slight general tumefaction of the neck externally, but no particular enlargement of the glands. Temperature, 104°; pulse, 13; respirations, about 35. The patient complained of a little pain in swallowing. No conclusion was come to, except that she had some microbic toxæmia. On the day after admission he heard that she had swallowed a small piece of rasher bone, after which the sore throat began. On further examination, he found a small area of cutaneous emphysema over the lower margin of the ribs on the left side, and came to the conclusion that she had probably perforated her œsophagus with the piece of bone. A number of staphylococci were found in the blood, the emphysema became more marked, and he was able to make out some left pleurisy and a slight pericardial friction rub. They considered the question of operation, but there was no indication as to which side of the neck it should be performed on. On the fourth day in hospital she was unconscious and moribund. Bleeding and an injection of normal saline solution restored consciousness, but the effect did not continue, and she died quite suddenly. At the post-mortem the emphysema was marked, a small amount of pus and fibro-purulent material was found in the left pleural cavity, and there was, perhaps, some air in it; there was also some fibro-purulent pericarditis, and emphysema in the abdominal cavity all round the left kidney. In the œsophagus, just below the level of the cricoid cartilage there was a double perforation, one hole being a little lower than the other. Some pus around the holes was evidently the cause of the great redness, but no distinct abscesses had formed. There was no sign of a bone to be found anywhere; it had probably got softened and made its way downwards, and was possibly subsequently discharged.

CIRRHOSIS OF LIVER.

Dr. **PEACOCKE** showed a specimen of cirrhosis of the liver from a woman, æt. 46, who had always lived a temperate life. For twelve months she thought she had been getting stouter, but did not complain of illness until a fortnight before admission to hospital. She then noticed that she was getting rapidly more swollen, but her condition did not interfere with her health. When he saw her in hospital she was suffering from extreme respiratory distress; her abdomen was enormously distended and tense, and the abdominal wall was œdematous; the lungs, too, were œdematous. The apex beat of the heart was heard in the third space, and a systolic murmur was heard over it. The urine was very scanty, high-coloured, and slightly albuminous. The distention was due to fluid, which had come on with great suddenness. He had the abdomen opened and drained, fourteen and a half pints of fluid being measured, apart from a considerable amount which escaped. Drainage was continued for forty-eight hours, three to four pints being measured daily. Her condition was never satisfactory, and he had no expectation that she would do well. In her history she had no vomiting. She remained with slight elevation of temperature for a few days, and then became duller, finally lapsing into coma for forty-eight hours, and then dying. The liver exhibited was cirrhotic. The surface was nodular and extremely hard, and a microscopic section showed very advanced cirrhosis. The spleen, also exhibited, was the ordinary enlarged spleen met with in such cases. The case was interesting from the fact that it showed that the intake of alcohol was not necessary to the condition.

Dr. **DAWSON** said the contention that cirrhosis of the liver and alcoholism were not directly related was borne out by a converse observation. It had been pointed out by the late Dr. Conolly Norman and by Dr. Mott, of the London County Asylums, that cirrhosis was a rare occurrence in asylum post-mortems, although a large proportion of the cases admitted to pauper asylums were alcoholic. Dr. Mott explained the fact by saying that, owing to weakness of the nervous system, the alcohol acted on it before it had time to act on the liver. Although that explanation did not appear to him to explain the fact, the fact itself bore out what Dr. Peacocke had said regarding the view which was gaining ground—that alcohol was not the direct cause of cirrhosis.

Professor **O'SULLIVAN** said his experience was quite in accordance with Dr. Dawson's remarks. Within the last week he had three cirrhotic livers in his laboratory, in none of which was there the slightest suspicion of alcoholism.

Dr. **TRAVERS SMITH** cited three cases of cirrhosis in children, in all of which there was a distinct history of alcoholism. In a case in which the patient declared that she had never taken alcohol, he had found she was taking a "quack" medicine which was largely whiskey. He certainly thought that alcohol had something to do with the condition.

A FORM OF AORTITIS ASSOCIATED WITH SUDDEN DEATH.

Professor **O'SULLIVAN** exhibited a specimen showing a form of aortitis associated with sudden death. Some years ago he had received the heart of a young soldier who had dropped dead on the march. He was apparently perfectly healthy. The appearance of the heart struck him as being very unusual, and he observed that immediately above the commencement of the aorta, along the line of the valves, there was an abrupt rise in the surface level, which continued for about an inch upwards into the vessel, and then as abruptly descended again, forming a sort of table-land across the vessel a quarter of an inch or more higher than the rest of the surface. The left coronary artery was obstructed by the excrescence of the surface, which he took to be the cause of death. The specimen had gone astray, but he was able to exhibit a similar specimen from a young man who had been found dead a few days before in a lavatory. The condition of the heart was almost identical to the other. There was very little degeneration compared with an ordinary case of atheroma. The amount of over-growth of the inner coat of the vessel, as compared to the amount of degeneration, was enormous. There was some fatty degeneration in the central part of the big area. The orifice of the right coronary artery was practically closed; the opening of the left coronary artery was also reduced to small dimensions. A small depressed area, about an inch from the sinuses, was stained red, and found to have undergone a different degeneration from atheroma. Under the microscope was seen a great rise in the inner coat, composed of a reduplication of the inner tissue, but in the middle coat the elastic tissue was cut and torn, and split by masses of cell infiltration which ran along the course of the vasa vasorum. The natural conclusion was that both cases were syphilitics, although there was no direct evidence.

Dr. **TRAVERS SMITH** said it appeared to him that the cases differed more in degree than in kind from ordinary atheroma, and he thought it extremely likely that syphilis was the primary cause of the change in the middle coat.

Dr. **LITTLE** said that anything that threw light on the cause of death in cardiac disease was most important. He had made post-mortems on a great many people who died of cardiac disease, and in some cases he had wondered why they died, while in others he had wondered how they lived so long.

The **SECRETARY** said he agreed with Dr. Travers Smith that the difference between the condition shown and ordinary atheroma was a question of degree. Atheroma was not a very definite condition; it was rather the sum of a great many different changes in various parts of a vessel wall; and he saw no histological differences between those seen in the specimen and those seen in atheroma.

SURGICAL KIDNEY.

Dr. **MOORHEAD** exhibited a specimen of surgical kidney taken from a woman, æt. 42. Two days previous to admission to hospital she had suddenly got a shivering fit, with pain in the abdomen and vomiting. He found distinct crepitus at the base of the left lung, and rigidity of the abdominal wall, which yielded slowly to pressure. Her temperature, appearance, and respiration became typical of acute pneumonia, of which she developed further distinct symptoms later. There was some pus in the urine, and the patient suffered from frequency of micturition, from which he concluded she had also some cystitis. The dulness in the left lung gradually increased, until about two-thirds of the lower lobe had become consolidated. Her temperature ran up to 104° or 105°, and so remained for a fortnight. Her strength rapidly diminished, and she died. Bacterial examination of the pus in the urine gave staphylococcus aureus, and the sputum gave a pure culture of the same. The abdominal organs were all found to be healthy, with the exception of the bladder and kidneys. The former showed acute cystitis, and the left kidney was enormously large and studded with abscesses. The left ureter was extended and acutely inflamed. The pus from the abscesses gave a pure culture of staphylococcus aureus. The base of the left lung, instead of showing resolving lobar pneumonia, was studded with small abscesses, and showed typical septic broncho-pneumonia; the pus of the abscesses showed the same organism. The origin of the trouble was the bladder. It was the first instance in which he had found the staphylococcus aureus producing the particular group of symptoms.

Dr. **Goulding** asked if there was any evidence of endocarditis?

Dr. **Moorhead** replied that the thoracic organs, with the exception of the lung, were normal.

PYÆMIC KIDNEYS.

Dr. **Peacocke** exhibited specimens of pyæmic kidney from a man, æt. 60, who had been complaining for some years of what was called kidney disease. He was in apparently good health until January 3rd, when he noticed his urine scanty, and was becoming restless at night. On January 6th he became dull and restless, and delirious at night, and on January 11th, eight days after the onset of serious symptoms, he was admitted to hospital unconscious. He died a few hours afterwards. A small quantity of urine drawn off by the catheter contained pus and albumin. All the organs were found to be healthy, except the kidneys and bladder, which had red spots, and showed cystitis. The kidneys were not very enlarged, but there were patches showing evidence of the septic process.

Professor **Scott** said the kidneys were smooth and fairly tense; somewhat patchy on section. Under low power there were great granulations lying between the tubules locally. He got no organisms in staining by Gram's method, but with other methods some groups of micro-organisms turned up. He had no proof as to what organisms they were, as the kidney had got into formalin before he could make cultures. Nor was there any proof as to whether the cystitis was first or last.

INFECTIVE MOUSE TUMOURS.

Dr. **Harvey** exhibited specimens of infective mouse tumours obtained originally from Dr. Bashford, of the Imperial Cancer Research, which had been transplanted for five or six generations, and grew successfully in 40 to 60 per cent. of the mice inoculated with it. The tumour was found normally in mice; one tumour would be sufficient to inoculate 100 mice. The transplantations were generally difficult, and it took some time for the tumour to accustom itself to the new race. Dr. Bashford stated that when the tumours were first inoculated they generally contained a certain amount of the old stroma, which degenerated; then the epithelial elements grew and formed a tumour; but the stroma in the new mouse was taken from the mouse itself. The appearances were different in different sections of the same tumour, and varied still more in different tumours. He had worked entirely with one tumour, but there were already certain alterations in it. The tumours showed a great tendency to degenerate, and even in parts which looked fairly normal one found great fragmentation of nuclei.

Professor **Scott** said he had found hereditary tumours in certain strains of mice which grew so big that the mice died, but they looked rather like a sarcoma than an epithelial tumour, and they never showed any tendency to go back.

Professor **O'Sullivan** said the question of infiltration was a very important one. Dr. Harvey had got a tumour which went through the ribs, and it looked to him like the way an aneurysm would work through, rather than a carcinoma.

ANEURYSM OF AORTA.

Dr. **Peacocke** exhibited a specimen of aneurysm of the aorta from a man, æt. 40. He had noticed last summer a slight draw in his breathing, which, however, became better until colder weather set in. Early in December he became very breathless, with troublesome cough, and he was admitted to hospital in January. The chief physical signs were rather those of a pleural effusion than an aneurysm. The apex beat was in the third right intercostal space. No tubercular bacilli were found in the sputum. An X-ray examination showed a dark shadow over the upper part of the chest towards the left side. Examination of the larynx was impossible, as the man was in such extreme distress. He grew worse and worse, and died suddenly after a severe attack of dyspnœa. At the post-mortem they discovered the aneurysm, with an unusually large clot firmly fixed in it, as exhibited.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held on March 20th, 1908.

Dr. C. **Chapman** in the Chair.

A paper on a case of GRANULAR KIDNEY in a girl, æt. 15, probably due to congenital syphilis, was read by the **Chairman**. The patient had always been delicate, but it was not until three weeks previously that advice was sought on account of extreme difficulty in breathing and swelling of the feet and legs. The left ventricle was much hypertrophied, and the second sound at the base was accentuated: no thrill or murmur could be detected: the radial arteries were hard and thickened. The liver was enlarged nearly to the umbilicus. The urine was of specific gravity 1010, and contained 2½ per cent. of albumin and granular casts. The condition gradually became worse, and the patient died seven months later.

Post-mortem.—Both kidneys were markedly granular, the right weighing 2 oz. and the left 1½ oz. Inherited syphilis was suggested as the most probable cause of the condition found in the patient, as the bridge of the nose was depressed and the child's development was of one six years her junior, and the face had an aged aspect. There was no history of any one of the generally recognised causes of renal inflammation. The mother had had four miscarriages, while of the two children born at term, one died at 8 months from marasmus.

Dr. **Porter Parkinson** said it had long been suspected that many forms of nephritis were due to syphilis, both congenital and acquired, and to the former even in the adult. As Dr. Bradford has recently said, a large number of cases of nephritis suspected to be due to cold were probably also predisposed to by syphilis.

Specimens and drawings of a case of ACUTE PLEURO-PNEUMONIA, with extensive fibrinous plugs visible to the naked eye in dilated lymphatics, were shown by Dr. **George Carpenter**. The child, æt. 9 months, was suddenly taken ill and died of pleuro-pneumonia of the right apex in 48 hours. At the autopsy the solid lung displayed in profusion over the consolidated portion, areas which had the appearance of follicular stomatitis, and were of somewhat irregular outline. On microscopical examination these areas were seen to be made up of leucocytes and fibrin in varying proportions; the walls consisted of an endothelial lining only. In no part of them was there any alveolar structure or any suggestion of a destructive process. They contained encapsuled diplococci, and were evidently dilated lymphatics filled with the same material as that found on the pleura.

Dr. W. **Ewart** was inclined to regard the case as one of ulcerative peri-bronchitis with sub-acute broncho-pneumonia of mixed fibrinous and corpuscular type.

A case of Abdominal ballooning due to widespread Anterior Poliomyelitis was shown by Dr. F. **Langmead** in a child of 1 year and 8 months. There were evidences of a very extensive involvement of the anterior cornua which had occurred 18 months previously. The legs were useless and allowed great mobility, easily meeting behind the head. The back was sharply curved to the left in the lumbar region. The abdominal muscles were paralysed, especially on the left side, so that, on coughing or crying, two rounded protrusions were produced, due to local yielding of the abdominal wall. The delivery was a normal one.

Dr. G. A. **Sutherland** said that, in his experience, this complication was a very rare one. In this case the onset was very early, viz., when the child was 3 months old, and that increased the difficulty of diagnosis. He showed photographs in two cases which had been under his care of congenital absence of a certain area in the abdominal wall, which closely simulated infantile paralysis.

A case of Mongolian Imbecility, associated with other malformations, was also shown by Dr. **LANGMEAD**. The patient was an only child, and in addition to the characteristic signs of mongolian imbecility was the subject of (*a*) Congenital Morbus Cordis, probably due to an imperfect septum ventriculorum, and (*b*) An accessory auricle on the right side.

The **CHAIRMAN** asked whether these cases were connected with attempts made at abortion? He knew of one case in which he believed attempts had been made unsuccessfully, and the child was a mongolian idiot, though the previous three children were normal.

Dr. G. E. **SHUTTLEWORTH** said that some time ago, in trying to get the ætiology of a mongolian child, the daughter of a lady in fair position who had a contracted pelvis, he found that she had been persuaded to undergo a starvation diet in order to have a small child. The result was the birth of a mongolian imbecile at full term.

A case of

CHRONIC RHEUMATOID DISEASE

of both knee-joints was shown by Dr. F. **PARKES WEBER**. The patient, a boy, æt. 10½, had enlargement of the lymphatic glands, ankylosis of both knee-joints, and limitation of movement in the hip-joints. He drew attention to the relative painlessness and consequent insidious progress of such chronic rheumatoid affections in childhood.

Dr. **CAUTLEY** asked whether there was any evidence of gonorrhœal infection?

Dr. **SUTHERLAND** said he did not think the case was typical of any one disease. If there was an acute onset with marked lesions at 2½ years of age that was against it being pure rheumatism. He thought it was due to some septic infection which had involved both joints and heart.

Dr. **PARKES WEBER**, in reply, said that when he first saw the case it did not remind him of gonorrhœal rheumatism, and he saw no evidence of gonorrhœal infection.

Dr. J. **PORTER PARKINSON** showed a case of

TUBERCULOSIS OF THE KIDNEY WITH PYONEPHROSIS.

The patient was a girl, æt. 9. During the last 18 months she had suffered from attacks lasting a few days, with fever, headache, and pain in the left side of the abdomen. During the last attack a quantity of custard-like material came away with the urine. The liver was not enlarged, but the spleen extended slightly below the costal margin, and immediately below this, but more deeply situated, was a mass extending downwards for 2 or 3 inches, resistant and slightly nodular, with a rounded lower end like a kidney. It was dull except for the colon resonance which could be obtained over it. The right kidney was also thought to be enlarged. Tubercle bacilli had been found in the urine, which was reduced in amount, being from 12 to 16 oz. daily. It was acid, and deposited a large amount of pus; there was a trace of albumin, but no blood. During the last five weeks she had increased 6 lb. in weight, and the pus had almost disappeared from the urine.

Mr. **HUGH LETT** said that an attempt should be made to find out the efficiency of the opposite kidney by separation of the urine, and if it were working well, he would advise nephrectomy. Tuberculous affections of the kidney were often very chronic, and he had seen cases in which the disease had existed for years, the patient having gone on well under palliative treatment, but the present case seemed to be one requiring operation.

Dr. **CARPENTER** said that the bacillus could not always be found in the urine because the corresponding ureter might be blocked, as had happened in a case of his. If a case of tubercle of the kidney were seen early and there was no involvement of the bladder, removal of the kidney was satisfactory. But if the ureters on both sides and the bladder were involved, operation was out of the question.

Dr. **PORTER PARKINSON**, in reply, thought that the case would be far better treated by the ordinary medical measures than by surgery.

Sections of a Subcutaneous Fibrous Nodule removed from an infant, aged 7 months, were shown by Dr. **GEORGE CARPENTER**. The child was apparently free from rheumatism. This nodule had been removed from the neighbourhood of the angle of the left scapula, and there were also nodules in the occipital region. The nodule possessed a thin fibrous capsule, and was composed of a richly cellular alveolar tissue, free from organisms.

A case of Laryngeal Stridor in an infant of 6 months was shown by Dr. **GEORGE CARPENTER**. Since 2 weeks old it had breathed "like croup"; there was much mucopurulent discharge from the anterior and posterior nares, but the nasopharynx could not be examined digitally for adenoids. The epiglottis and ary-epiglottic folds felt normal. There was no narrowing of the glottis; the cry was natural.

Dr. **CAUTLEY** thought the proper treatment was to remove the adenoids.

Dr. **CARPENTER**, in reply, thought the present condition might be due to reflex spasm. He was not sure that there were adenoids.

A case of "Cerebral Diplegia" in a boy, æt. 6, was also shown by Dr. **CARPENTER**. The condition dated from 8 months of age. He had oscillating nystagmus; the upper extremities were weak and tremulous on use; he had never walked, and the lower extremities were adducted and stiff, and the reflexes exaggerated. He was of feeble intellect, and unclean in his habits. There was no history of syphilis or of any intracranial disorder during infancy.

A Mongol, aged 5 months, with "Congenital Morbus Cordis," was shown by Dr. **GEORGE CARPENTER**.

A specimen of "Congenital Stricture of the Left Ureter," with the kidney and bladder, were shown by Dr. **GEORGE CARPENTER**.

A case of "Juvenile Tabes" was shown by Mr. **SYDNEY STEPHENSON**. The patient, a girl, æt. 14, had bilateral optic atrophy, imperative desire to micturate, absence of one knee-jerk, and enfeeblement of the other. The family history was suggestive of a syphilitic taint, although the patient showed no personal stigmata of inherited syphilis.

A case of "Infantile Hemiplegia" in a girl, æt. 8¾, was shown by Dr. F. W. **HIGGS** and Mr. P. **TURNER**. The hemiplegia appeared after a series of fits, at the age of 10 months. There were lower facial paresis, spastic paralysis of the arm, with athetosis of the hand and fingers, and paresis of the leg with a talipes varus, which was only present when the child walked quickly, and which was probably of an athetoid nature also.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD MARCH 19TH, 1908.

The President, Mr. T. H. **BICKERTON**, F.R.C.S., in the Chair.

DR. W. CARTER gave an address on

REMINISCENCES OF FORTY-TWO YEARS' PROFESSIONAL LIFE IN LIVERPOOL.

Dr. **CARTER** remarked that, owing to recent reviews of the advances in medicine and surgery by Dr. Waters and Professor Rushton Parker during a period almost contemporaneous with the time of his residence in Liverpool, he would confine himself to a statement of some of those public controversies and events in which he had taken part. The first and perhaps the most trying was

The Contagious Diseases Acts.—Believing that these degraded both the womanhood and the manhood of the country, he was obliged to oppose them. In conjunction with the late Dr. Nevins, Dr. Ewing Whittle, and others, they established a National Association for their repeal in March, 1875, at a meeting at St. George's Hall, Liverpool, and decided to start a journal, the *Medical Enquirer*. He was Hon. Secretary to the Association and sole editor of the journal, also a purely honorary position. The work lasted until the repeal of the Acts in 1886, Dr. Nevins distinguishing himself above all others by his zeal and work.

Public Abattoirs.—The next public controversy was that concerning the position of the public abattoirs and hide market in a densely populated part of the city and very near to the Royal Infirmary. On behalf of a deputation from the Medical Institution he presented in 1884 to a meeting presided over by the then Mayor statistical tables proving the greater unhealthiness of the district than of any other district generally similar anywhere in Liverpool. This was confirmed by a subsequent report made by Dr. Stopford Taylor, the then Medical Officer of Health; and later still, in February, 1903, he was invited by the Committee of the Royal Infirmary to meet the Estate Committee and endeavour to dissuade them from renewing the lease of the abattoir. With the late Sir William Banks and Mr. Robert Gladstone, he strongly urged this course on the authorities, and trusted that this evil would ere long be removed. Dr. Carter next spoke of his prolonged efforts in the promotion of total abstinence both in Liverpool and elsewhere. Another controversy which was maintained for many years was that concerning the notification of infectious diseases without the slightest discretion being allowed in any case. He presided over a large meeting of the medical profession in that theatre in September, 1882, on the subject. After prolonged discussion and numerous meetings, a compromise was agreed upon, and the form now employed was sanctioned.

Medical Defence Union.—The attempt to persuade the late Sir William Jenner to found a Medical Defence Union, its subsequent formation by Mr. Rideal, and, later still, the Presidency by the late Mr. Lawson Tait, with Dr. Carter as a Vice-President, were mentioned, and every hearer urged to join the present ably-conducted Union. In 1870-71 the visitation of Liverpool by a severe outbreak of smallpox was the occasion of Dr. Carter's writing a series of articles in the late *Medical Times and Gazette*, after examination of all the returns supplied by the parish medical officers in charge of the public sheds. The mortality was strikingly the inverse to the number and size of the cicatrices. Many years later, therefore, when the practice of some medical men had arisen of making one small pin-prick and terming that efficient vaccination, he felt bound to bring the matter before the Lancashire and Cheshire Branch of the British Medical Association on February 28th, 1889, at which a resolution adverse to this was come to at a large meeting.

The Congo Atrocities.—On March 23rd, 1904, at a large public meeting held at the Philharmonic Hall under the Presidency of Mr. Emmott, M.P., the Bishop of Liverpool proposed, and Dr. Carter seconded, resolutions which had the effect of starting the Congo Reform Association. As Chairman of the Professional Sub-Committee of the Tropical Diseases School since its formation, he felt much embarrassment at times owing to his having to protest against the extravagant laudation in the annual reports of the school of King Leopold of Belgium, and when invited to accompany the President of the School and some of his colleagues to Brussels to luncheon with the King last August twelvemonth, he was obliged to refuse the invitation. He did not blame those who went, nor the gentleman who sent him the invitation, but he never could have ceased to blame himself if he had gone, nor to feel indelibly disgraced.

Midwives Bill.—When the midwives registration controversy arose, he felt bound, under the conviction that many humble homes were wrecked through the spread of pureperal fever, owing to the carelessness of uneducated and ignorant women, strongly to support the Bill for the education and registration of midwives. The matter was very hotly discussed on May 11th, 1894, at a large meeting held in that room, when his motion on the subject was lost by a large majority. He published his speech, copies of which were requested by the Royal College of Physicians for their library table, and finally, as everyone knew, an Act was passed in 1902 compelling the education, certification, and supervision of all women practising as midwives.

Generous Liverpool.—Dr. Carter lastly drew attention to the generosity and public spirit of the wealthy men of Liverpool, especially mentioning Mr. Sutton Timmis, who after the death of his wife communicated to Dr. Carter through his friend, Mr. Wade Deacon, his desire to place £10,000 in the hands of trustees for promoting a cancer research, over the committee for carrying out which he (Dr. Carter) had presided, and still continued to preside as Chairman. He mentioned other splendid acts of generosity on the part of the same gentleman, and finally spoke of the extraordinary response to the appeal made by himself a few years ago for the family of the hero, Dr. Smyth, Liverpool contributing hundreds of pounds. Rich and poor alike gave, one poor man sending twopence, another sixpence, a poor dressmaker beseeching to be allowed to make clothes for the children, and overjoyed when allowed to do so; but no class contributing so generously or so generally as the medical profession, who alone could estimate the great risks and the noble way in which that heroic man, like a true soldier, had met them.

A hearty vote of thanks, proposed by Dr. Macfie Campbell, and seconded by Mr. Rushton Parker, was accorded to Dr. Carter for his excellent address.

The meeting on Thursday, March 26th, 1908, was entirely devoted to the exhibition of clinical cases.

Among those of special interest were two by Dr. H. R. Hurter—(1) Acrocyanosis chronica anæsthetica (cum gangrena) a condition allied to Raynaud's disease and erythromelalgia. Male, æt. 35. (2) Female, æt. 23, with congenital morbus cordis and defective physical and mental development. Height 4ft. 7in. Has been under treatment for hysteria.

Dr. A. Gordon Gullan—(1) Raynaud's disease, male, æt. 56. Previous attack eight years ago, lasting 12 months. Note: Typically red, congested face, swollen purple (asphyxial) condition of fingers and toes, soles of feet, ears. (2) Myxœdema, woman, æt. 55, Menopause at 50, disease developed gradually, since typically. Note: swollen face, malar flush, glazed dry skin, large swollen tongue, spade-like hands, subnormal temperature, infrequent feeble pulse.

Dr. Percy Marsh—(1) A case of meningitis in which Calmette's reaction was positive, the cerebro-spinal fluid showed lymphocytes, did not reduce Fehling's solution. Treatment, Koch's tuberculin (T.R.) recovery. (2) An infant with chronic basilar meningitis. Symptoms: marked retro-colic spasm, rigidity of extremities, tremors, no optic neuritis, cerebro-spinal fluid turbid ("polymorph" leucocytes), no reduction of Fehling's solution. No organism by culture.

Mr. Hugh E. Jones showed two ear cases—(1) W. P. R., chronic suppurative otitis media with granulations. Headache, giddiness, pain, diplopia, optic neuritis; watch heard on pressure only, bone conduction exaggerated. Complete postaural operation. Healing with disappearance of all symptoms and return of hearing. (2) A.W., æt. 52. Acute suppurative otitis media without perforation of drum membrane. Acute apical mastoid abscess (?) primary, with extension into neck and exposure of dura mater of posterior fossa and the sigmoid sinus. Operation, March 4th.

Dr. John Hay—(1) Pseudohypertrophic paralysis in a man, æt. 23. (2) General paralysis of the insane in a woman, æt. 30. No history of syphilis. (3) Locomotor ataxia and general paralysis of the insane in a woman, æt. 40. No history of syphilis. (4) Youth, æt. 20, illustrating stunted growth from heart disease in early life.

Some surgical cases were shown by Dr. R. W. Murray, Mr. Keith Monsarrat, and Mr. J. F. Edmiston. Interesting skin cases were exhibited by Drs. Stopford Taylor, R. W. McKenna, and Dr. Leslie Roberts, and various ophthalmic cases by Mr. A. Nimmo Walker.

A demonstration was subsequently given in the theatre of Lumiere's colour photography as applied to fresh pathological specimens, illustrated by seventy lantern slides, including human and comparative pathology (macroscopic and microscopic), by Mr. G. Hamilton.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday, April 2nd, 1908.

The President, Dr. John McCaw, in the Chair.

The Hon. Secretary, Dr. **Howard Stevenson**, read the report of the Committee on Hospital Abuse, and it was agreed that the resolutions of the Committee should be printed and circulated among the members, and considered at a meeting on April 16th.

Mr. **Fullerton** showed a patient who had suffered from a fracture of the fore-arm, and in whom the bones failed to unite and the arm was useless. After other methods had failed, Mr. Fullerton riveted the bones, and the union was now perfect. A radiograph showed very beautifully the bones and the rivets.

Dr. **Dempsey** read notes of a successful case of Cæsarian section. The patient was a woman, æt. 27. She had had two previous pregnancies, both terminated by craniotomy. On examination the true conjugate was found to be 2½ ins. She stated that she was the ninth of eleven children, that she had been nursed on the breast, but had developed rickets. She was 5ft. high, and bandy-legged. Dr. Dempsey advised Cæsarian section, and admitted her to hospital and prepared for operation on December 23rd, two days before confinement was due. He operated on the appointed day, Drs. J. B. Moore and McLorinan assisting, and the operation proved easy and the loss of blood almost nil. Recovery was uneventful, and the mother and child were discharged in a month, both well. Dr. Dempsey concluded with some remarks on the relative advantages of this and alternative operations.

Dr. R. J. **Johnstone** said that he had done two cases, the first in a woman suffering from inoperable cancer, who became septic and died in a few days; the second successful. He did not think pubiotomy was justified with a conjugate of less than 3 in.

Dr. **Hicks** also spoke, emphasising the simplicity and safety of the operation in suitable cases.

Dr. J. H. **McKee**, of Harrogate, read a short paper on "Harrogate and its Treatment," in which he described the various springs and the therapeutic uses to which they were put.

Drs. Dempsey, McKisack, Davison, Kevin, and the President discussed the paper.

Dr. **Cecil Shaw** read a paper on "Squint in Childhood," based on notes of over 300 cases. Dr. Shaw said that he did not purpose to discuss the highly technical question of the causation of squint, but just pointed out that it was always associated with errors of refraction, and that its successful treatment was attained by the early correction of those errors. In his 326 cases hypermetropic astigmatism was present in 79 per cent., hypermetropia in 19 per cent., and mixed astigmatism or myopia in 2 per cent. only. In no less than 16 instances more than one member of a family was affected. While 75 per cent. of cases appeared before 5 years of age, only 30 per cent. came for treatment before 5, most cases being neglected till the sight was found defective at school. There was great difficulty in following up hospital cases, which were apt to cease attending when cured, but he had been able to follow up about 50 per cent. of his cases, and found among these that treatment with glasses and atropine resulted in the cure of 50 per cent. and the great improvement of 20 per cent. If the optical treatment did not result in cure in a year or so, and if there were good vision in the squinting eye, a tenotomy or similar operation might do good, but was not to be advised otherwise, he thought. After 7 per cent. operation a further 7 per cent. were cured and 3 per cent. improved. When the squint was treated while still occasional, before it became fixed, the results were still better, 74 per cent. being cured and 22 per cent. improved. The chief point of the paper was to call the attention of the family practitioner to the immense advantages of the early treatment of squint, as in that way the squint could most likely be cured without operation, and the sight of the squinting eye would be preserved from slow deterioration. This desirable result could only be attained by the co-operation of the family doctor, who usually saw the case in the early stage. In concluding, Dr. Shaw emphasised the fact that children suffering from squint are medical cases, to be treated by medical men, and ought not to be allowed to fall into the hands of the prescribing optician or any other quack.

Drs. Killen, Cunningham, MacIlwaine, and the President discussed the paper.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 5th, 1908.

Hæmoptysis.

The treatment of hæmoptysis is simple enough, consisting in three drugs administered, combined or concurrently—ergotin, hippo and adrenalin.

The patient, kept in a horizontal position, the head low, without a pillow, is enjoined to absolute silence. The ice-bag is placed on the chest, and mustard leaves to the calves of the legs, while hot bottles are applied to the feet.

The ergotin can be given subcutaneously, and at the same time 2 grains of hippo every quarter of an hour until nausea sets in, while iced and acidulated drinks are given moderately.

Adrenalin is a good adjuvant, and may be combined with ergotin as follows:—

Ergotin, ½ dr.
Sol. of adrenalin, 6 drops.
Tincture of digitalis, 12 drops.
Tincture of cinnamon, 1 dr.
Cognac, 1 oz.
Syrup, 1 oz.
Water, 4 oz.

A tablespoonful every 2 hours.

Erythema of Infants.

Erythema, or dermatitis, resulting from the contact of the epidermis with the urine and fæcal matter, is at first limited to the buttocks, and finally extends to the thighs, legs and back. It is easily cured when taken at the outset by washing with some astringent infusion (walnut leaves) and the application of an absorbent powder (subnitrate of bismuth).

Where the affection is chronic the treatment is not so simple. The cause of this dermatitis is to be found in gastro-intestinal disorders, consequently attention must be paid to the feeding of the children in regulating their little repast, which is frequently sufficient to cure the affection.

M. Quillier recommends washing the parts each time they are soiled with absorbent cotton and boiled water, and, when dried, applying a mixture of fuller's earth, subnitrate of bismuth, and oxide of zinc. Ointments are generally irritating.

Treatment of Purulent Ophthalmia.

The classical treatment of purulent ophthalmia of infants by nitrate of silver has been abandoned by Dr. Westermann, who obtains the same results from the more gentle method of instillations of argyrol—

Argyrol, 10 gr.
Water, 1 dr.

Three drops are instilled into the eyes every three hours. After 48 hours of this treatment methylene blue is substituted—

Methylene blue, 1 gr.
Water (sterilised), 1½ oz.

Four drops, every four hours, between the eyelids. After two or three days of this treatment, finely powdered iodoform is blown into the inferior cul-de-sac twice a day for the space of two days, after which 1 drop of laudanum is instilled every morning for eight days, completing the treatment.

Treatment of Obesity.

The treatment of obesity is, above all, hygienic, but certain therapeutic means come in as adjuvants.

Purgatives hold the first rank. Stout persons are generally constipated through sluggishness of the liver and atony of the intestine. Saline purgatives are particularly indicated, and might be given once a week.

The use of alkalines, such as bicarbonate of soda or mineral waters are indicated for their stimulating effect on the diverse arthritic manifestations.

The administration of iodide of potassium enjoyed great favour for a long time, but to-day it is practically abandoned in the treatment of polysarcia. It is useful, however, in concomitant affections (asthma, rheumatism deformans, arterio-sclerosis). The thyroid treatment, which gives such remarkable results in myxœdema, suggested the idea to Leichtenstein, Wendelstadt, Bourneville, of treating obesity by the same method, and brilliant successes were recorded; but after repeated trials it was discovered that the thyroid treatment was not favourable to every case, and, on the other hand, its prolonged use was not without danger.

Without rejecting completely this treatment, which may be suitable to certain varieties of obesity, it should be prescribed with caution.

The thermal cure should not be neglected when possible—Chalet-Guyon, Vichy, Marienbad, Carlsbad, Kissingen, Hombourg—completed by massage, exercise and sudations.

GERMANY.

Berlin, April 5th, 1908.

At the Society of Surgeons, Hr. Rinne discussed the
Differential Diagnosis of Typhlitis and So-Called Disease of the Appendix.

Since, some years ago, having a case under his care in which the diagnosis was for a long time doubtful, and which at last turned out to be one of appendicitis, his interest had been aroused in the subject, and since that time in making gynæcological examinations, in all women suffering from perityphlitis—a total of 370—he had ascertained that amongst this number 41, or 11 per cent., had some affection of the genital system. In one-third of these there was no appendicitis; the diagnosis was therefore wrong.

As regarded differential diagnosis, the history was to be considered first. If the disease was bilateral, it was probably an affection of the adnexa. If the tumour was high up on the pelvic wall its origin was probably the appendix; if it lay around the uterus it would be adnexal. If general peritonitis was the first thing noticed, then the seat and character of the pain, the tension of the abdomen, and the course of the disease would be considered. That one was liable to errors in the consideration of these points was shown by two cases in which a ruptured tubal pregnancy was mistaken for peritonitis from appendicitis. The diagnosis was often, therefore, very difficult, and even impossible; but it was always well to treat the case as if perityphlitis was present—*i.e.*, to operate in doubtful cases.

Hr. Müller suggested that the pain zones of the skin of the abdomen should be utilised in coming to a conclusion, as those of appendicitis were different from those of disease of the adnexa.

Hr. Gottschalk was of opinion that the pain gave no clue as to diagnosis. This would be more difficult in chronic cases, especially when there was an acute exacerbation in the course of chronic disease of the adnexa, a mistake could easily be made. A very accurate examination would prevent errors.

Hr. A. Pincus communicated a note on
Therapeutical Attempts with Trypsine and Amylopsine
in inoperable malignant tumours. No harm was done by the treatment, nor any good. Post-mortem examinations showed no characteristic changes. In two cases of extensive tuberculous glandular disease of the neck, one in an adult and one in a child, there was some retrogression of the disease in the glands but no recovery.

Hr. Seefisch showed a case of
Volvulus of the Ascending Colon.

The patient was a working man, æt. 45, who for a long time had suffered from pain in the stomach after eating, and who was suddenly taken ill on January 11th with violent pain, vomiting, and collapse. The abdomen was of boardy hardness, the most tenderness on pressure in the right side. In the belief that the case was one of perforation of the vermiform appendix, an operation was performed the same night. Some odourless exudation was found in the abdomen. The cæcum and vermiform appendix were not in their usual place, but the speaker found a tense tumour to the left of the incision. After enlarging the incision this was found to be the twisted and displaced ascending colon, which was swollen and of a blue-red colour. The vermiform showed no other changes. The twisted loop, the mesentery of which was very long, was untwisted. During the toilet of the peritoneum some peppercorns came into view, and on further search a perforation of the anterior wall of the stomach not far from the pylorus. This was stitched round and over, and the abdomen well washed out and closed. Recovery was uninterrupted. The speaker thought the perforation was the first occurrence, and the volvulus the result of the vomiting.

Hr. Seefisch also showed a youth, æt. 19, who fell from the second storey of a house and fractured the first lumbar vertebra. There was paresis of both legs and transient paralysis of the bladder, which required the catheter on two occasions. He had pain in the left side, which in the course of six weeks amounted to violent colic. Röntgen illumination showed two concretions of the right ureter. The ureter was now opened and the concretions removed, the ureter being again closed. Recovery.—There could be no infection of the urinary passages that led to the formation of the concretions. There was probably a causal connection between the fracture of the vertebra and the calculi.

At the Medical Society Hr. Klapp spoke on the
Treatment of Phlegmons of the Sheaths of Tendons.

He pointed out the indifferent results that had been obtained even in recent times. He claimed that better functional results were obtained by the Bier method—*i.e.*, by smaller incisions and permanent stasis. By following this plan the function of the tendon would be retained in about half the cases. The idea had occurred to him that as good results might be obtained by the small incisions without the stasis. In a series of cases he had omitted the latter, and had made small lateral incisions in the fingers, sometimes as many as four, and had been satisfied with the results obtained.

AUSTRIA.

Vienna, April 5th, 1908.

Cutaneous Absorption.

At the Gesellschaft, Oppenheimer related his experiments on normal and pathological skins to determine the amount absorbed by the skin in disease and health. The substance used was jothion, which is absorbed rapidly when the skin is in a healthy condition, appearing in the urine in less than one hour after application.

In cutis atrophia idiopathica the drug is long in appearing in the secretions, and very scanty when it does appear, four hours at least after painting on the skin. In scleroderma universalis with a histological epidermis the rigid deposit in the cutis narrows and almost closes the vessels as well as the sebaceous and sudatory ducts which diminishes and delays the absorption more than an hour and a half, but this retardation is even less than it is in the atrophic skin. The glands of the skin seem to play an active part in this absorption, and to determine how far these participated cases of lichen ruber acuminatis universalis, ichthyosis congenita universalis and syringo cyst adenoma were acted on; but, strange, all these did not differ much from the normal condition. Hyperkeratosis and parakeratosis, which affect the follicles and sudatory glands, do not affect the absorption. On the other hand, there is a distinct difference of absorption in the smooth bald skin and that densely covered with hair. In the bald head the jothion is absorbed very slowly, while the hairy head takes it up greedily. It seems the epidermis plays an active part in the absorption from the diffusion effects of that structure more particularly on the sebaceous glands.

Röntgen Rays and Epilepsy.

Robinsohn gave a few examples of epilepsy, and expounded a new method in the *technique* of cerebral radiology whereby a number of our blunders may be avoided. He exhibited a case of traumatic epilepsy where the Röntgen rays exposed a shadow about the size of a walnut, lying in the upper part of the cerebral hemisphere and having every appearance of an alveolar tumour. To remove the deception many examinations must be made, with varying results. To avoid this Robinsohn uses two sensitised plates, which he calls the double method, wherein the weak and the strong, exposed by the same light can be brought into contrast. By this means the imperfect shadow is greatly reinforced and the morbid condition more accurately observed. Benedikt said he had recently diagnosed several epileptics with the Röntgen rays, but at first he had to confess there was much confusion in his mind with the Pacchionian cavities in the vault of the cranium, where a grey cloud seemed to linger. This nebulus which he showed, was not a traumatic affection, but rather a neoplasm. In another case of a traumatic nature this nebulus was found in a rhomboid or longitudinal depression in front of the sagittal suture. In front of this depression a spoon-like spicula of bone could be seen protruding. The patient complained of severe spasms in the toes of the opposite side of the body.

Redlich thought all these diagnosis very ingenious, but he had to confess he could not diagnose genuine and symptomatic epilepsy by means of the Röntgen rays. He then related two cases to prove his scepticism. They were both diagnosed by the rays as symptomatic epilepsy, but at the post-mortem the one had tubercle in the left frontal lobe of the brain, the second had an extensive glioma in the same region. There was great danger in relying too much on the Röntgen rays in cerebral disease.

PHYMOSIS.

Pollak, from Prague, gave a description of a method which he practises in relieving phymosis in the infant. He does not circumcise, but makes a longitudinal incision back to the corona. He then pushes all back and puts a few stitches in the wound and leaves it to heal, which it does with excellent results.

BLOOD-LETTING IN NEUROSIS.

Theilhaber is a firm believer in bleeding for the relief of neuralgia and other pains in gynæcology. He tells us that we bleed for renal diseases, uræmia, cerebral diseases, poisoning by gas, etc., and why not relieve the tension in neurosis. Dyes relates cures by bleeding in lead poisoning, others avert eclampsia by the same means, while Eversbusch relieves ophthalmia by the same method.

The indications for relieving neuralgia is when the blood tension is high. The same may be performed with pain in the abdomen, cephalalgia, sleeplessness, arthritis, and the climacteric period. Scarification of the portio will relieve nervous metrorrhagia, atonic hæmorrhagic metritis, or persistent bleeding when the vascular tension is high, but is contra-indicated in chlorosis.

HUNGARY.

Budapest, April 5th, 1908.

The Secretary of the Society of Dermatologists has lately read a paper on the progress of the prophylactic study of syphilis of late years. He said that there was renewed activity in this direction among the medical profession in recent times. The reasons were not an increase in the number of cases, nor a more severe course of the disease, but better statistics and the discovery of the bacillus of syphilis. The spread of syphilis could be limited by means which applied to the general public and the individual. The former included control of prostitution, but had proved a failure. Impracticable also was the suggested compulsory report of cases by physicians. A better measure was the education of the public as to the nature of the disease. Instructions should be given how to avoid infection innocently. He made a plea for increased facilities for treatment in hospitals and dispensaries. The Secretary, Dr. Huber, thought that at the present time the most valuable prophylaxis against syphilis ought to be practised by the medical profession in their relations with their patients. Since no methods were known to abort the disease after infection occurred, the most important duty was a thorough treatment.

At the recent meeting of the Medical Society, Dr. Kubinyi read a paper on the

CLEANSING OF THE VAGINA.

He said that the question of the preliminary cleansing of the vagina has been dealt with exceedingly much, and still is not yet satisfactorily settled. So much is true, that the cleansing of the vagina has a decided bearing on the morbidity of the puerperium. He bases his conclusions on statistical and bacteriological investigations. Three per cent. solutions of creosol were employed for the irrigations, and he absolutely denies that any disinfectant effect can be obtained with the 1 per cent. solution. The average number of cases in which no rise of temperature occurred during the puerperium was usually about 68 per cent., while during the two years in which no irrigations were employed this number sank to about 53 per cent. In the operative cases in which the cleansing was more complete and thorough, the number of cases in which no fever was present was even greater than the average. In a number of instances in which streptococci were demonstrated in the vagina before douching, a marked decrease in the quantity of growing organisms was noticed within a few hours after the irrigation had been given. The writer claims that if such a procedure is attended by the good results mentioned, there is no reason why it should not be employed, provided that it is not attended by any harmful results, and he does not believe that such occurs in the method advocated.

Dr. Lesner reported a case of

POISONING FROM POTASSIUM CHLORATE.

The patient, a man, æt. 27, purchased at a drug store a bottle containing fifty 30-centigramme tablets of potassium chlorate. Though the printed directions were to dissolve one tablet in the mouth every hour or so, the patient used the entire 50 during 18 days. On the nineteenth day the patient complained of itching, and after three days the trunk, forearms, wrists, thighs, legs and ankles were seen to be covered with innumerable reddish macules. There were also numerous petechiæ. There was no nausea, diarrhœa, or headache. The patient made a slow but uneventful recovery.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

The University Bill.—The chief interest of the week has, of course, been the appearance of the long-promised University Bill, and on all sides it is discussed with the greatest vigour. Naturally, there are differences of opinion, but on the whole medical opinion is decidedly in its favour, and this is specially true among those who have had any experience in educational affairs. A few irreconcilables, members of the association run by the late Dr. McKeown, have maintained their principles by cursing the Bill from the first report of its conception all through its period of gestation, and it is hardly to be expected that they will be silenced by its appearance; but their opposition was looked for, and is not counted of much importance. The fact, too, that it is opposed by certain politicians does not dismay its friends, for such opposition is loked on as merely a show of fight to satisfy election pledges, and whatever weight it might carry is fairly neutralised by the fact that the leading business men of the city are strongly in its favour. The Belfast Medical School has made great advances of late years, and there are a large number of young men connected with it who feel that if we are left to work out our own ends in University matters we can establish a strong and successful school with a degree that will command respect wherever Ulster men go. The raw material is excellent, as has been stated again and again by teachers from other schools who have come to Belfast, and if a properly equipped school is provided by Government and private generosity, and a high standard maintained by examiners, there is no apparent reason why these high aspirations should not be realised.

LETTERS TO THE EDITOR.

CONJUNCTIVITIS NEONATORUM.

To the Editor of The Medical Press and Circular.

Sir,—There can only be a general agreement with the editorial views which you express in your last issue upon the above subject. Nevertheless, it has been and is maintained that the term "ophthalmia" is a group name which should be retained on "practical" grounds, inasmuch as inflammation of the conjunctiva in the new-born is produced by a variety of morbid germs. Just so, however, is it in the case of conjunctivitis of the adult. In both the causes of the disease are in every way identical. Moreover, at least 90 per cent. of the cases of conjunctivitis neonatorum are due to gonococcic infection. How absurd, therefore, it is to describe them as purulent "ophthalmia," when the same disease in the adult is properly designated purulent conjunctivitis. As you rightly surmise, the newer generation of ophthalmic surgeons will probably recognise that there are no "practical" grounds for the retention of such an unscientific anachronism as "ophthalmia."

I am, Sir, yours truly,
Percy Dunn.

Wimpole Street, London, W.

A QUESTION OF FEES.

To the Editor of The Medical Press and Circular.

Sir,—The extraordinary case which came before the law courts last week, in which a dental surgeon sued the husband of a patient for £570 for work performed on his wife's mouth, suggests to me that the time has come for the whole subject of fees to be considered by medical men. Surgeons' fees have grown to an exorbitant scale, and there is a widespread distrust of them by the public on that account. Some of the specialists have destroyed the good name of the profession by their excessive fees, by their general rapacity, and the way they send patients from one to the other. On the other hand, the physician, whose art is, I consider, the more scientific and infinitely more difficult, is being crushed out of existence, while the general practitioner at the other end of the scale is being starved on fees that amount in pence to the surgeon's and specialist's fees in guineas. (Moreover, the general practitioner often loses his patients, who are annexed by the consultant or specialist.)

What is to be the remedy? Are we to look to a higher standard of education for the general practitioner, with the rising tide of post-graduate instruction as a final touching-up? Or are we to be driven on the principle, *Ut quimus, quando ut volumus non licet*? I am hopeful that the former will be the ultimate virtue.

I am, Sir, yours truly,
G. P. T.

OBITUARY.

WILLIAM WOOD, M.R.C.S., L.S.A.

Dr. William Wood, whose death we regret to announce at Garton-on-the-Wolds, near Driffield, was for many years a familiar figure in the East Riding. He passed through his medical course in London, Glasgow, and Paris, and at one time held the appointment of Demonstrator in Anatomy at Glasgow. While continuing his studies at King's College, London, he was attached to the residential medical staff at King's College Hospital, and during that time he devised a surgical appliance for the treatment of excision of the knee-joint. In 1857 he became a member of the Royal College of Surgeons, and about that time he succeeded his father in an extensive practice at Middleton. He acted for over 40 years as Medical Officer to the Driffield and Beverley districts, and also held other appointments. Dr. Wood was possessed of a keen sense of humour, and during his professional experiences, which lasted over 50 years, had ample opportunity for the collation of a rich fund of anecdote and reminiscence. He was an enthusiastic sportsman, a good shot with a rifle, at one time a follower of the Holderness Hounds, and for 25 years a member of the Derwent Anglers' Club, Scarborough.

SURGEON-CAPTAIN J. NESBITT PATTERSON.

On Thursday last, Surgeon-Captain Patterson, of Earlestown, Lancashire, succumbed to an attack of influenza, after only three days' illness. The deceased gentleman qualified in 1878, having studied at Queen's College, Belfast, and the Ledwich School of Medicine, Dublin. He went thence to Earlestown and built up a lucrative practice. He was a member of the local Urban Council, and only a few days ago was re-elected without opposition an overseer of the poor and chairman of the Warrington Board of Guardians. He also occupied the post of Surgeon-Captain to the 1st V.B.S. Lancs. Regiment.

SPECIAL ARTICLES.

THE NEW UNIVERSITY BILL.

Mr. Birrell's long-promised University Bill for Ireland was introduced on the 31st ult. and received with almost universal approval. His scheme proposes to establish two new Universities—one in Dublin and one in Belfast. The University in Dublin will take the place of the Royal University, which will cease to exist. It will include the Colleges at Cork and Galway and a new College in Dublin. The Belfast University will include the Belfast College, and probably at a later date Magee College, in Londonderry. The Senates of both Universities will be nominated at first, and hold office for five years. After that they will be elected academically. There are to be no religious tests, and no public money is to be paid for denominational education.

The powers of the Senate will be similar to those of other Universities. They will have the appointment and dismissal of the professors, though the first professors in the Dublin College would be appointed by a Statutory Commission, to be specially set up for each University. A dismissed professor would have a right of appeal to the Visitor, and the Visitor to the Crown, acting through a board, nominated *ad hoc* according to the nature of the dispute.

The Professors in the existing Colleges at Cork and Galway will go on. They hold their position under tenure from the Crown, and nobody proposes to interfere with them if they wish to go on. They will remain Professors of the University on the old terms. When they die or retire the Senate will appoint their successors under the provisions of the charter. It is thought desirable that the new Professors of the new College in Dublin should be appointed by a Statutory Commission which it is proposed to set up. There will be two Commissions—one for Dublin and one for Belfast—and they will have powers to sit together when joint interests arise. Otherwise they will be independent. There will be Commissions of seven members each—four elected by the Senate and three nominated by the Crown. It has been stated that the post of President of the Dublin College will be offered to Dr. D. Coffey, the Professor of Physiology in the Catholic University Medical School.

The official income of the Queen's Colleges, now standing at £56,500, will be increased to £100,000, of which Belfast will get £28,000, the new College in Dublin £32,000, and Cork and Galway £18,000 and £12,000 respectively. Belfast will also get a building grant of £60,000, and the Dublin College one of £150,000.

There is no doubt that Mr. Birrell's scheme has followed, as we foreshadowed some time ago, the line of least resistance, that is to say, the lines suggested by the Robertson Commission. We referred in our last issue to the probable effect of the establishment of new Universities on the Royal Colleges in Ireland, and we also drew attention to the disastrous consequences which would result from the paralysis of such bodies, both from the view of the medical profession and of the State. We trust, therefore, that immediate steps will be taken by these bodies to bring their position before the official promoters of the University Bill, with a view to securing some recognition or compensation for the injury which must result to them.

So far, all opinion on the Bill is based on Mr. Birrell's introductory speech, as the measure itself has not been printed for a sufficient time for its close study. One point is certain to cause active discussion, namely, the question as to whether the professors are to be appointed by the Senate or by the Crown. As Mr. Balfour pointed out, "it is only by appointment by the Crown you can be sure of not being unduly influenced by academic surroundings. . . . It is not often that the Senate would be anxious to go outside the limits of a certain number" belonging to the University. Another most important point is the question of the fees to be charged by the Colleges, as it would be a most undignified position if the various educational bodies were to engage in efforts at underselling one another. This is all the more important since underselling would be so very easy in the case of State-aided institutions. The Financial Clauses, too, will probably require amendment.

THE HEALTH OF THE NAVY.

The annual report on the Health of the Navy for the year 1906 (*a*) recently issued contains the usual statistical returns of disease in the Navy.

These returns show a continuous improvement in the general health of the Fleet, as compared with that of previous years. Not only are the case, invaliding and death ratios for the year under review lower than the average ratios for the last nine years, but the average loss of service for each person has dropped from 12.79 to 10.60 days, and this year's ratios are, under each heading, the lowest recorded since 1856.

The total force was 108,190, and the total number of cases of disease and injury was 77,842, which is in the ratio of 719.49 per 1,000, being a decrease of 119.3 per 1,000, as compared with the average ratio of the last nine years.

The average number of men sick daily was 3,144.77, giving a ratio of 29.06 per 1,000, and showing a decrease of 6.00 in comparison with the last nine years' average. The ratio per 1,000 of men sick daily on the various stations was: On the Home Station, 32.09; Channel, 21.51; Atlantic, 23.92; Mediterranean, 24.68; North America and West Indies with Particular Service Squadron, 31.04; China, 34.83; East Indies, 29.22; Australia, 28.16; Cape of Good Hope, 24.46; and Irregular List, 55.19. The Channel Fleet shows the lowest sick rate, and the Irregular List the highest, as was also the case during 1905.

The total number of persons invalided was 2,436, which is in the ratio of 22.51 per 1,000, and shows a decrease of 5.73 per 1,000 in comparison with the average of the last nine years.

The total number of deaths was 399, giving a ratio of 3.68 per 1,000, which shows a decrease of 1.46 per 1,000, in comparison with the average ratio for the last nine years. Of this number 269, a ratio of 2.48 per 1,000, were from disease, and 130, a ratio of 1.2 per 1,000, from injury.

As regards different diseases there were 2,950 cases of *influenza*, with 3 deaths. More than one-third of the cases occurred on the Home Station. There were 57 cases of *diphtheria*, with 3 deaths. There were 184 cases of *enteric fever*, with 32 deaths. The case ratio shows a decrease on the average of the previous nine years. There were 216 cases of *Mediterranean fever*, with 134 invalidings and 5 deaths. There were 54 cases of *dysentery* with 2 deaths, and 436 of *malaria* with 3 deaths. Of local diseases there were 904 cases of *diseases of the nervous system* with 13 deaths; 885 cases of *diseases of the eye;* 669 of *diseases of other organs of special sense* with 5 deaths; 675 of *diseases of the circulatory system* with 243 invalidings and 44 deaths; 8,165 of *respiratory diseases* with 134 invalidings and 31 deaths; 11,556 of *diseases of the digestive system* with 287 invalidings and 19 deaths; 600 of *lymphatic and glandular diseases* with 2 deaths; 767 of *diseases of the genito-urinary system* with 81 invalidings and 12 deaths; 671 of *diseases of the organs of locomotion,* 10,950 of *diseases of the connective tissue and skin,* 16,672 of *wounds and injuries* with 168 invalidings and 121 deaths. Nine persons committed suicide.

Of *tubercle* 290 cases with 216 invalidings and 39 deaths are recorded. Both as compared with last year and with the last nine years, the case and invaliding ratios show a satisfactory decrease, while the death ratio is identical with that of last year, but shows a decrease on the nine years' ratio. For the first time in these reports the cases of tubercular disease have been classified, with the following results:—Of the total number of cases, pulmonary tubercle contributed 256 cases, with 35 deaths; tubercle of glands, 8 cases; tubercle of testis, 7 cases; tubercular disease of joints and bones, 6 each; tubercular meningitis, 3, all fatal; acute miliary tubercle, 1 fatal case; tubercle of larynx, tubercular ulceration of rectum, and tubercular lupus, 1 case each.

Of *venereal diseases* the total number of cases recorded is 13,193, viz., *chancroid,* 1,672; *syphilis primary,* 1,888; *syphilis secondary,* 3,153; and *gonorrhœa and its sequelæ,* 6,480 cases. Chancroid gives 13 invalidings; syphilis primary, 10 invalidings; syphilis secondary, 163 invalidings and 4 deaths; gonorrhœa and its sequelæ, 93 invalidings and 2 deaths—a total of 279 invalidings and 6 deaths. The total number of days' loss of service was 316,631, while the average daily number ineffective from these diseases was 867.46.

The enormous amount of sickness from these diseases shows very little sign of any diminution as years go on. A slight fluctuation is noticed year by year, but the case ratio for the year under notice is practically identical with the average ratio of the last nine years. Nearly all other diseases show a pretty steady yearly decrease; these remain *in statu quo.* Australia shows the highest case ratio. The case ratio on that station was 214.75 per 1,000—an increase of 58,57 as compared with last year, and of 56.73 in comparison with the average ratio for the last nine years. At the same time it is worthy of note that Brisbane, where apparently a modified Contagious Disease Act is in force, is noted as being practically free from these diseases; and the medical officer of the *Pegasus* reported that at Noumea, where the French authorities rigidly enforce a Contagious Disease Act, not a single case was contracted, although leave was freely given to the crew during all days of the visit of the ship to this port.

The Appendix contains an interesting and careful report on Caisson Disease by Staff-Surgeon Rees, who recently acted as secretary to a committee appointed by the Admiralty to inquire into the subject. He suggests that safety in decompression may be secured by attention to two points—limiting the time of exposure and bringing the diver up slowly.

Royal Army Medical Corps.

Capt. J. H. R. Winder, M.D., B.Ch., from Malta, has been appointed to the Irish Command at Belfast for duty. Capt. D. Harvey, M.B., has been directed to proceed to Naini Tal for duty in the Station Hospital during the summer months. Sergt.-Major Harwood, the warrant-officer at the Connaught Hospital, left Aldershot on Saturday for service at Bermuda. Capt. E. Brodribb, M.R.C.S., from the Royal Army Medical College, has been appointed to Shorncliffe, as specialist in ophthalmology.

Diseases following Earthquake in Jamaica.

The Medical Officer of Kingston, Jamaica, in his report on the health conditions in the city during the last year, traces many cases of chest and pulmonary troubles, stomach and liver complaints to the exposure and privation following the earthquake. He thinks the septic dust from the broken buildings blown about by strong winds through months of drought spread disease.

(*a*) Navy (Health). Statistical Report of the Health of the Navy for the Year 1906. London: H M. Stationery Office. 356. Price 1s.

REVIEWS OF BOOKS.

THE QUARTERLY JOURNAL OF MEDICINE. VOL. I. (*a*)

In this are several papers of great interest, among which we may mention one on "The Parathyroid Glands" (their function and relation to the thyroid gland). The author's object is to prove that the glands are portions of the main thyroid gland which have assumed functional activity, but have not yet formed vesicles. He brings forward evidence from (1) an evolutionary standpoint; (2) the comparative histology of the thyroid gland; (3) the comparative histology of the parathyroid glands; and (4) the embryonic and cystic adenomata of the thyroid gland. In the first place, the importance of the function of an organ depends on the duration of its existence, the vital functions being earliest developed. The long-established viscera will not be so subject to anatomical variations as those of recent origin. If the parathyroids possess the supreme importance attributed to them, their philogenetic age would be great, and their anatomical features should be constant as other ancient organs. Yet, more than any active organ in the body, parathyroids are liable to wide variation.

The author points out the very varied results obtained by different experiments after removal of the parathyroids, and explains this by the difficulty of performing the operation without injuring the thyroid gland and the likelihood of leaving some parathyroid tissue behind. He also quotes the definite statement of some experimenters that the more severely the thyroid is damaged the more likely is a fatal result to ensue.

The views of the author are founded on an examination, naked eye and minute, of the glands in the neck in 58 human subjects and 77 animals and birds. The following are his conclusions:—

(1) The parathyroids are not merely embryonic in nature. In the majority of specimens there are definite signs of cellular activity.

(2) They are portions of the main thyroid gland which have assumed functional activity, but have not yet formed vesicles.

(3) Parathyroids may develop into thyroid tissue, and intermediate types occur.

(4) The secretion of the parathyroids is a colloid material indistinguishable from thyroid colloid.

(5) The parathyroids, therefore, are glands essentially thyroidal in nature, possessing no peculiar functions, but engaged in the active secretion of the same substance as the thyroid gland.

This paper is accompanied by a very full bibliography of the subject, and is well illustrated.

In a paper on "Cervical Ribs, and their Relation to Atrophy of the Intrinsic Muscles of the Hand," the author refers to several cases he has seen since 1893 in which there was a wasting of the intrinsic muscles of the hand, which did not go on to progressive muscular atrophy, and where the wasting was not confined to the muscles supplied by a single nerve. A paper by Dr. William Thorburn in 1904 suggested that these cases were due to the pressure of a cervical rib on the first dorsal nerve, and on taking skiagrams of as many of these cases as could be traecd, 10 out of 14 showed well-marked cervical ribs.

Another paper of peculiar interest is one on "An Undescribed Form of Dwarfism Associated with a Spatulate Condition of the Hands." The authors describe 4 cases which they have seen; three of these were sisters, and the fourth case was also a female. The dwarfing and broadening of the hands gives the cases some resemblance to achondroplasia. That they are not cases of this affection, however, is shown by the following facts:—(1) The proximal segments in each limb are not relatively shorter than the distal. The hands when hanging by the side reach to about the normal position on the thighs. (2) The broadness of the hands extends to the terminal phalanges of the fingers, and not only to the proximal, so that the fingers are not conical, as in achondroplasia, and when the hand is held with the proximal phalanges closely approximated, the two distal phalanges are also closely approximated, so that there is no tendency to the appearance described by Marie as *la main-en-trident*. The last paper is one on "Ochronosis,". with a description of a case. The whole journal is well got up, and the illustrations, some of which are in colours, are beautifully reproduced.

THE EDINBURGH MEDICAL JOURNAL. (*a*)

This volume contains a number of useful and interesting papers, dealing with various branches of clinical work. Dr. W. J. Stuart gives an elaborate *résumé* of our knowledge concerning "Operative Injuries of the Thoracic Duct in the Neck"; Alexis Thomson discusses "The Making of a Shelf below the unduly Mobile Kidney"; and Miles reviews the recent literature on "The Surgery of the Prostate and on the Ulterior Results of Operations for Mammary Cancer." On the pathological side much interest attaches to the blood examinations made on a patient subsequent to excision of a ruptured spleen, by Matthew and Miles, and also to Monsarrat's paper on "Renal Sarcoma in Children." Clinical medical work is represented by Philips' paper on "Certain Adaptations of Percussion in the Diagnosis and Prognosis of Respiratory Disease," and by Sutherland's paper on "Pulmonary Hypertrophic Osteoarthropathy." Papers of interest to toxicologists, and to specialists in eye and ear work, and in diseases of women, are also included, and help to make the volume one of interest to all sections of the profession.

STEPHENSON ON OPHTHALMIA NEONATORUM. (*b*)

This very interesting monograph received the Middlemore Prize of the British Medical Association, and certainly, even if its value is only based on the amount of labour bestowed upon it by Dr. Stevenson, it well deserved recognition. The book begins with an account of the effect of ophthalmia on infants in the past, and is based on the statistics of numerous lying-in hospitals, London and provincial Poor-law maternities, foundling hospitals, and eye hospitals and clinics. We learn that, whereas the percentage of cases of ophthalmia in 15 Continental maternities prior to 1882 was 4.05, the percentage in six British maternities after that date was only 0.22.

The next section deals with the origin of ophthalmia, and in this the author refers to the many various theories which have held the field since Quellmalz in 1750 first insisted upon its connection with maternal leucorrhœa. The ultimate result of the author's inquiries is to determine the existence of two forms of ophthalmia neonatorum—a severe form which is always gonorrhœal in origin, and a milder form the outcome of the action of other organisms, traumata, and certain constitutional states such as syphilis.

The next section deals with the symptoms and histology of ophthalmia, and the two next sections with its diagnosis, prognosis and prevention. The section dealing with prevention is long and important, and its conclusion may be said to be that either a 1 per cent. solution of silver nitrate, or a 1 in 4,000 solution of corrosive sublimate, should be dropped into the eyes of every baby born in a public institution.

The last section of Dr. Stevenson's work deals with the treatment of ophthalmia, and we are glad to see that here he recommends some of the newer silver salts such as argyrol and protargol as a substitute for the nitrate of silver. A 25 per cent. solution of argyrol is what he personally uses.

Dr. Stevenson has bestowed an immense amount of time and thought on his monograph, and we are very glad to be able to heartily congratulate him on the result of his labours. Obstetrical specialists do not

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(*a*) "The Quarterly Journal of Medicine." Vol. I., No. 2. January, 1908.

(*a*) "Edinburgh Medical Journal." Vol XXII. New Series. Edited by Alexis Thomson and Harvey Littlejohn. Edinburgh and London: Young J. Pentland.

(*b*) "Ophthalmia Neonatorum, with special reference to its Causation and Prevention." By Sydney Stephenson, M.B., C.M., Ophthalmic Surgeon to Queen Charlotte's Hospital, London, &c., &c. Pp. 258. London: George Pulman and Sons. 1907.

require to be told of the truth of his conclusions, but there is still, we fear, a large body of medical men who are inclined to regard the precaution he recommends as unnecessary. We trust, however, that the figures in the book before us will go a long way to convert such doubters.

A SYSTEM OF MEDICINE. (*a*)

THE third volume of Allbutt and Rolleston's "System of Medicine" is divided into three parts. The first deals with general diseases of obscure origin; the second with the diseases of the alimentary canal; and the third with the diseases of the peritoneum. The volume has undergone very considerable rearrangement, and "in the main, especially as regards the more important articles, is a rewritten, rather than a revised, successor of Volume III. of the original edition." Amongst the many new articles may be mentioned Dr. Garrod's articles on rheumatoid arthritis, osteo-arthritis, and other forms of joint affections; Dr. Batty Shaw's article on pulmonary osteo-arthropathy; on achondroplasia by Dr. Poynton; on congenial hypertrophy of the pylorus by Professor Still; on the bacteriology of diarrhœa by Dr. Slater; on acute peritonitis by Drs. Allchin and Andrewes; and on sub-phrenic and other forms of peritoneal abscess by Dr. Acland.

In addition to these new articles, several others have been almost entirely rewritten. The more important of these are the articles on diseases of the mouth by Mr. Walter Spencer; on appendicitis, intestinal obstruction, and visceroptosis by Mr. Lockwood, Mr. Barnard, and Dr. A. Keith, respectively; and on the differential diagnosis of diseases of the anus and rectum by Mr. Mummery.

The third volume more than maintains the reputation of its predecessors, and from a literary point of view is in most respects admirable. It seems, however, a pity that in a book of this kind, on which so much labour has been spent, there should not be a freer use of illustrations.

HOLT ON THE DISEASES OF CHILDREN. (*b*)

IT is not often that we receive for review in the same month two works coming from the same country, both of which may be regarded as at the very top of their class. Yet recently we received for review Prof. Whitridge Williams' work on "Obstetrics," and now we have received Prof. Holt's work on "The Diseases of Children." The latter work, with which we are at present alone concerned, has reached its fourth edition, and has been thoroughly revised. It has also been somewhat enlarged. The principal alterations have been made in the sections of the book dealing with nutrition. These parts have been largely rewritten, and a considerable amount of new matter introduced. The remainder of the book has only been slightly altered.

The section devoted to nutrition consists of six chapters. The first is introductory, and deals with food constituents, and the purposes they serve in nutrition. Chapter II. deals with the dietary of the infant, and discusses in detail the various forms of foods, natural and artificial. There is some interesting information on the subject of proprietary foods, which, as the author points out, though not by any means perfect substitutes for breast milk, are often of considerable value for temporary use in pathological conditions. Chapter III. deals with the different methods of infant feeding—maternal breast, wet nurse, mixed feeding, artificial feeding, etc. It contains some most valuable tables dealing with percentage feeding, etc. Chapter IV. deals with feeding after the first year, and is also most interesting. Chapters V. and VI. deal respectively with the derangements of nutrition and diseases due to faulty feeding.

As we have already said, we consider Prof. Holt's work to be the standard work on the diseases of infancy and childhood, and we heartily congratulate the author on the fact that it has reached its fourth edition.

NEWMAN ON MOVABLE KIDNEY. (*a*)

THIS book contains a systematic consideration of the displacements and malformations of the kidney, and is based on the author's practical experience. The first chapter deals with the classification of the displacements and malformations of the kidney, and its normal anatomy. The second, third and fourth chapters deal with "movable kidney." The sixth chapter deals with floating kidney, and the seventh with fixed malpositions and malformations.

We look with interest to see what the author considers are the indications for and contra-indications to nephrorraphy in cases of movable kidney. He considers the operation should be recommended in all uncomplicated cases in which the pain is distinctly renal, where there is evidence that the displacement causes twisting of the pedicle of the kidney, and where gastro-intestinal symptoms are pronounced when the patient is active, but are relieved when she is at rest. On the other hand, he considers that the operation should not be performed when the symptoms distinctly referable to the mobility of the kidney are a small part of the trouble.

Dr. Newman's contribution to the literature of renal displacements will prove of interest and assistance both to surgeons and to physicians.

Tropical Disease Research.

A REPORT of the Advisory Committee for the Tropical Diseases Research Fund has just been issued. The revenue for last year was made up by contributions from the Imperial Government (£500), the Government of India (£500), from funds at the disposal of the Rhodes Trustees (£200), and £1,875 from the Colonial Governments. The whole made a total of £3,075. The expenditure was a grant to the Liverpool School of Tropical Medicine of £500, to the London School £1,083, to the University of London £750, and to Cambridge University £100. The total was £2,433. The Liverpool grant was employed for the payment of a lecturer in economic entomology and parasitology. A further grant has been applied for and the Advisory Committee have agreed to allot £500 extra to the School from April 1st, the amount to be applied definitely to work in connection with sleeping sickness. A programme of that work is to be submitted before the grant is made. The London School has made application for a further sum, and the Committee have decided on an extra grant of £1,000 for the establishment of a post of entomology. The Committee have also been approached by the Secretary of State for advice as to the existing conditions of sleeping sickness in Uganda. The Committee decided to advise that the measures to be adopted should include:—(1) The segregation of all persons known to be infected with trypanosomes in camps which should be situated in places free from glossina; (2) the removal of the apparently healthy from fly-infested areas to places where it is believed that no fly exists; and (3) the clearing of such bush as would afford shelter for the fly at all fords, ferries, landing places, and sources of water supplies, for a limited area, such cleared areas to be kept free of bush and cultivated with low-growing crops which could not afford suitable shelter for the fly. These recommendations have been approved by Lord Elgin, and steps are now being taken to carry them into effect.

(*a*) "A System of Medicine by Many Writers." Edited by Thomas Clifford Allbutt, M.A., M.D.Cantab., LL.D., D.Sc., F.R.C.P.Lond., F.R.S., F.L.S., F.S.A., Regius Professor of Physic in the University of Cambridge, etc.; and Humphry Davy Rolleston, M.A., M.D.Cantab., F.R.C.P.Lond., Physician to St. George's Hospital, etc. Vol. III. Pp. 1,040. London: Macmillan and Co., Ltd. 1907. Price 25s. net.

(*b*) "The Diseases of Infancy and Childhood." By L. Emmett Holt, M.D., Sc.D., Professor of Diseases of Children in the College of Physicians and Surgeons (Columbia University) New York, &c., &c. Pp. xvii and 1170, with 241 illustrations and eight coloured plates. Fourth edition, revised and enlarged. London: Sidney Appleton. 1907.

(*a*) "Movable Kidney and other Displacements and Malformations." By David Newman, M.D., Surgeon to the Glasgow Royal Infirmary, &c., &c. Pp. xii. and 233. Illustrated. London: Longmans, Green and Co. 1907.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Report of a Case of Degenerated Uterine Myoma.—Vander Veer (*Surgery, Gynæcology and Obstetrics*, March, 1908).—Under this heading is cited the history of a patient, æt. 53, married, two children alive, one 29 years, the other 22 years; a four months' miscarriage fourteen years previously. The patient was admitted to hospital suffering from a large abdominal tumour, which she had noticed first four years previously. The menopause was past three years. The bowels were very constipated. On examination the tumour was proved to be twice the size of a four-month pregnancy. Fluctuation was elicited. On opening the abdomen a thick-walled, non-adherent cyst presented; 18lb of fluid was evacuated, one cyst not being opened. It was then found that the tumour consisted of a myoma of the uterus. Sub-total hysterectomy was performed. The specimen proved to be multiple myoma of the uterus. Cyst of the uterus, resulting from degeneration of a large myoma. Compression and obliteration of the uterine cavity, with degeneration and destruction of the mucosa. The cavities were lined with a smooth, shining membrane, a portion of the large cavity was thrown into folds and distributed through it were yellow areas containing cholesterin crystals. H.

Stab Wound of Fœtus in Utero.—Steele (*Surgery, Gynæcology and Obstetrics*, March, 1908).—The history of the case is as follows:—On September 15th, 1907, Mrs. M., æt. 19 years, married 3 years, mother of a child 22 months old, stabbed herself with a knife in the right side of the abdomen in a fit of anger. The site of the wound being four inches to the right and one and a half inches below the umbilicus. At the time she was pregnant six and a half months. Patient was brought to hospital and the wound treated, being quite healed at the end of a week. On November 28th, 1907, she delivered herself of a live male child, normally developed and at term. It was observed, however, that in the lateral aspect of the abdominal wall, on the left side, one and a half inches above the anterior superior spine, was a wound through which intestines protruded. The intestines were wrapped in antiseptic gauze and the child brought to hospital. On examination a partly healed incised wound an inch long at the point indicated was demonstrated. The jejunum and ileum adherent to its margins protruded. The upper part of jejunum was enormously dilated. The lower part, all the ileum and colon were coiled up and adherent, and very narrowed in calibre. Meconium was found in the rectum. The abdomen was opened, but the contractions and adhesions made any operation impossible. The child lived eight hours. On post-mortem examination it was found that the jejunum was completely cut across by the stab wound at about six inches below its juncture with the duodenum. The points of interest are: how the child survived the wound and went on living and growing. Another interesting fact was the complete occlusion of the two divided ends of intestine of the fœtus, and the presence of nearly 3 oz. of glairy fluid in the stomach at the time of operation—ten hours after the birth. Literature upon subject reviewed. H.

The Diagnosis of Early Pregnancy.—McDonald (*Amer. Journ. of Obst.*, March, 1908).—In this paper the author enumerates the ordinary early signs on vaginal examination of pregnancy, and then describes other signs which are seldom—and some never—mentioned in text-books. The first is asymmetrical enlargement of the uterus, which may almost become a distortion, and may give rise to errors of diagnosis. It is sometimes likened to a face swollen from an inflamed tooth, and gives a different sensation to the hand than the part which is not hypertrophied. On palpation it seems as if a tumour is annexed to the uterus, and it has been diagnosed as a tubal pregnancy. It has been thought by Dickinson and others that the harder, firmer side represents the side of gestation, while Hubl, Schauta, and Landau believe that the softer side is the location of the pregnancy. The next sign is flexibility of the isthmus of the uterus, which depends upon the softening and vascularity of the uterine tissue connecting the cervix and corpus uteri. Other signs are the "jug" sign, in which the body of the uterus is likened to the bulging part of a jug, while the cervix is the spout. This sign depends upon enlargement of the uterus, so that it may cause a notable protuberance or bellying. It does not occur until the third or fourth month, so is not of great value in the early weeks, when the enlargement is slight and often asymmetrical. Ladinski has recently drawn attention to a spot upon the anterior wall in the median line just above the junction of the cervix, where a marked change in consistency is said always to occur. This spot is said to be elastic and fluctuating in character. The signs of compressibility (Hegars) and flexibility of the isthmus, taken with intermittent contraction and uterine enlargement and softening, allow of a positive diagnosis in the early weeks of pregnancy. F.

Recent Advances in Obstetrics: "Better Procedure."—Cragin (*Amer. Journ. of Obst.*, March, 1908).—As compared with the past, our better procedure to-day is based largely upon a better knowledge of obstetric pathology and the mechanical problem of delivery. Realising, as we now do, the seriousness of the lesion in pernicious vomiting of pregnancy, and how important a *rôle* is played by disturbed metabolism, we are no longer satisfied with the ordinary examination of the urine for albumin, casts and urea, but have it examined by a chemist, the nitrogen partition determined, and the presence or absence of acetone, diacetic or oxybutyric acid, indican and bile pigment ascertained. There is no one of the laboratory findings nor groups of findings which can be relied on exclusively for prognosis or indication for treatment. It is only when they are studied in connection with the clinical picture of the patient that our decision should be made. As to the treatment of pernicious vomiting of pregnancy, the writer believes that the best results are obtained by colon irrigations, rectal feeding for a short time only, and early emptying of the uterus. Recent knowledge of chorio-epithelioma demonstrates well the fact that prolonged menorrhagia or metrorrhagia following labour, abortion, or operation for hydatid mole should be looked on with suspicion, and that early diagnosis and hysterectomy alone give hope of satisfactory results. In the treatment of puerperal infection, our knowledge of the ease of spreading the infection has brought about one improvement in procedure—viz., the rule to keep out of the uterus unless it contains materials which should be removed, and if the removal of infected material is needed, to do this with the least possible injury to the uterine wall so as to avoid opening new avenues of infection. Frequent and careful observations on the size of the child's head as compared with that of the pelvic canal, especially in cases which have had a previous difficult labour, will often tell us the time beyond which pregnancy should not continue, and induction of labour two weeks before term will often secure a relatively easy and safe birth for a child which otherwise would be lost. F.

Arrest of Hæmorrhage after Labour.—Brock (*Practitioner*, January, 1908).—The clinical features of a post-partum flooding leave no doubt in the writer's mind that the bleeding is venous. The blood from the huge maternal sinuses is carried to the inferior cava by large veins, which are valueless. Unless the mouths of the sinuses are securely folded together, regurgitation must result. The treatment of mild cases of P.P.H. is thoroughly agreed upon. That of serious P.P.H. resolves itself into the treatment of regurgitant venous hæmorrhage, the extreme gravity of which depends on the fact that the blood which is pouring into the uterus is regurgitating from the inferior vena cava through valveless veins. Its correct treatment, therefore, must be carried out by one of two methods (1) Either by applying direct pressure to the bleeding sinuses, or (2) by elevating the pelvis and compressing, not the aorta, but the inferior vena cava by precisely the same manœuvre, and thus stopping the backwash of blood from the latter. F.

MEDICAL NEWS IN BRIEF

Schools for Mothers.

"A SCHOOL FOR MOTHERS" was started recently in St. Pancras, London, as an interesting experiment in the education of poor mothers in the feeding and training of their children. The Manchester Ladies' Public Health Society held a meeting at the Town Hall on April 1st to hear about the scheme from the Hon. Mrs. Bertrand Russell.

The Lady Mayoress (Mrs. Edward Holt) presided, and said that after visiting the new school she was fully satisfied that it was in a position to do much good work.

Mrs. Redford, the President of the Society, said that most of the things that were being done in the London school had been more or less undertaken by the workers of the Society in the poor quarters of Manchester.

Mrs. Eckhart mentioned that during last year the Manchester lady health visitors paid more than 20,000 visits to homes where there were babies. The instruction given at these visits was of incalculable value.

The Hon. Mrs. Russell gave an interesting description of the school, which is placed in a cheap shopping street near St. Pancras Station. It had already, she said, done something to lessen infant mortality. Of every 1,000 babies born, she said, about one-fifth died, and in many places the proportion was higher. The infant mortality was now probably as high as it was 60 or 70 years ago, and it was clear that something drastic must be done to bring the infant mortality into line with the improvement in general health. The school had a big shop window, filled with pictures of rickety babies, and it displayed an invitation to passing mothers to come in and learn how to keep their babies from becoming bow-legged. A cookery teacher from the London County Council came down to give demonstrations in cheap cooking—"How to prepare Irish stew for fivepence," and so on. It was an important part of the scheme to get the father interested in the welfare of the mother and child. Fathers were invited to come to the school, and after a cup of coffee and a pipe they received "talks" on hygiene. They had not yet solved the question of the older girls, "the apprentice mothers," but they hoped to develop a system of education for these on lines already successfully followed on the Continent. It would be necessary ultimately to open a milk depôt for the use of mothers who could not feed their babies themselves. Prizes were given to the mothers who attended regularly and who followed the advice given. The mothers paid a penny a fortnight each for the weighing and for the classes. The school was now treating about 100 babies a year, and was preparing the mothers for the care of many hundreds of other children. It was estimated to cost about £300 a year. A school on the same lines had been recently opened in Birmingham. The school was helping to impress on the mothers the importance of hygiene and the sacredness of child life. Mrs. Russell denied that they were pauperising the women.

The new school was warmly commended by Dr. Helme.

Dr. J. M. Rhodes said that in his opinion the slum owners were largely responsible for the horrible "slaughter of the innocents" which went on year by year.

Dr. Niven moved a resolution in favour of forming a school for mothers in Manchester, and requesting the Ladies' Public Health Society to form a committee to inaugurate a scheme, with the co-operation of persons interested in the subject of infant mortality.

Dr. Hutton seconded the resolution, and it was carried.

Germicides and Disinfectants.

DR. SAMUEL RIDEAL gave, on April 2nd, at the London School of Tropical Medicine, a demonstration of the Rideal-Walker test for determining the efficiency of disinfectants. The test was invented by Dr. Rideal in collaboration with Mr. Ainslie Walker in order to determine the relative values of germicides. Dr. Rideal used for the purposes of demonstration bacillus typhosus, and the test consisted in exposing one portion of a growth of the typhoid germ to the action of a standard strength of carbolic acid, and another to that of the particular disinfectant to be tested, and in determining the extent to which the germ has been destroyed in each in the same length of time. The test has been adopted by the War Office, the Admiralty, and other Government departments, as well as by municipal and other public authorities in Great Britain and the Colonies. Professor Hewlett, in the course of a discussion which followed, said he would like to emphasise that the public were constantly being defrauded by having foisted upon them various so-called disinfectants which had frequently no germicidal action whatever. Not only were the public defrauded in this way, but there was also very grave danger introduced when a person believed he was using something which would actually destroy germs and was thereby lulled into a sense of security when in reality no sense of security was justified. There was a growing need for some limitation of various articles which were put on the market as disinfectants when they were not efficient as such. Nothing in the way of disinfectants should be foisted upon the public which had not been proved to be germicidal in their action.

Small-pox Outbreak near Grantham.

A SPECIAL meeting of the Grantham Rural District Council was held at the Guildhall on April 1st.

Dr. C. H. D. Robbs, the medical officer, said it appeared there were four cases of small-pox at Woolsthorpe-by-Belvoir, and they were clearly traceable to a man who came back to England about three weeks ago on a training ship, landing at Southampton. He was ill when he landed, and went to Woolsthorpe, and he was not seen by a medical man until Sunday last. He walked about the village suffering from modified small-pox, and as a result of that three other people came into contact with him and had caught the disease, two of the cases being very serious. The nursing available was very limited indeed, and it was almost impossible with the present means at their disposal to even approach the question of the isolation of patients. In reply to questions put by members of the Council, Dr. Robbs said the four cases were in three houses. The epidemic had got a fortnight's start of them, and vaccination was not in a very good state. In one house affected there were three small children.

The Clerk mentioned that there were cases in various ships at Southampton, and he had received notice that other soldiers had been on those vessels. One had came into Manners Street, Little Gonerby, and another man who had not yet arrived was going to Belvoir. He was now at Woolwich. He did not know what boat the affected man had come on.

The Council decided to take two empty houses in the immediate neighbourhood which are in a isolated position, furnish them, and then quarantine not only the patients, but as far as possible the contact cases.

The Chairman thought it was desirable that they should find out why the authorities let those people go as they did.

Mr. Ernest Harnack.

THE case of Dr. Hall Edwards, of Birmingham, has caused the public to notice the equally distressing case of Mr. Ernest Harnack, of the London Hospital. Mr. Harnack has been a sufferer for ten years, and has recently undergone an operation—the third serious one within the last six months. As head of the X-ray department of the hospital, Mr. Harnack has carried out frequent experiments, and some of his discoveries have proved of much value. "After I had been engaged in the work about three or four years," said Mr. Harnack to an interviewer, "I began to feel a tingling of the fingers. I thought at first that it was caused by developing the plates, but the true explanation soon became apparent. Since that time I have suffered great agony. In 1900 a finger-nail was removed. Then in course of time I lost all my nails. Last October I was operated upon for a growth on the back of the left hand. At Christmas I found that the growth was recurring, and in the middle of January I underwent another operation. The third finger was amputated; also, it being feared that the growth was of a malignant character, all the glands of the left arm were removed. At the same time the right hand was operated upon, for it was covered with ulcers. The hand was scraped, and skin from the left arm was grafted upon it. Altogether I was on the operating table two and a half hours. Unfortunately, the skin grafted on to the right hand gave way, and a few days ago three fingers were removed—I have now only the little finger and thumb, so that the hand is practically useless." Mr. Harnack is only 40.

The Notification of Consumption Cases in Edinburgh.

THE Edinburgh Medical Officer of Health reported to a meeting of the Health Committee of the Town Council on March 31st that during the year in which the order had been in force 804 notifications had been received. The monthly returns since March of last year showed the following results:—March, 140; April, 7; May, 51; June, 55; July, 61; August, 51; September, 44; October, 63; November, 69; December, 41; (1908) January, 66; February, 88. It was also stated that in consequence of this disease having been admitted to the list of notifiable diseases, the work of the Medical Officer's department had greatly increased, as 513 dwelling-houses, representing 667 apartments, had been visited and disinfected, while the separate articles dealt with numbered 7,836. The total cost of notification was £64 7s. 6d.

Health of Irish Towns.

THE deaths registered in the Dublin area for the week ending 21st ult. represented an annual mortality of 25.5 per 1,000 of the population. There were 8 deaths from influenza. The rate in Dublin is exceeded by that of only four European cities in the list of the Registrar-General of Ireland: St. Petersburg 32.1, Warsaw 29.1, Trieste 31.1, Venice 28.3. The following towns in Ireland presented for the four weeks ending 21st ult. rates of 20 or over: Armagh 22.3, Belfast 26.4, Clonmel 21.8, Cork 27.9, Drogheda 20.4, Galway 24.3, Kilkenny 22.1, Limerick 28.3, Lisburn 23.9, Londonderry 20.7, Lurgan 25.4, Portsdown 24.6, Sligo 27.6, Tralee 48.9, Waterford 29.7, Wexford 25.7. The lowest rate is that of Dundalk, 16.

PASS LISTS.

University of Durham Faculty of Medicine.

The following candidates passed the Second Examination for the Degree of Bachelor in Medicine during March, 1908:—Anatomy, Physiology, and Materia Medica.—Pass List.—William George Bendle, Eliot Watson Blake, Francis Percy Evers, Ivor Stanley Gabe, Cyril Gray, Howard Tomlin Hunter, George Eric Warner Lacey, Thomas Alfred Peel, Elliot Jessie Ramsbotham, Harold Frieze Stephens, Alfred Tulloch Thompson, Charles Sim Thompson.

The following candidates have passed the First Examination for the Degree of Bachelor in Medicine, March, 1908:—I.—Elementary Anatomy and Biology, Chemistry and Physics.—Harold Fairclough (Honours, Second Class). Pass List.—Eric Lawrence Hancock, James K. Johnston Haworth, John R. D. Holtby, L.R.C.P. and S.Glas.; Edwin Kidd, Colin Mearns, Fred. Phillips, B.A., Alex. Gordon Taylor. II.—Elementary Anatomy and Biology.—Fife Appleton, Ronald G. Badenoch, William L. Clements, Arthur T. Crilley, Norman Hodgson, James Kerr, Francis J. Lidderdale, Sydney E. Murray, Andrew G. McFarlane, John George Ogle, Charles H. Robson, Sidney Scott, William A. Slater, Thomas C. Storey, Samuel K. Young. III.—Chemistry and Physics.—Robert Ernest Bell, Arthur S. Hopgood, Russell V. Steele. IV.—Elementary Anatomy.—Sam Phillips Bedson, B.Sc., Theonie Renée Burrell. V.—Elementary Anatomy, Chemistry and Physics.—William Guy Lidderdale.

Trinity College, Dublin.

THE following candidates have passed the Intermediate Medical Examination, Part II.:—Adrian Stokes, Charles M. Finny, David L. M'Cullough, passed on high marks; Marius A. Diemont, Beatrice Hamilton, John H. Woodroffe, Peter H. Lemass, Herbert de L. Crawford, Robert Dixon, Douglas M. Moffatt, Roelof A. Albertyn, Euphon M. Maxwell, Edmond F. Lawson (Sch.), Perceval G. Leeman, Thomas M. Crawford, Hilgard Müller, William P. H. Smiley, Vicars M. Fisher, John G. Ronaldson, Arnold K. Henry, John B. Burgess, George F. C. Healy, John G. Dods, Samuel V. Richardson, Arthur C. Hallowes, Victor B. Best, Richard H. Mathews, Charles H. Denham, Brindley H. Moore. Previous Dental Examination (Materia Medica): George Elliott. Anatomy and Institutes of Medicine: Arthur A. Smith. Physics and Chemistry: Maurice Horan.

Royal College of Surgeons in Ireland.

PRIZE list, winter session, 1907-1908:—Descriptive Anatomy—Junior: J. Prendiville, first prize (£2) and medal; A. G. Mosbery, second prize (£1) and certificate. Senior: J. T. Duncan, first prize (£2) and medal; P. J. Wigoder, second prize (£1) and certificate. Practical Anatomy—First year: V. J. White, first prize (£2) and medal; I. M. Swanepoel, second prize (£1) and certificate. Second year: T. M. Thomson, first prize (£2) and medal; F. W. Warren, second prize (£1) and certificate. Practice of Medicine—R. Adams, first prize (£2) and medal; J. Menton and Miss C. F. Williamson (equal), second prize (£1) and certificate. Surgery—R. Adams, first prize (£2) and medal; G. C. Sneyd, second prize (£1) and certificate. Midwifery—J. Menton, first prize (£2) and medal; Miss I. M. Clarke and Miss C. F. Williamson (equal), second prize (£1) and certificate. Physiology—J. T. Duncan, first prize (£2) and medal; F. W. Warren, second prize (£1) and certificate. Chemistry—T. P. Roberts, first prize (£2) and medal; M. J. Hillery, second prize (£1) and certificate. Pathology—J. S. Pegum, first prize (£2) and medal; H. R. Tighe, second prize (£1) and certificate. Physics—M. J. Hillery, first prize (£2) and medal; T. D. Condell, second prize (£1) and certificate. The following lectures and practical courses of the summer session commenced April 1st—Biology, Practical Chemistry, Histology, Materia Medica, Operative Surgery, Public Health and Forensic Medicine, and Dissections.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

THE following candidates have passed the preliminary examination, March, 1908.—B. Glasson (with honours), A. J. Almeida, D. W. Beamish, T. K. Beattie, A. E. Brandon, P. D. Daly, H. S. Digges, R. Edgar, J. J. Elliott, H. C. Hatch, Miss G. McHugh, J. H. Madden, A. Morris, M. J. Mullen, C. Murray, A. F. I. Patterson, G. E. Pepper, R. Slaney, T. S. Smith, F. R. Swanton.

THE results of the inoculative tests made in connection with the suspected cases of rabies at Northampton were negative, and the Muzzling Order was revoked on the 31st ult. by an Order which came into operation on April 4th.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.**

SUBSCRIPTIONS.

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Dr. Jervois Aaron's paper on "Dysparcunia in the Male" is marked for early insertion.

Dr. S. J. Ross is thanked for his communication, proof of which will be sent him in due course.

Mr. H. M. L.—The subject is one which only remotely affects the medical profession. It is moreover fraught with legal technicalities and dangerous to handle. We do not therefore feel justified in taking the matter up in our columns.

THE CIGAR HYGIENIC

If a Harley Street specialist is right in declaring that the better the cigar the more harmful it is, it must be extreme solicitude for our health that leads a man we know to advise our selection from his cigar-case.—*London Opinion.*

Mr. W. H. W.—Your communication reached us as we were "at press," too late for present issue.

Anti-Quack.—The business would seem to be conducted by the father and daughter, who constitute the so-called "Limited Liability Company." We are making inquiries.

Flumen.—In the annual report of the Port of London sanitary authority it is announced that in the Thames training ships there were 130 cases of sickness during 1907, the most serious being seven of scarlet fever on board the "Arethusa," and eighteen of enteric fever on board the "Cornwall." The Medical Officer states that there was a previous epidemic of enteric on the "Cornwall" in 1903. The cases numbered sixteen, and the outbreak was attributed to blankets, purchased as second-hand, which had been used in South African concentration camps. In the present instance, although the source of infection has not been definitely traced, suspicion, says the report, points to bedding being again responsible.

Meetings of the Societies, Lectures, &c.

Wednesday, April 8th.

Hunterian Society (London Institution, Finsbury).—8.30 p.m.: Annual Discussion on Rheumatism (opened by Dr. F. Taylor). Dr. Poynton and Dr. Horder will speak on the Bacteriological Aspects of Rheumatism and Mr. Luff on the Irregular Manifestations of Rheumatism and their Treatment.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. J. Cantlie: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. C. O. Hawthorne: The Clinical Anatomy and Physiology of the Nervous System.

Thursday, April 9th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20, Hanover Square, W.).—7.45 p.m.: Specimens will be shown by Dr. Herbert Spencer and Mr. Alban Doran. Short Communications by Dr. Macnaughton-Jones, Dr. Kedarnath Das, and Dr. Nepean Longridge. Paper by Dr. Herbert Williamson and Dr. Eardley Holland: A Case of Intra-Uterine Death of the Fœtus occurring in Six Consecutive Pregnancies, with Observations upon the Importance of the Examination of the Fœtal Tissues for the Presence of the Spirochaeta Pallida.

Harveian Society of London (Stafford Rooms).—8.30 p.m.: Mr. L. B. Rawling: The Surgical Treatment of the Incompletely Descended Testis. Clinical Cases will also be shown.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. G. Oliver (Harrogate): Recent Studies in Arterio-sclerosis.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical Out-patient (Mr. Carson); X-Ray (Dr. Pirie). 3 p.m.: Medical In-patient (Dr. G. P. Chappel). Demonstration of Cases of Fever (at the North-Eastern Fever Hospital, St. Ann's Road, N.): Dr. F. Thomson. 4.30 p.m.: Throat Operations (Mr. H. W. Carson).

Friday April 10th.

Royal Society of Medicine (20, Hanover Square, W.).—4.45 p.m.: General Meeting of Fellows of the Society: Ballot for New Fellows.

Royal Society of Medicine (Clinical Section) (20, Hanover Square. W.).—8.30 p.m.: Short Papers by Dr. J. Graham Forbes and Dr. F. Langmead: Fatal Lymphocythæmia in Early Life; and Dr. Francis Hawkins: A Case of Multiple Rheumatic Nodules in an Adult.

Society for the Study of Disease in Children (11, Chandos Street, Cavendish Square, W.).—5 p.m.: Mr. H. Lett: Intussusception associated with Severe Purpura. Mr. J. P. Parkinson: Tetanus Neonatorum. Mr G. Pernet, Mr. L. Guthrie, Dr. G. Carpenter, Mr. P. Parkinson, and others: Cases.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. R. F. Bickerton: Clinique. (Eye.)

Appointments.

Barris, J. D., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer at the City of London Lying-in Hospital.

Cooper, H. G., M.B., B.C.Cantab., Public Vaccinator for the Altrincham District of Cheshire.

Fedden, W. Fedde, M.S., M.B.Lond., F.R.C.S.Eng., Surgeon to Out-patients at the Kentish Town Department of the Hampstead General and North-West London Hospitals.

Herapath, Charles Edward Kynaston, L.R.C.P.Lond., M.R.C.S., Junior House Surgeon at the Bristol Royal Infirmary.

Kemp, Charles Gordon, M.B., B.S.Durh., L.R.C.P.Lond., M.R.C.S., Resident Casualty Officer at the Bristol Royal Infirmary.

Pirie, W. Rattray, M.B., C.M.Aberd., Assistant Physician at the Aberdeen Royal Infirmary.

Smith, G. F. Darwall, M.B., B.Ch.Oxon., F.R.C.S.Eng., Physician to Out-patients at the British Lying-in Hospital, Endell Street, London.

Troup, Arthur G., M.B., Ch.B., D.P.H.Aberd., Assistant Pathologist at the Sussex County Hospital, Brighton.

Whitehead, A. E., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Bridlington District of the county of York.

Vacancies.

County of Lanark.—Middle Ward Isolation Hospital.—Resident Physician. Salary, £150 per annum, with board, etc. Applications to the Subscriber, W. E. Whyte, District Clerk, Hamilton.

Ayr District Asylum.—Junior Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and laundry. Applications to Dr. McRae, Glengall, Ayr.

Borough of Cambridge.—Medical Officer of Health. Salary, [illegible] per annum. Applications to J. E. L. Whitehead, Town Clerk, Guildhall, Cambridge.

Stirling District Lunacy Board.—Medical Superintendent of the District Asylum, near Larbert. Salary, £700 per annum, with house, etc. Applications to James Dobbie, Solicitor, Clerk to the Board, 3, Port Street, Stirling.

Manchester Royal Infirmary.—Resident Medical Officer of the Convalescent Hospital, Cheadle. Salary, £150 per annum, with board and residence. Applications to Walter G. [illegible], General Superintendent and Secretary, Manchester Royal Infirmary.

County Council of Cumberland.—County Medical Officer of Health. Salary, £700 per annum. Applications to C. B. Hodgson, Clerk, The Courts, Carlisle.

Joint Counties Lunatic Asylum, Carmarthen.—Second Assistant Medical Officer. Salary, £160 per annum, with board, lodging, washing, and attendance. Applications to W. Morgan Griffiths, Solicitor, Clerk to the Visitors, Carmarthen.

Edinburgh District Asylum, Bangour Village.—Second Assistant Physician. Salary, £120 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent, Bangour Village, Uphall.

Richmond Hospital, Dublin.—A Throat Surgeon; third Assistant Physician, and a third Assistant Surgeon.—Immediate applications to A. Smith, Secretary and Superintendent. (See Advt.).

Cambridgeshire, etc., Asylum.—Second Assistant Medical Officer. Salary, £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, 18, Emmanuel Street, Cambridge.

Births.

Farnfield.—On March 31st, at Mere, Wilts, the wife of William Walter Farnfield, M.R.C.S., L.R.C.P., of a son.

Wells.—On April 2nd, at Orleans Lodge, Twickenham, the wife of Arthur G. Wells, M.B., B.S. (Lond.), M.R.C.S., of a son.

Marriages.

Gillett—Bancroft.—On March 30th, at Wilmington, Del., U.S.A., Henry T. Gillett, M.D., of 15, King Edward Street, Oxford, to Lucy Bancroft, second daughter of William P. Bancroft, of Wilmington, Del., U.S.A.

Hammand Fraser—McMullen.—On April 2nd, at Brixton Independent Church, London, David Hammand Fraser, M.A., M.B., B.C., of Herne Hill, London, to Annie Isabel, second daughter of William McMullen, L.R.C.S.I., etc., of Brixton Road, London.

McBride—Hulbert.—On April 2nd, at Stephen's Church, Ealing. Walter, son of P. McBride, M.D., F.R.C.P.E., and F.R.S.E., of Edinburgh, to Lillian, daughter of Maurice C. Hulbert, J.P., of Ingleside, Ealing.

Williams—Robson.—On April 4th, at St. George's, Hanover Square, W., Commander H. P. E. Tudor Williams, Royal Navy, only son of Colonel H. P. Williams, of Rhayader, Radnorshire, to Phyllis Margaret Mayo, second daughter of A. W. Mayo Robson, D.Sc., F.R.C.S., of 8, Park Crescent, Portland Place, London, W.

Deaths.

Brown.—On March 30th, at Summerlands, Heathfield, Sussex, Alfred Brown, M.R.C.S.Eng., L.S.A., formerly of Wandsworth, in his 83rd year.

Lecky.—On March 31st, at the Sussex County Hospital, Brighton, Henry Collier Lecky, M.A., M.B., D.P.H.Oxon., aged 29, second son of John Lecky, of Putney.

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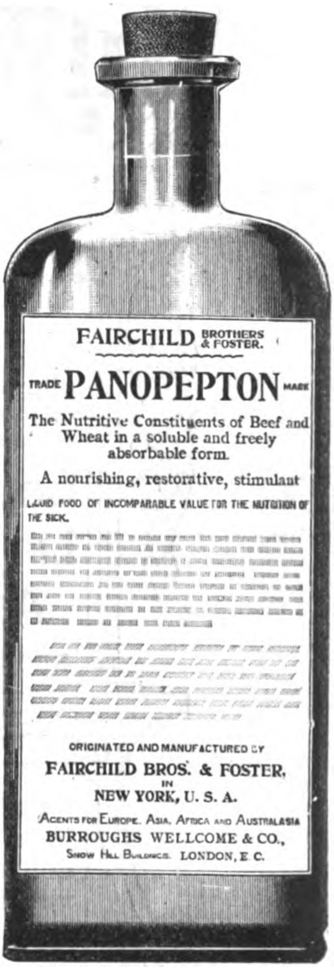
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NOTES AND COMMENTS.

Blackfriars on the Warpath. IT almost seems that the key to the prevention of unqualified practice lies in the hands of the Society of Apothecaries, for that ancient company is possessed of powers against those who infringe the rights of its members, such as no other professional body is armed with. The trouble has been that these powers, like the law against Sunday trading and the right of a Bishop to licence midwives, have been in abeyance so long that they are correspondingly difficult to enforce. It is, however, hopeful to see that the Society is now apparently actuated by a spirit of greater enterprise, and that it is putting its powers to the test of the law courts. Last week a herbalist, one William T. Gregory, was before Judge Tindal Atkinson at Edmonton County Court as defendant in an action brought by the Apothecaries' Society to recover a penalty of £20, for "attending, advising, and supplying medicines as an apothecary" in a particular case. As ill-luck would have it, this case was one of a poisoned hand, and the defence put in was the herbalist acted as a surgeon, which is lawful, and not as an apothecary, which is unlawful. The judge held that this defence was good, because the patient suffered from an injury from an external cause, and the case was of minor import. The action was consequently dismissed.

Apothecary or Surgeon. As the patient died from blood-poisoning, it is difficult to say which is the more commendable institution, a judge who classes the loss of human life in a "minor" category, or a law which allows a man to be mutilated by a quack, but not dosed except by an apothecary. The exact extent of an apothecary's sphere is very difficult to define at this period in the world's history, when people have long ceased to "use the 'pothecary," and have taken to "sending for the doctor." The modern general practitioner who dispenses his own medicines is, we take it, the nearest representative of the man who, in his day, was little more than a prescribing chemist, but to get a conviction it would probably be necessary to prove that the offender both attended a patient and furnished him with drugs. In spite of the ancient quarrels between the apothecaries and the surgeons, it is, however, beyond doubt that it was well within the apothecary's function to attend to minor surgical cases, such as cut fingers and crushed toes, as well as ailments, such as venereal diseases which, for some esoteric reason, are now classified with surgery. Although the Society of Apothecaries lost this case, we sincerely hope they will not be discouraged now that they have put their hand to the plough, as there is nothing likely to win greater recognition and gratitude for their company than the wholesale and rigorous prosecution of all unqualified pretenders to medical skill and knowledge.

Legal and Canine Specialists. THE manner in which the legal mind looks at quack practice may be gauged by another case heard last week. The Veterinary College, likewise galvanised into activity, obtained a conviction against a "canine specialist" for acting as a veterinary surgeon, and the defendant appealed. Legally, there was no doubt of the justice of the conviction, and the Court of three judges before whom the appeal came had no alternative but to uphold it. That they did so with reluctance was shown by the comments made by two of them, Mr. Justice Ridley and Mr. Justice Darling. The former of these gentlemen said that in his experience just as good advice was to be had from a canine specialist as from a qualified veterinary surgeon; and the latter that, "he reluctantly followed his brother." Mr. Justice Ridley doubtless is painfully aware that his opinions only carry weight in virtue of the position to which it pleased his friends to call him, but even he might possibly understand that there are certain advantages which accrue to a community through having its professions stocked with persons of certain guaranteed acquirements and under certain disciplinary control, and that though it may not be impossible that a layman could conduct a case in court, or give legal advice better than certain barristers, at the same time it is generally admitted that practice at the bar should not be thrown open to any squalid adventurer who cares to thrust himself forward.

The M.D.U. at Clerkenwell. ALTHOUGH the independence of the judiciary is considered a cardinal doctrine of the constitution, it often puzzles people why certain individuals should be raised to a place above their fellows, where they can with impunity give vent to any opinion they choose, without the object of their strictures having any remedy against them. Quite recently Judge Edge had before him in the Clerkenwell County Court a case in which a Miss Cropper sought to recover from Dr. F. H. Stokes, of Canonbury, the sum of £17. It was alleged by her that a cheque for £42 had been given to the defendant on the understanding that the sum claimed would be refunded out of it. Dr. Stokes denied that any such agreement had been made. The judge, in giving his decision, took occasion to state that he did not believe a word of Dr. Stokes's evidence, and refused him leave to appeal. Happily, owing to the action of the Medical Defence Union, it was arranged that a memorial should be presented to the judge by Mr. Dickens, K.C., setting out the grave dishonour which those remarks imputed to Dr. Stokes, and the impossibility of a gentleman of his position and character going into open court and committing gross perjury. The memorial was signed by many leading members of the profession. Judge Edge said that in all his life he had never heard of such a proceeding, but that he was glad to have the memorial, because if he had unintentionally done a wrong to Dr. Stokes he would be glad to set it right. He then made some comments on the memorial, and finished up by observing that he was willing "to accept the explanation" that Dr. Stokes's' memory had failed him as to the facts that had taken place. One must be grateful that even this tardy reparation was made, and we congratulate Dr. Stokes and the Medical Defence Union on obtaining it; but the incident only serves to emphasise the desirability of His Majesty's judges performing the duties for which they were appointed without indulging in speeches, comments, and witticisms at the expense of the parties who appear before them. The habit is a growing one, and we do not remember any period in history since the time of Judge Jeffries when such unbridled license was given to their tongues by judges on the Bench. This fashion does not conduce to the more effective administration of justice, and it sets an exceedingly bad example to the bar.

Removal of the Heart.

The marvels of modern surgery seem to have attained their climax at New York. According to the American Correspondent of the *Daily Express,* the most daring surgical operation ever attempted in America was performed at St. Joseph's Hospital on April 5th, and we are prepared to admit that if the description given is true it was certainly the greatest triumph over natural difficulties of which we have ever heard. The report given states that a certain athlete was stabbed in the heart during a street row and carried to the hospital, where he was promptly placed on the operating table. His condition appears to have been desperate. "More out of scientific curiosity than any hope of saving Mr. Inglis's life, the surgeons removed a portion of two ribs, and then took out the heart." We like the moderation of the reporter in claiming that only "a portion" of the two ribs was removed, when "two entire ribs" would have sounded so much more dramatic, but even the exiguous knowledge of anatomy that is included in a general education might have sufficed to make a sub-editor pause before believing that a living human heart could be taken out through the space allowed by the removal of a portion of two ribs. However, three stitches were put in the heart and that organ replaced. Two hours later the patient was well enough "to describe the assault and identify the assailant." The item of news is headed, "What They Do in New York. Man's Heart Replaced." This is the sort of stuff which is served up to the readers of the journal which recently advertised itself as "the reliable Express!"

National Union of Public Health Authorities.

A meeting of the Provisional Council of the above Union was held recently at the Grand Hotel, London, for the purpose of considering the rules of the association and the transaction of other business. The draft rules prepared by the Chairman and the Hon. Secretary, after being carefully considered and in a few respects amended, were adopted and ordered to be submitted to a Conference of the Union to be held on May 28th at Caxton Hall, Westminster.

LEADING ARTICLES.

THE IRISH UNIVERSITY BILL.

Mr. Birrell must, on the whole, be warmly congratulated on the immediate success which has attended the introduction of his Bill for the extension of University education in Ireland. Protests have been made, and objections have been taken to many of its clauses, but there is an absence of any organised opposition, and this is no small success, when we consider the many and obvious pitfalls which lie in the way of any scheme that could be proposed. The Bill, as it is printed, is, however, as the President of the Queen's College, Cork, has pointed out, largely a measure for dissolving a number of existing institutions and for setting up a body of Commissioners who shall shape a number of new ones from the *débris* of the old. Present criticism may therefore be directed to the omissions of the Bill, to its fallacies as regards finance, to the constitution of the governing bodies of the proposed Universities, and, indeed, to the reasons for or against the scheme as a whole; but until the Executive Commissioners have been appointed and have drawn up their scheme for the creation of the new Colleges, it is obvious that the real and final criticism cannot be made. For this reason, it seems that once the principle of Mr. Birrell's scheme is admitted, the Bill becomes of very secondary importance to the constitution of the Executive Commission, and to the principles which it selects to guide it in the discharge of its duties. In the case of the University in Dublin, three of the Commissioners are to be appointed by the Crown, and four by the new Senate. The Belfast Commissioners are to be similarly appointed. We publish in another column a forecast which is generally accepted as representing, so far as it goes, the Senates of the two Universities. It is almost certain that, in the case of the University in Dublin, the great majority of the Senate will be representatives of Dublin, and therefore we can quite understand the anxiety which the authorities of the Queen's College in Cork display as to the effect which the statutes of the Executive Commission may have on their College. All such statutes must, however, be placed before Parliament for final ratification before they become effective. Up to the present the main objections to the Bill have come from the Ulster Unionist Party, who object to the principle of watertight religious education compartments; from Cork, which objects to the non-establishment of a Cork University, on the ground that it is strange that a University is denied to the South, which asks for one, whilst it is forced on the North, which does not wish for one; from Magee College, because it has not been included as a constituent College of the new Belfast University; and from all the bodies concerned on the ground that the financial provisions are inadequate. On the other hand, the staff of the Queen's College in Belfast have adopted a series of resolutions, which our Belfast correspondent has summarised, and which unanimously express approval of the proposed establishment of a Belfast University.

PROPOSED PUBLIC HEALTH LEGISLATION.

In spite of the fact that the British national system of practical public health administration is probably the best in the world, it must be confessed that there is still room for improvement. The polluted state of many of our streams and rivers, for instance, constitutes a standing reproach to modern sanitary science. If we turn to individual slums, again, we find an appalling death-rate, and even yet such obvious questions as the eradication of tuberculous cattle, the control of the milk supply, and the lessening of a hugely disproportionate infantile mortality, have not been effectually dealt with. Under these circumstances, those who are interested in health problems will welcome the Bill which is being introduced into Parliament by Dr. George Cooper, for many years Chairman of the London County Council's Public Health Committee. His avowed aim is to amend public health administration so as to put an end to the gross neglect by local authorities of many essential sanitary duties. Nor is it possible seriously to gainsay his proposition that slums, public nuisances, and other sanitary evils abound all over the country, in spite of Acts of Parliament. In his attempt to remedy this defective legislation, Dr. Cooper proposes to apply several general principles. The first is to substitute compulsory for permissive powers wherever feasible. There can be little doubt that if this proposal were adopted, a vast amount of needful reform would be effected, as it were, by a mere stroke of the pen. In the projected Bill, County Councils are given full powers to bring to book local authorities neglecting their sanitary duties. This plan would probably be found more economical and more convenient than any attempt to enlarge the powers of a great central authority. The metropolis, which is a kingdom in itself, already has a municipal control over subordinate authorities in the special Public Health Committee of the London County Council. A further important matter dealt with in the proposed new Bill is that of payment of salaries. As a step towards relieving the medical officers of health and sanitary inspectors from local pressure, it is proposed that half the salaries should henceforth be paid by the County Councils. This condition would, of course, give the Councils a voice in the matter of dismissal of such officers, whom it would free materially from intimidation, acting now as a dead weight on the energies and the efficiency of an all-important class of public servants. Among minor details it is proposed to legalise the position of the health visitor, who constitutes an undoubtedly useful agent in the work of reforming the slums. One of the most noteworthy points in the Bill is that which makes it compulsory on every County Council to appoint a medical officer of its own. At present, many of the smaller county authorities have no such officer, while others take the part services of an officer jointly with another authority, or else they appoint one at a nominal salary. Dr. Cooper proposes that in future county medical officers should give their whole time to their duties and reside within their district. The reforms outlined in this useful and unassuming Bill have long been urgently needed, and we are glad to see that a practical measure has at length been introduced by a medical man. It is to be hoped that Parliament will find time to pass this most desirable piece of social legislation.

CURRENT TOPICS.

The Oral Use of Serums.

In The Medical Press and Circular of January 31st and Feb. 7th, 1906, we published an important communication on "A New Method of Serum-Therapy," by Dr. D. Montgomerie Paton. For eight years the writer had been studying, clinically and experimentally, the use of serums exhibited by the mouth. During that time he had used over twenty million units of anti-diphtheritic serum and forty gallons of simple plasma of the horse, sheep, and ox. This article made a short statement of some of the results obtained, but the writer hoped to put the whole work more fully before the profession in book form. In the treatment of over fifty cases of tubercle of all kinds the oral use of the simple plasma of the horse and sheep proved itself capable of transferring to the patient the resistance of the animal to the disease. On June 2nd, 1907, we published a further communication on above by Dr. D. Montgomerie Paton, confirming, as he pointed out, the results and conclusions published in his work, "New Serum-Therapy," (*a*) in which he advocated the oral use of serums, both normal and the produce of acquired immunity, for various diseases. We ourselves emphasised the importance of his work in the following terms:—"Among our original communications in the present issue will be found one of much interest from Mr. Montgomerie Paton, of Melbourne. It deals with the passive raising of the opsonic index by immune serum administered by the mouth. Last year the same observer published some original papers in the Medical Press and Circular upon the use of serums in many pathological conditions. His results were of a striking and suggestive nature. . . . . Should these observations stand the test of extended clinical experience they may possibly advance the science and art of serum-therapy by leaps and bounds." This being so, we confess to some surprise on reading the following paragraph in our contemporary (*b*), viz.: "We are informed that Dr. Latham, when reading the paper referred to in our issue of last week, under the heading, 'The Serum Treatment of Tuberculosis,' stated that the local and internal use of normal serum in many diseases characterised by tissue destruction was introduced by Dr. Hort, to whom he took the opportunity of expressing his indebtedness in connection with his paper." It will be a source of gratification to Dr. Paton to find that his original conclusions and work are confirmed in the independent work of others here; and though, anxious as our contemporary is to duly credit original work, they have overlooked the fact that Dr. Hort (*c*) himself, in a communication recently published states:

(*a*) "New Serum-Therapy." By D. Montgomerie Paton, M.R.C.S. Eng., L.R.C.P.Lond. Pp. 320. London: Bailliere, Tindall and Cox. 1906. Price 6s.

(*b*) The *British Medical Journal*, April 4th, 1908, p. 831.

(*c*) "The Therapeutic Uses of Normal Serum." By E. C. Hort, B.A., B.Sc., Univ. Paris, M.R.C.P.Edin. The *Lancet*, February 15th, 1908, p. 487.

"Since writing this paper I learn that in Australia a number of diseases have been treated by Dr. Montgomerie Paton with anti-diphtheritic and other serums administered by the mouth. The cases he has published seem to confirm amply the value of normal serum-therapy that I have independently arrive dat."

Cerebro-Spinal Fever in Dublin.

We referred a few weeks ago to the rumours that several cases of cerebro-spinal fever have occurred this spring in Dublin, and we hoped that steps might be taken to prevent a genuine outbreak of the disease. Unfortunately, we learn that the number of cases has greatly increased in the last few weeks, and there is grave reason to fear that Dublin is about to suffer as New York, Glasgow, and Belfast have suffered in turn. In the face of this situation it is of importance to inquire what steps the sanitary authorities are taking to deal with the situation. In addition to publishing quietist statements in the newspapers, we cannot find that they are doing anything. It is true that last week a special meeting of the Dublin Corporation was summoned to declare cerebro-spinal fever a notifiable disease; but those who know Dublin will not be surprised to learn that the necessary quorum to form a meeting did not attend. In all seriousness we wonder how long the citizens of Dublin are going to tolerate this official contempt for their lives. We think it was Whitman who spoke of the "tyranny of elected persons." Nowhere would he have found a better example of this tyranny than in the Dublin Corporation. It is not to be wondered at that the party of publicans and slum-owners which control that body should treat the lives of their constituents with indifference as long as those constituents are satisfied.

Proposed Memorial to the late Dr. Connolly Norman.

We desire to draw attention to a report which appears in another column of a meeting held at the Royal College of Physicians in Dublin during the past week with the object of initiating a movement for the erection of a memorial to Dr. Connolly Norman, the late highly-distinguished head of the Richmond Asylum. The secretaries of the committee appointed to draw up details of the proposed memorial are Dr. Donelan, the newly-elected Resident Medical Superintendent of the Richmond Asylum, and Dr. Fleury, from whom any further information can be obtained by those desirous of joining in this effort to perpetuate the memory of so distinguished an alienist.

Two Forthcoming International Congresses

Within the last few days the first circulars have been issued for two International Congresses—the International Congress on Tuberculosis, to be held in Washington in September and October of the present year; and the International Medical Congress, to be held at Budapest in August and September, 1909. The work of the former is divided into seven sections, viz.: Pathology and Bacteriology; Clinical Study and Therapy; Surgery and Orthopædics; Tuberculosis in Children; Social, Industrial, and Economic Aspects of Tuberculosis; State and Municipal Control of Tuberculosis; Tuberculosis in Animals and its Relation to Man. In addition to the discussions in the sections, an exhibition will form an important part of the work of the Congress. The International Medical Congress, on the other hand, will have its work divided into twenty-one sections, and the provisional programme is of the usual comprehensive character. It can hardly be claimed that Congresses of this catholic character do much to advance the cause of science. The most prominent men of science are absent, and the papers read are heard with little attention. As a means of promoting personal intercourse between scientific workers, however, they are useful, and we have no doubt that the Congress at Budapest will give a very pleasant week to those who attend it.

Adequacy of Poor-law Hospital Staffs.

The understaffing of many Poor-law Infirmaries has long been notorious, and undoubtedly lies at the root of various abuses. From time to time gross instances of the kind are brought to light, and the public newspapers are provided with a seven-days' scandal. There is no evidence, however, that the central authority has ever attempted to deal comprehensively with this important question. At the same time, it must be clear to the Poor-law Inspectors that many of the institutions it is their duty to visit are woefully understaffed, and it will be interesting to learn from the inevitable Royal Commission that will some day investigate Poor-law administration what steps they have taken to have matters remedied. On the other hand, it is not often that a complaint is made of overstaffing, even in these days of occasional palatial extravagance on the part of Guardians. Bristol appears to contribute one of these exceptions, if we may accept the statement of a Guardian, who said that two years ago the Poor-law Hospital had 117 inmates and a staff of 118. A few days ago he found 116 members of the staff to 100 inmates. The number of nurses was given as 51, an allowance that certainly seemed to be liberal, even allowing for an occasional influx of patients. While it would be a pity to check any reasonable provision for efficient nursing, the ratepayers have at the same time a right to demand a careful supervision of expenditure in that direction.

Vanishing Anthrax.

Anthrax is one of those diseases whose origin and natural history are so well known that its ultimate extinction is within the range of international prevention. In the United Kingdom we are happily free from endemic anthrax, and the majority of cases of the disease are due to imported wool. Not long ago a mysterious case was investigated by a Coroner's jury in the City of London, where a governess was found to have died from anthrax. The only probable route of infection appeared to have been infected food. Last week a case occurred in Bradford, where a wool-comber was found to have died from pulmonary anthrax. Deceased had to lift the wool, which came down a shoot, and place it in the washbowls. The premises were disinfected twice a day, and disinfectant was put in the washbowls. It is clear, however, that a workman thus engaged would be exposed to a certain amount of dust, which might readily be infected by anthrax bacilli. The jury made the commonsense recommendation that the bales of wool should be opened and steeped in disinfectant before being handled. The mere disinfection of bales, which was said to have been carried out in this instance, clearly had not destroyed the vitality of the specific organisms. It is interesting to learn that the large shop in which the case occurred has been free from anthrax for two years past, a fact which speaks volumes for the efficiency of modern methods of prevention in this dangerous trade.

Preventive Inoculation for Enteric Fever.

It seems not improbable that the future control over some, at least, of the specific infectious maladies will be by means of inoculations of various kinds. In the case of enteric fever there has accumulated a wonderful amount of evidence in favour of its preventive efficacy. Any special experience in that direction is therefore of much value. We note that in the *Journal* of the Royal Army Medical Corps, Lieutenant J. H. Graham reports recently that the 3rd Coldstream Guards (Egypt) were asked to undergo inoculation in the left flank against enteric and typhoid. The number who underwent the operation was 331, of whom only one contracted fever. Out of 381 uninoculated, 14 took fever, of whom one died. This is a sufficiently striking experience, and affords a lesson likely to be appreciated by the Army medical authorities. The saving of life among our Indian troops by the universal introduction of a really trustworthy preventive of enteric fever would be almost incalculable.

Another Resuscitation Fable.

Once again the newspapers have been flooded with paragraphs relating the wonderful story of a "return to life." It seems that the son of a Covent Garden tradesman residing at Brixton was seized with an epileptic fit, in which he was attended by a medical man. By some misunderstanding the relatives thought the latter said the patient was dead, and he was accordingly "laid out." Some little time afterwards he was found to be alive, and another fable of resuscitation was forthwith launched upon the world. On being summoned, the medical attendant said there was nothing unusual in the affair, and that when he left the patient on the first occasion he told the friends that he was practically "dead to the world." The narrative will no doubt find a place in the literature of those who are fond of parading the bogey of live burial. As a matter of fact, it is neither better nor worse than most of the fables they are pleased to put forward as evidence. It has often been insisted in our own columns that no single case of evidence that could absolutely establish the fact of live burial has hitherto been forthcoming. No case, that is to say, which could be said to be scientifically proved. Meanwhile every case, like that at Brixton, simply shows how extremely difficult it is to be buried alive.

PERSONAL.

The King has granted permission to Mr. A. F. MacCallan, M.B. (Cantab.), F.R.C.S., Chief Inspector for Ophthalmic Purposes under the Egyptian Government, to wear the Third Class of the Order of the Medjidieh, conferred on him by H.H. the Khedive.

By the will of Miss Mary Condar, the Royal Infirmary of Ryde benefits to the extent of £1,000.

Mr. R. J. Ranken Lyle has been appointed the first Professor of Midwifery in the University of Durham.

Professor W. D. Halliburton, F.R.S., of King's College, London, had the degree of LL.D. conferred on him by the University of Aberdeen.

A tablet, bearing an appreciative inscription, has been placed in the Royal Portsmouth Hospital to the memory of the late Dr. Alfred Lloyd Owen.

Lieut.-Colonel A. E. Tate, R.A.M.C., has been appointed Deputy-Assistant Director-General of the Royal Army Medical Corps at headquarters.

Mr. W. C. Bridgeman, M.P., Treasurer of the Hospital for Invalid Gentlewomen, has received an anonymous donation of £1,000 to the building fund.

The Graduation ceremony of Edinburgh University was held on April 10th, when the honorary degree of Doctor of Laws was conferred upon the Right Hon. Richard Caton, Lord Mayor of Liverpool.

Mr. J. Ward Cousins and Mr. Henry Rundle have retired from the staff of the Royal Portsmouth Hospital and been elected Consulting Surgeons. Mr. Ward Cousins has served on the acting staff for 48 years and Mr. Rundle for 34.

Mr. H. J. Hutchens has been elected to the post of Heath Professor of Comparative Pathology and Bacteriology at Durham University in succession to Dr. G. R. Murray, who has been elected University Lecturer in Medical Jurisprudence.

The First Lord of the Admiralty has appointed Inspector-General James Porter, C.B., M.D., to be Director-General of the Medical Department of the Royal Navy, in succession to Inspector-General Sir Herbert M. Ellis, K.C.B., K.H.P., F.R.C.S., LL.D., who has resigned.

At the Victoria Hotel, Manchester, on Saturday, Dr. Alfred D. Macnair was entertained to dinner by his fellow-practitioners in Broughton, upon the occasion of his leaving the district. After dinner Dr. Hamill, on behalf of the subscribers, presented him with an illuminated address which expressed the high esteem in which Dr. Macnair was held by his friends.

The Duke of Marlborough, K.G., has been appointed President of the English Committee of the First International Life-Saving Congress, to be held at Frankfort-on-Main early in June. Dr. W. Collingridge, Lieut.-Colonel Macpherson, C.M.G., R.A.M.C., and Mr. G. H. Makins, C.B., are among the other members. Mr. S. Osborn, F.R.C.S., is the Honorary Secretary.

Certifying Surgeons, Factory Act.

The following appointments under this Act have been made:—Dr. Thomas Pierse, for the Wexford district of Wexford; Dr. C. R. Wood, for the Shoreham district of Sussex; Dr. A. M. A. James, for the Kingscliffe district of Northampton. In consequence of the death of Dr. J. Servia, an appointment as certifying surgeon at Bellshill, in Lanark, is vacant.

A CLINICAL LECTURE

ON

THE CLINICAL VARIETIES OF CHRONIC RHEUMATISM.

By J. TEISSIER, M.D.,

Professor of Clinical Medicine in the University of Lyons.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

THE question of chronic rheumatism is still far from clear, in spite of the assiduous bacteriological and pathological research of recent years, and we are still constrained to look to clinical data for the purpose of classifying the cases described under this head. For this reason, although logically it would be preferable to limit the term chronic rheumatism to cases in which there is a history of a previous attack of acute rheumatism that has become chronic, we are fain to group under this term, at any rate, to begin with, all the clinical groups which it has become customary to comprise in the category of chronic rheumatism, including the joint affections which are generally admitted to be due to the influence of damp cold.

In this somewhat heterogeneous group we are enabled, by the aid of clinical analysis, to distinguish three groups of symptoms which are clearly defined: primary deforming arthropathies, running a regular, progressive, symmetrical non-inflammatory course, with a tropho-neurotic basis in the etiology whereof nothing can be invoked beyond damp cold; chronic joint affections consequent upon acute articular rheumatism or some infective disease (chronic infective rheumatism); and, lastly, chronic diathetic arthropathies dependent on intoxications and certain non-intoxications.

This classification, which is purely clinical and etiological, obviously differs little from that which, in common with Dr. Roque, I adopted in 1897.

The first of these affections, deforming polyarthritis, or "poor man's gout," comprises a group of symptoms clinically, if not pathogenetically, well defined. As a rule the joint manifestations are multiple with a progressive invading tendency, involving at first the small joints and passing on to the larger joints, invading successively and symmetrically the homologous members, and producing special deformities. These joint manifestations are almost invariably preceded by sensory disturbances—cramps, tingling and spasms—often lasting for many months. The joints are symmetrically involved, and present the familiar deformities with, in the larger joints, osteophytic growths and muscular atrophy. The periarticular tissues are thickened and infiltrated, the skin is smooth and shiny, as it were adherent to the bone, the synovial membrane is thickened, the cartilage undergoes velvety degeneration, and the bone is eburnated and decalcified. Skiagraphy shows the disappearance of the articular cartilages, while in places the bone is abnormally permeable to the X-rays. The muscles are atrophied, although there is no marked reaction of degeneration, the skin is also the seat of trophic disturbances, and neuritis in one form or another is often present.

This deforming polyarthritis runs a very characteristic course. There is a first period, lasting one or two years, which is characterised by sensory disturbances of the neuritic kind, slight fever, and diminished excretion of phosphates. The second period is marked by the steady invasion of the joints, which runs on for years. The third stage is that of immobilisation and cachexia. This stage is often complicated by Bright's disease, and these patients for the most part succumb to uræmic accidents unless they happen to be carried off by consumption, slow to develop, but with a rapid termination. Cardiac troubles are exceptional in this form. Endocarditis occurring in the course of chronic rheumatism is, I believe, restricted to rheumatism of the infective types.

This variety of chronic rheumatism is, in my view, a tropho-neurotic arthritis. Its clinical resemblance with nervous arthropathies, the symmetrical distributions of the joint lesions, and the tendency to hemiplegia appear to justify this view. Moreover, anatomical proof is forthcoming, for several of us have found well-marked meningeal thickening in such cases. We hold these lesions to be primary, and that the articular lesions are secondary thereto, so that the latter are of medullary origin.

This tropho-neurosis is probably of infective origin, although the specific germ has not so far been isolated. The lesions are non-inflammatory, but are essentially degenerative. With regard to the etiology, in addition to cold damp we must mention other predisposing causes: unhealthy surroundings, ancestral rheumatism, tuberculosis, etc. The last-named only acts as a predisposing cause in the cases under consideration, which are not tuberculous rheumatism, but para-tuberculous.

There does not appear to be an acute form of deforming poly-arthritis, the cases reported by Abrahams belonging, in all probability, to the group of infective rheumatism. The same remark applies to the chronic deforming rheumatism of childhood. Among the partial forms must be mentioned *morbus coxæ senilis*, an affection characterised by irregular deformities and good general health, although death from Bright's disease is always possible, and the vertebral form which requires to be distinguished from the true rhizomelic spondylosis, as described by Pierre Marie.

We will now pass on to the second group, that of chronic, post-infective arthropathies. These affect two forms: "chronic rheumatism" and "chronic infective pseudo-rheumatism," which correspond exactly to ordinary acute articular rheumatism and acute infective pseudo-rheumatism. Both in reality are of microbial origin, so that they present the same constitutional symptoms, and may be placed in the same category. The discovery of the affection now known as infective pseudo-rheumatism, after upsetting the classification of acute arthropathies has also modified that of chronic arthropathies, and it is at present generally admitted that every affection capable of setting up acute arthritis may further give rise to the chronic forms. We are thus confronted with a fresh series of cases of chronic rheumatism with deforming tendencies, varying in their clinical features according to the determining infection, but which may be classed together by reason of the nature of their complications (the frequency of visceral affections, more particularly endocarditis) and their anatomical distribution (special tendency to attack the synovial membranes and the peri-articular tissues, with marked tendency to ankylosis).

From a practical point of view, we must consider three common clinical types of chronic infective rheumatism: the true rheumatic form, the blenorrhagic form, and the tuberculous form.

The first variety, which was recognised by Charcot, Ball, and Bouchard, though controverted by the English school, appears to be tolerably frequent. As a rule the affection follows the acute form by sudden retrogression of the constitutional symptoms and limitation to three or four large joints. In this variety there are few, if any, sensory disturbances, and the resulting deformities are different. The damage bears specially on the synovial membranes, as can be seen by the aid of skiagraphy. There is no tendency to involvement of all the joints; indeed, we often witness a tendency to local improvement. But there is marked liability to endocarditis, especially mitral, but sometimes aortic. It may be stated that the presence of endocarditis in a young subject apparently suffering from deforming rheumatism is sufficient to establish the true rheumatic origin of the arthropathic syndrome. This true chronic rheumatism may be general or partial. If general, it may be grave in consequence of the extension of the process to all the peri-articular fibrous tissues and to the adjoining serous sacs as well as of the cardiac lesions. When partial, it may attack a large joint, the peri-articular tissue (scapular peri-arthritis), or the fibrous tissues (retraction of the palmar aponeurosis).

We must also admit the existence of cases of deforming polyarthritis (of the tropho-neurotic kind) in the subjects of past acute, articular rheumatism. In such cases we must suppose that the debilitating effects of the acute rheumatism have paved the way to the latter affection.

The blenorrhagic variety has long been known to us, with its peculiar tendency to involve the peri-articular tissues and its rapid course towards ankylosis, fibrous to begin with, but becoming osseous, whence the frequency of blenorrhagic rhizomelic spondylosis.

As in the preceding form, there are no sensory disturbances or amyotrophy, and no signs of compression. It does not necessarily run a progressive course, and marked improvement is not uncommon.

Tuberculous rheumatism, first described by Poncet, is almost always chronic, and is due to direct infection by the tubercle bacillus, or to the toxins elaborated by the latter; that is to say, a specific inflammation of the synovial membrane or a toxic inflammation of the periarticular fibrous tissues (arthropathy, which is histologically tuberculous or tuberculinous arthropathy). The relationship of this variety of chronic rheumatism with tuberculosis is quite clear. It occurs either in admittedly tuberculous subjects who present pulmonary lesions of a slow type, suffering, it may be, from typical white tumour; or else we find in the rheumatic subject a tuberculous lesion either apparent or latent; or it may be that the symptoms of chronic rheumatism make their appearance in a subject who is himself healthy, but whose ancestors or collaterals are largely tuberculous.

Tuberculous rheumatism assumes numerous forms, from slight local manifestations, the simplest form of local synovitis, to ankylosing rheumatism of the hip, or the common type of deforming polyarthritis, as well as the generalised form with invasion of the large serous cavities and ultimate explosion of miliary tuberculosis in the lungs. Just like blenorrhagic rheumatism, tuberculous rheumatism displays a marked tendency to ankylosis, which is, after all, only the expression of a general property of the tuberculous poison to set up adhesions in the serous membranes (especially the pleuræ and pericardium), and to induce tissue sclerosis. Here, too, the spinal column may be attacked and ankylosed (tuberculous spondylosis).

It is by no means an easy matter to establish the tuberculous origin in a case of chronic rheumatism. It may be clinically probable, but in most instances cultivations and inoculations of the synovial liquid fluid give negative results, cytological observations give uncertain data, and hæmatology throws little or no light on the subject. There remain the sero-reaction, which is of doubtful value, and the tuberculin test, which is risky. Skiagraphic examination shows nothing distinctive. We must, therefore, content ourselves with the clinical indication without being able to provide a more exact explanation of the pathology and pathogenesis of these tuberculous manifestations.

We may add that alongside tuberculosis and blenorrhagia there seem to be a chronic scarlatinal rheumatism and a syphilitic rheumatism, still little known.

We now come to the third category, comprising chronic arthropathies of toxic or auto-toxic origin. My own view is that these are not, properly speaking, cases of rheumatism at all. This can be shown by clinical analysis, which enables us to point to the differential characters of these affections, and to contrast them with those of true rheumatic arthropaties.

This group comprises all the chronic articular manifestations that occur as the result of poisons that are recognised to be liable to provoke inflammatory and trophic lesions of joints (alcohol, lead), and a whole series of joint deformities which are indubitably due to general auto-intoxication, from camptodactyly (rheumatism of gastric dilatation) to the Hippocreatic finger and biliary rheumatism, comprising also a long series of uricæmic deformities, deformities that range from Heberden's nodes, the most strictly limited form, to the most generalised forms of rheumatic gout and the arthropathies that are premonitory of interstitial nephritis.

These are constitutional diathetic manifestations. They stand in an indifferent relationship to the infection and are secondary at most. Cold damp may determine inflammatory outbreaks, but in reality the *primum movens* of the arthropathy is the constitutional disturbance due to auto-intoxication, and the nutritive disturbances thus engendered.

The features that distinguish them from arthropathies of infective origin are the following:—

1.—The morbid process never attacks the cartilage; at any rate, to begin with, on examining with the X-rays the inter-articular cartilages are seen to be in perfect preservation, in spite of well-marked deformities.

2.—The bony deformities, the swellings, and the nodular outgrowth become pale on the screen, and in the skiagraphic print they appear as white patches, showing their uric or uratic origin.

3.—The skiagraphic print may not reveal any precise modification of the kind. This means that the inflammatory tendency has been limited to the peri-articular tissues that alone share in the nodular deformity.

4.—These arthropathies are specially limited to the smaller joints, and show no tendency to generalisation. They are subject to outbursts betraying, it may be, striking alterations of size, and be associated with multiple visceral manifestations of the coexisting dyscrasia.

5.—Diathetic rheumatism is frequently accompanied by vascular, arterial and venous lesions; hypertension is the rule, renal sclerosis and aortitis, associated or not with Hodgson's inadequacy, are common, and there is an increase in the number of eosinophiles.

6.—This form of chronic rheumatism often gives rise to outbreaks of the nodular form, displaying a marked affinity for connective tissue, fibrous tissue and periosteum, etc., whence a very great variety of clinical forms dependent on the seat and the extent of the nodular outgrowths. All these manifestations find a ready explanation in the natural affinity of uric acid for white tissues, fibrous ligaments and aponeuroses.

Uricæmia, whether inherited or acquired, appears indeed to be the fundamental underlying cause of these various syndromes. The diathetic states thus caused belong consequently to the great arthritic family, of which, along with gout, they constitute the two principal manifestations.

This is why we sharply separate these arthropathies from the group of common rheumatic affections, and this distinction, which is of such great importance from the point of view of pathogenesis, is clinically indispensable since it entails altogether different diathetic and medicinal indications.

To sum up, true chronic rheumatism is of infective origin, but the infection may provoke arthritis in two different ways: (1) indirectly by trophoneurotic process, that is to say, by the primary action of the poison or the toxins on the central nervous system and the medullary roots; (2) directly by the action of bacterial poisons on the synovial membranes or the peri-articular, connective and fibrous tissues. Active infections tend to attack the joint forthwith; they have septicæmic tendencies, which are often revealed by heart lesions; this is infective chronic rheumatism. Infections that exert a slow but prolonged action act preferably on the nervous system, and it is through its intermediary that they produce trophic disturbances; this is tropho-neurotic deforming rheumatism.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Patrick Maxwell, M.D.Ed., F.R.C.S.I., Ophthalmic Surgeon to Jervis Street Hospital, Surgeon to the Royal Victoria Eye and Ear Hospital, Dublin. Subject: "Internal Squint."*

HARVEIAN LECTURE.

SOME POINTS IN CONNECTION WITH THERAPEUTIC IMMUNISATION. (a)

By SIR ALMROTH E. WRIGHT, M.D., B.Ch.Dub., F.R.C.S.I.

THE Lecturer discussed first the importance of taking the opsonic index in cases which are to be treated by therapeutic inoculation. It was pointed out that vaccines must be used with care as regards dosage, and the ill-effects resulting from tuberculin inoculation, when it was first used for therapeutic purposes, served as an illustration of the dangers resulting from giving too large doses of vaccines. The determination of the opsonic index both before and after inoculation always serves as a useful guide as to the dose of vaccine to be given, and as to the time of giving it. If the index is not determined, then, for safety's sake, a very small dose of vaccine is usually given, and often the full beneficial effect is not obtained.

1. In some cases of staphylococcus infection, where there is a local visible lesion, *e.g.*, a boil or carbuncle, then the action of a given dose of vaccine can be observed by the local effects produced, and thus the dosage can be gauged; the same guide is present in some cases of tubercular lesion of the skin.
2. In some cases the pyrexia present serves as a guide to the therapeutic effect of the vaccine, but where the temperature becomes normal, often the lesion is not healed, and then the opsonic index is the only reliable guide to the dose to be used, This applies to the treatment of pulmonary tuberculosis by inoculation.
3. In some chronic cases, where the treatment is of long duration and the progress slow, *e.g.*, in tubercular disease of the joints, cases of cystitis, &c., the determination of the opsonic index is necessary as a guide to the dose and time of inoculation.
4. In some cases where the symptoms are latent and the lesion is not visible the index must be taken.
5. In cases where the disease is running a rapid course, *e.g.*, in septicæmia, there is danger in attempting to determine the dose of vaccine by the therapeutic effect produced for two reasons—(*a*) time does not admit of delay, (*b*) an excessive dose may be fraught with great danger. In these cases the opsonic index is the only reliable guide.
6. In some cases, a single dose of vaccine effects a cure, and here the experience of previous cases gives one an idea of the dose to use. If this is followed by the desired result, it is, of course, unnecessary to determine the opsonic index.

Sir Almroth Wright now proceeded to discuss some practical points relating to "The Pathology of Inflammation." He pointed out that there are two important factors to consider—(1) the emigration of the leucocyte (Metchnikoff's theory), (2) the transudation of lymph.

In cases of a local inflammatory lesion—

1. It is important that there should be a plentiful local supply of blood and lymph.
2. It is important that the blood and lymph should have protective substances.
3. It is important that a plentiful supply of healthy leucocytes should find their way to the local lesion.

Instances of the "Miscarriage of Inflammation" were furnished thus—

1. Where there is excessive serous effusion, and too few leucocytes as in a tubercular serous pleural effusion.
2. In abscess formation, where the leucocytes are dead, where the protective substances are absent from the fluid exuded, and where the digestive action of the fluid produced by the disintegration of the leucocytes has an inimical effect on the healing process.
3. Where a sinus or a fistula is produced, or in cases where there is much induration round a lesion the healing processes of inflammation are retarded by the adverse local conditions.
4. In cases where there is great dryness of the tissues affected by the inflammatory process the deficient supply of protective substances owing to the small amount of fluid exuded delays recovery.

The Lecturer gave many instances of the manner in which these miscarriages of inflammation could be remedied, *e.g.*, (1) by removal of excess of fluid in "serous effusion," and abscess; (2) the flushing of the local lesion in cases where there is a deficient

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(*a*) Abstract of the Harveian Lecture delivered before the Harveian Society of London, March 26th, 1908.

supply of lymph to the part. This can be brought about by the administration of citric acid internally or by the local application of hypertonic solution of sodium chloride with sodium citrate. (3) Lastly, and most important, the protective substances of the lymph can be increased in amount by the therapeutic administration of an appropriate vaccine in proper doses.

LUMLEIAN LECTURES.

POINTS OF PRACTICE IN MALADIES OF THE HEART. (a)

By Sir JAMES SAWYER, M.D., F.R.C.P.Lond.,
Senior Consulting Physician, Queen's Hospital, Birmingham, &c.

LECTURE III.

In the frequent admixture in practice of functional disorder and of organic disease of the heart, in some cases the one of these, in others the other, is to the fore. So, in the true view of them, we have four great clinical groups of cardiac maladies. We have simply organic diseases; we have simply functional disorders; we have organic diseases complicated by functional disorders; and we have functional disorders complicated by organic disease. To these four groups, by the light of recent researches, we must add another —namely, one in which intrinsic functional disturbances of the heart's musculature are to be found. In practice, this is not always a distinct and separate group, because disorders of the cardiac musculature may complicate any of the four cases just distinguished. The healthy functioning of the heart depends upon several qualities in its muscular tissue. We have a myo-neurogenic explanation of the heart's working, in advance of the neuro-myogenic theory of the times just ago. In wasting diseases, in convalescence from acute diseases, especially from those of a pyrexial character, under the effects of various toxins, of autogenetic origin or of microbic infection, the vital qualities of the heart's musculature become impaired. In such impairment of those vital qualities we find the explanation of many cases of cardiac enfeeblement, of temporary valvular incompetence, and of temporary dilatations of cardiac cavities. In this wider conception of cardiac maladies, the observations and experience of the clinician enable him to distinguish unerringly to which group any particular case may belong, and this in most cases at once, or soon, in the others after longer watching. This complexity of cardiac maladies is what we find in practice. It would, indeed, be strange if disease of an organ so vital as the heart is in a patient's consciousness were not complicated by functional disturbance, of the kinds of such disturbance which are of emotional or of neurotic origin. Such disturbance is natural in the circumstances. And it is natural that the heart, linked as it is to many other organs by circulatory and by nervous connections, should be disturbed by extrinsic irregularities. Our therapeutics confirm this view. How often in practice do we omit the use of cardiac sedatives, of cardiac excitants, of cardiac tonics, of vaso-constrictors, of vaso-dilators, which so easily beset us, and all very useful when applied appropriately, to find such omission good, the heart's disturbance abated, and then to find the patient's comfort consummated under Gregory's powder, or under soda and calumba with an effervescent!

The nervous temperament, or nervous diathesis, as some prefer to call it, is the background, and, to change the metaphor, also the groundwork or basic principle, of most of the dynamic disorders of the heart. It is the basis of all the dynamic disorders of the organ, if there be excluded toxic causes, as the excessive use of tea or of tobacco, auto-toxic causes, as goutiness, and as what may be called copræmia from excessive fæcal retention, and also if there be excluded spanæmia, and also, what is little accounted of in these days, plethora, and also if there be excluded those disturbances of the myocardium which are marked by impairment of tonicity and of contractility in any part of that highly specialised musculature, and also if there be excluded certain rare cases of bradycardia, and of tachycardia, with or without exophthalmia. With these exceptions, the nervous temperament is the basis of the inorganic maladies of the heart. The recognition of that temperament is the clue to their successful management. In these affections the signs of the patient's disposition interpret the symptoms of his indisposition. A temperament is an individual peculiarity, a type of idiosyncrasy, of the physical organisation of a sentient and intelligent being, by which the manner of acting, feeling, thinking and suffering is affected permanently. Our definition of a temperament may include other beings besides human ones. For an instance: the manifestations of temperaments can be well studied in horses, and they may be studied in them with advantage to our understanding of those manifestations in our own kind. A temperament is a variant within certain limits of the natural organisation of living individuals. That there are temperaments in human beings is an ancient doctrine in medicine. Yet, that there is a nervous temperament is a notion which does not seem to have been uttered until fifty years ago. It might be regarded as a product of our later civilisation. But it seems to be a very old human characteristic, the differentiation of which has been recognised only in our own time. It was not until modern physiology had unravelled many of the mysteries of the nervous system that the marks of this emphasis of that part of our being could be distinguished. The wide diffusion of incomplete information is a note of our time; except for it, there appears not to be more nervousness now than of old. Dr. Pritchard, in his great essay on temperaments, published in 1835, described four temperaments, namely, the sanguine, the phlegmatic, the choleric, and the melancholic. (a) Dr. Laycock, lecturing in 1862, described six temperaments: the nervous, the sanguine, the phlegmatic, the bilious, the lymphatic, and the melancholic. He found that, "persons nervously active from predominant innervation are of the nervous temperament." (b) Such persons might be said to have a nervous system which is "highly strung." They have been said to be especially liable to nervous diseases. The truth would seem to be that they are no more liable to nervous diseases with "coarse" lesions than anybody else; but that all other nervous diseases are peculiarly their own. The phrase, a person of nervous temperament, and the words, a neurotic, are not of identical connotation. A neurotic person is one of this temperament in an extreme degree of it, or one in whom a nervous temperament of lesser degree is not under control. A neurotic is a person with one or more nervous symptoms. Such symptoms may be subjective, or they may be objective, or they may be both. These symptoms of the neurotic may be called neurotisms. All the dynamic maladies of the heart, other than those excepted just now, are marked by neurotisms, and have their essence in them. There are, too, the mixed cases in which functional disturbances blend, variously, with the signs and effects of organic disease.

Some persons of this temperament may be known by their eyes, with sclerotics unduly exposed, their eyes showing a breadth of sclerotic between the cornea and the upper lids—a sure sign, but one often absent. Temperaments appear oftenest in men. Few women show them decidedly. But when a woman is of the nervous temperament, in her it is well marked. Various temperaments may appear to be mixed in one person. A man of nervous temperament is quick in manner, if he have not a slowness which is obviously a calculated one; he may talk volubly and eat fast; he is apt to "overdo" everything into which his feelings enter, and they enter into most of his doings; he is apt for hobbies, and is often a collector of curiosities. If a good man, he is likely to make a worry of his goodness; if bad, he is apt for treasons and stratagems. Lingual physalisation is a name I suggest for a constant mark of this neuropathic type. When a patient of this temperament shows his tongue in the usual way, two broken rows of small air-bubbles are seen in the moisture upon its dorsal surface. Each row skirts the lateral edge of the tongue, and lies about a seventh of the width of the organ from this edge, a row of bubbles on each side. I have found this appearance in hundreds of cases. Its pathognomy is unerring. How does it arise? The Newtonian rule is safe, that we are to admit no more causes of a natural phenomenon than such as are true and enough. A little emotional increase in the viscidity of the mouth's moisture, as in fear, and a little emotional increase in the mouth's movements, as of swallowing, which is a physical accompaniment of what is called tenderness, and lingual physalisation results. There are other signs of this temperament. Laycock knew that temperamental signs could be made out from handwriting. A little study of the subject, accordingly to the modern French school of graphology, yields points of medical suggestiveness.

(a) Abstract of Third Lecture delivered before the Royal College of Physicians, London, Thursday, April 2nd, 1908.

(a) "The Cyclopædia of Practical Medicine." Edited by Drs. Forbes, Tweedie, and Conolly. Vol. IV. London. 1835.

(b) *Med. Times and Gaz.* 1862.

We recognise with one consent that each case of functional disorder of the heart needs its own particular treatment, in medicines, in dietetics, in education, and in self-discipline. If we can cure worry, that undue solicitude which Shakespeare called,

"A hell-hound that doth hunt us all to death"—

if we can cure worry, we are far towards the cure of many cardiac neurotisms. Worry is curable in a large proportion of instances, and that permanently. Often worry is only a continued form of impatience. The line of impatience in each case must be found, and the patient taught to develop resistance thereunto. He can develop such resistance in most instances. Worry usually is wearing and destructive. For the most part patients are to be helped against it. At the same time, experience in practice reveals that there are some worriers to whom worry appears to be a vital necessity, and in whom it is not to be resisted with advantage. How great, how curative, how durable in neurotic affections is the power of a patient to overcome harmful worry, under sympathetic and judicious medical guidance, is not recognised sufficiently. Each of us will prepare for such patients his own simple, comprehensive, and assimilable forms of an optimistic philosophy. Many such patients can be set aright if we establish in them the pursuit of a sound ground-work for daily happiness, for example, as in Chalmers's formula, by their pursuit of "something to do, something to love, and something to hope for." As in most nervous ills, the physician should be an adroit inspirer of hope, and of the patient's desire of cure, and, believe, he will get it.

It has long been known that strong and excited action of the heart, especially in a woman of nervous temperament, may cause murmurishness of the heart's first sound, as that sound is heard at the apex of the organ, and even develop there a systolic murmur. In a case purely of this kind the signs of organic cardiac disease are wanting. The abnormal sound disappears as the excitement subsides, this change often occurring during auscultation, if the murmur be observed for a few moments. More recent work in practice has elucidated this dynamic endocardial murmur. Such a murmur has been called by Potain a "souffle de consultation." He noted it: as arising with an acceleration of the beats of the heart, without any modification of the respiratory rhythm; as accompanying emotional disturbance, with the heart of normal size, and the pulse, although rapid, never irregular. Such is Piatot's account of the matter. (*a*) This is the murmur which might lead an incautious observer to a diagnosis of mitral insufficiency where no such inadequacy exists. I find this souffle de consultation is always systolic; it is to be found usually only in the mitral area, at and about the impulse point; it comes and goes under auscultation, that is, it alternates under observation, with a pure first sound; sometimes it is heard in the aortic area, too, and there, too, it is intermittent; very rarely it is aortic in site alone. Further, it is to be heard that this murmur, when it occurs in the anterior mitral area, goes with, accompanies, and is synchronous with the first sound; it does not take the place of that sound there, as the true murmur of mitral regurgitation does. The souffle de consultation is recognisable as an addition to a weakened first sound. The murmur of mitral regurgitation replaces the valvular part of the first sound and masks the muscular portion of that sound. We know that the murmur of mitral regurgitation is audible usually in the left vertebral groove; in rare instances it is inaudible there. But the mitral souffle de consultation is limited, almost always, to the impulse point; it may also be audible at the inferior angle of the left scapula, but only with the extremist rarity. One may think that this bellow's puff of emotion, when it is mitral in place, arises from some perversion of the muscular part of the heart's first sound, or from insufficiency of that part of mitral closure which is ruled by the papillary muscles, or from both, under an emotional disturbance of cardiac innervation. When this puff is aortic in area, the fine edges of the aortic valves may give for the moment a sonorous vibration to the blood passing the aortic orifice; one may opine that such an error of the lunulæ "getting in the way" would arise from arterial spasm.

Mitral insufficiency is the most frequent of all the chronic valvular affections of the heart. It is more frequent in practice than all the other valvular diseases of the heart put together. Mitral regurgitation, dependent upon organic mitral insufficiency, is marked by well-known physical signs. With some exceptions, such insufficiency is the mark of a lesion which had its local beginning in an acute rheumatismal endocarditis, usually, or in a mild form of other microbic endocarditis, rarely. Such endocarditis is exudative and proliferative in its processes, with the organisation of new products. The valves become thickened, hardened, and bound by adhesions, and a chronic endocarditis, leading to sclerotic changes, sometimes follows the acute process. Sometimes, but in my experience very rarely, the endocarditis appears to be in a chronic form from its outset. Whenever the characteristic murmur of a mitral insufficiency marking endocarditis may appear, it has come to stay. Instances of its disappearance are almost unknown. I have never known one. It must be admitted, however, that complete recovery without any valvular damage is possible, especially in young subjects, and especially after prolonged rest and quiet in bed. Potain gives the good name "holosystolic," wholly systolic, to the murmur of mitral regurgitation, so clearly and cleanly does it go with the ventricular contraction. The murmur is strong, often rough, often like the noise of a jet of steam, of equal course, with no maximum. Its tone may be high from the first, especially in young subjects, and its pitch lowers progressively, accordingly as the insufficiency increases or the myocardium fails. (*a*) Sometimes, though rarely, mitral regurgitation, as it is declared by its murmur, exists for many years without any other consequent abnormality whatsoever. A lady is still under my observation who has enjoyed this very exceptional immunity for about forty years. If with the murmur there be any other of its associated abnormalities, say, in pulse, size of heart or of liver, other complications are sure to follow. Usually the period of complete compensation is brief. We notice how much longer this time is in the well-to-do, with sobriety and light work, than in our experience of hospital patients. This malady is a typical disease of the heart. Sooner or later the valvular lesion causes hyposystole, arterial hypotension in the greater circuit, arterial hypertension in the lesser circuit, with cardiac dilatations, venous stases, hepatic, renal and other congestions, œdemas and dropsies.

Accentuation of the part of the heart's second sound which arises at the mouth of the pulmonary artery and is best heard in the "pulmonary" area, found and taught by Skoda in early stethoscopy, is an expressive sign of organic disturbance in the heart's dynamics. Its interpretation is significant in practice.

(*a*) "Traitment des Maladies du Cœur par l'hygiène et les agents physiques." Par M. le Docteur A. Piatot. Paris. Steinheil. 1898.

(*a*) "Sa tonalité, élevée dès le début, surtout chez l'enfant, s'abaisse progressivement à mesure que l'insuffisance s'exagère ou que le myocarde faiblit." Traitement des Maladies du Cœur, &c. Par M. le Docteur A. Piatot. Paris. 1898.

in diagnosis, in therapeusis, and in prognosis. This accentuation is an unfailing token of rise of tension in the pulmonary artery, of a threatening change in a vital circuit of the blood, which is beyond those tactile and metric tests which try variations of tension in systemic arteries. In health, the second sound is louder in the "aortic" area than in the "pulmonary." A louder pulmonary second sound marks some obstruction in the pulmonary circuit. It is like the banging of a door which before was closed with little sound. This sign is united with lesions of the mitral valves and of the mitral opening. Either insufficiency of the mitral valves or narrowing of the mitral opening, or both, add a new hindrance to the blood stream in the lesser circulation. In so far as such a hindrance elicits increased systolic force in the right ventricle, by so much does it raise tension in the pulmonary artery, and so accentuate the pulmonary second sound. Old mitral regurgitation or old mitral stenosis, or both, may be without this accentuation, or even with a pulmonary second sound less loud and clear than in health. This may arise from failure of the right ventricle, or from tricuspid regurgitation, or from both. In mitral disease, when the right ventricle at last fails to countervail the obstacle in the left side of the heart, the tension in the pulmonary artery falls, and with it the loudness of the pulmonary sound. When, too, in mitral disease, the tricuspid valves fail in their office, tension in the pulmonary artery falls. It would seem that this quasi-compensatory tricuspid regurgitation arises from widening of the ring of insertion of the valve, in the course of dilatation of the right ventricle, so that the valve cannot close the enlarged opening. In mitral disease, in the comparison of the pulmonary second sound with its aortic concurrent, we note that the aortic second sound is weakened relatively by the lowered systemic tension which results from mitral defects. Thus there is a pseudo-accentuation of the pulmonary sound. Such sound of normal loudness is not to be judged accentuated because it co-exists with a weak aortic sound. Hence a difficulty in practice which only long experience can solve; but it solves it quickly and surely. My observations lead me to conclude that the presence or the absence of accentuation of the pulmonary second sound, or a high or a low degree of such accentuation, are valueless in a diagnosis between mitral stenosis and insufficiency. Each of these variants of mitral disease, whether singly or howsoever blended, adds an obstacle in the lesser circuit, and tends to increased tension in the pulmonary artery. So long as this obstacle is countervailed by the right ventricle, so long is the pulmonary second sound louder than in health. When this saving force fails, as by dilatation of the right ventricle or by degeneration of its walls, or by both of them, then the pulmonary sound fails too, and may be almost lost, or quite. When mitral disease first arises, the pulmonary second sound accentuates, but slightly only. During the usual period of quasi-health, from the time of convalescence from the usual initial acute endocarditis until the time of other complications, the sound remains but slightly reinforced; during this period, which may vary from a few weeks or months to a few or to many years, it is usually as loud as the aortic sound, or a little louder, but not so markedly. Towards the end of this time, when tension in the pulmonary artery is nearing the point of prevailing over the compensatory force of the right ventricle, accentuation becomes very distinct, and reaches its loudest range. Then this sign is a grave one. It marks a height of tension not likely to be borne long. Then, as a straw upon the back of a labouring camel, some little effort or difficulty breaks down compensation. A little bronchial catarrh, and compensation fails, accentuation falls, viscera and surface congest, anasarca comes, and dropsies. Then by rest, by suitable evacuants, by indispensable digitalis, patients are likely to lose these later sequelæ of their mitral disease. As such an one improves, the pulmonary second sound swells again, as the right ventricle recovers its countervailing. With a rising sound comes recovery. But the complications of this later stage of mitral disease cannot always be removed even once; and if removed once, or oftener, at last treatment gains little or nothing. Then compensating powers are finally overcome; the pulmonary second sound strengthens no more.

In the removal of the congestive and dropsical complications of advanced mitral disease, my experience confirms the therapeutic efficacy of the well-known combination of powdered leaves of digitalis, with squill and blue pill. I have found that one pill, containing a grain each of the powder of digitalis leaf, of powdered squill, and of the officinal blue pill, given thrice daily, suffices usually. In some cases a larger proportion of digitalis in the pill is necessary for the good effects of the remedy; in such the dosage of the drug should be increased, under skilful guidance and observation. This pill is often quoted as Baillie's pill, of the great Matthew Baillie, of this College. His pill, however, contained, in his own words, "five grains of the pilula hydrargyri, combined with one grain of the dried powder of squills and half a grain of the dried powder of digitalis," and he prescribed it in hydrothorax, when, as he wrote, "dropsy of the chest does not depend upon any diseased structure of the heart." (*a*) The powder of the leaf, in pill, and the infusion of the pharmacopœia, have proved, in my practice, to be the best forms of administration of digitalis. Therapeutics, so far as it concerns the treatment of patients by drugs, in organic diseases of the heart, and especially in that condition of those diseases in which what we know as compensation is at fault, turns very largely upon the questions, in what case to exhibit digitalis, how to do so, and in what case to withhold it. Some sterling rules of practice in these particulars were reached by Withering, and laid down by him in his classical book upon the foxglove. (*b*) These rules have been refined since, notably in the distinctions between renal and cardiac diseases and dropsies, and generations of physicians of long practice have come to much clearness in the indications for the use of this great remedy. Digitalis is by far the best of the remedies of its kind. What it can do some other remedies can do in part; but none even that part so well. Digitalis has no succedaneum. As to when to give it or not, my own practice is, never to give it unless the indications for its use are complete, never to give it merely because the heart is affected; but to give it always, and then in efficient doses, when the veins and the arteries at the same time point to its use, namely, when the veins are too full and when the arteries are not full enough, and the pulse is soft.

Phlebotomy is necessary in danger of death from distension of the right cavities of the heart. In such a case I have seen the moribund saved by venesection. In such cases the old proud claim has been realised, *multos mortis e faucibus eripimus*. The more sudden the distension the greater the need for blood-letting. As the blood flows from the opened vein, the engorgement of the systemic veins, and consequently the paralysing distension of the right side of the heart, are diminished effectually; the right ventricle becomes able to propel its contents through the lungs, and so a fair supply of oxygenated blood is given to the brain and to the cardiac musculature. A cardiac cavity is a hollow muscle like the urinary bladder; hyperdistension of either results in its paralysis, with full retention of its contents. It is in cases of chronic bronchitis and pulmonary emphysema complicated by dilatation of the dextral cardiac cavities, that mortal danger most frequently arises from engorgement of the right side of the heart. In hospital practice I saw a woman, a chronic bronchitic, æt. 50. Upon becoming an in-patient her lips were bluish, with distended veins of neck, with orthopnœa, small and feeble pulse, lower extremities and hands œdematous, cardiac dulness increased transversely, with diffused impulse, hepatic dulness increased, sibilant and sonorous rhonchi all over chest, with large crepitations at bases of lung, and with scanty urine, one-fourthly albuminous. In four days she appeared to be moribund, labouring, with tracheal râles, for her

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(*a*) "Lectures and Observations in Medicine." By the late Matthew Baillie, M.D. Printed in London in 1825. Baillie ordered in his last will that 150 copies be printed, "but not published."

(*b*) "An Account of the Foxglove and some of its medical uses, &c." By William Withering, M.D., &c. 1785.

breath, with lips and tongue now purple, face deeply congested, veins of neck greatly distended, continued orthopnœa, and radial pulse irregular and almost imperceptible. The right median basilic vein was opened, and six ounces of very darkly coloured blood taken. The relief was at once; the pulse became regular and of fair volume, the dyspnœa lessened much, and also the venous distension, and the lips and face resumed an almost normal hue. In a fortnight she left the hospital—her œdema gone, and her urine free from albumin.

Within the thirty years last past, therapeutics in cardiac maladies have evolved two peculiar remedial procedures of importance, in certain varieties of physical training, and in certain respiratory exercises. Before that time rest usually was pressed in chronic heart cases, with no idea that any form of movement could be salutary. As to the forms of physical exercises, Oertel, in 1875, following ideas which Stokes had expressed, advised muscular exercises; these he arranged in the form of walking up slopes, in progressively augmented ascensions, and to these he added a dietary restricted as to fluids.

A physiological appreciation of the various forces concerned in the circulation of the blood makes clear the physical foundations of the remedial employments of respiratory exercises. The use of these exercises is indicated strikingly in many cardiac maladies, in organic diseases of the heart, and in neurotic disorders of the organ. In the latter I have found them aidful in assuaging the cardiac consciousness. Such exercises for cardiopaths appear to be of our own times. They are usually helpful in any form of hyposystole, and especially are they adjuvants to the blood flow in the pulmonary and hepatic circuits. I have found much benefit in practice from the twice daily use of frictions, prolonged for a few minutes, of rubefacient embrocations to the skin over the heart.

The remedial uses of alcoholic stimulants, under judicious guidance, in many heart cases are well known. The power of alcohol, when suitably exhibited, to evoke and to sustain the action of the heart's musculature is well established. I have found alcoholic remedies especially useful in practice in cardiac maladies when combined with spicy aromatics and anti-spasmodics, and I think we might revive the use of two good old cordials—of two old and good hearteners, usquebagh, which was officinal in the pharmacopœia of the College in 1677, and ipocrasse, which is a tincture of ginger and other spices in red Burgundy.

ORIGINAL PAPERS.

NOTES ON A CASE OF

GRAVES' DISEASE TREATED BY THYROIDECTOMY. (a)

By WILLIAM TAYLOR.

As the treatment of Graves' disease still remains in a somewhat unsettled state in this country, I thought it might be of interest to bring the notes of the following case before this section of the Academy, and add some remarks upon the surgical treatment of this condition.

M—— K——, a dressmaker, æt. about 24, was admitted into the Meath Hospital under my care on April 7th, 1906.

Her history was as follows:—On December 26th, 1900, she noticed that her left eye seemed to be larger and more prominent than the right. Her colour, which had hitherto been good, altered very noticeably. Her face seemed to become generally swollen and the skin assumed a greenish hue. Six months after the left eye was noticed to be prominent her right eye also became prominent, but the prominence never seemed quite so pronounced as that of the left eye. At this time she developed an insatiable thirst, and used to drink enormous quantities of water. She likewise developed an inordinate desire to eat sweets. Her heart began to trouble her, and palpitations became very distressing. She could scarcely sleep at night on account of the rapid, tumultuous beating of her heart, and her mother was unable to occupy the same bedroom with her on account of the violence of the heart's action. Then her neck became swollen, the enlargement appeared first on the right side, and gradually extended across the front of the neck. Nervousness made its appearance. She became easily frightened, dreaded going out of the house at night, and she began to give way easily to tears. In short, as she told me, she became "hysterical." She was compelled to give up cycling to business because of her nervousness, her palpitations, and the breathlessness from which she suffered on the least exertion. Even when walking to business she was compelled to stand still for a few moments on account of the palpitations and breathlessness. Ultimately she was unable to go to business, and she became very depressed and got into very low spirits. Neuralgic pains now appeared in her head and face. Her stomach and feet became swollen—her feet so much so that she had to remove her boots on getting to business. Her hands likewise became swollen so that she experienced difficulty in putting on her gloves. Loss of memory was noticed, and she developed a dislike towards and a feeling of distrust and suspicion of her friends. Her temper became very irritable. She had some dysphagia, and occasionally experienced a sensation of suffocation. Her face flushed frequently, and she often perspired profusely.

She felt a throbbing sensation in the back of her neck, and complained of severe headaches. The latter were so severe that she thought she would go mad. Her hands became very tremulous, and she had a tendency to let articles drop. At the same time she frequently felt her legs suddenly give way, and felt that they were unable to support her. She complained of pain over her heart, and once over the left eye. When very ill she slept badly, and always awoke in great fright. She was restless, and tossed about in bed. Her appetite was generally good; she vomited occasionally, and complained at intervals of abdominal cramps. The bowels were constipated. There was amenorrhœa. She frequently felt feverish and weak. Dr. Lennon saw her, and took her into the Meath Hospital, where she remained for some two months, and for six months subsequently she followed his advice and took the medicines he prescribed. She improved for a time, and then relapsed. The patient attributed her condition to a fright she received on the Easter Monday prior to the onset of her symptoms, the fright being produced by a car upon which she was driving being almost upset. From that day she felt nervous.

The condition on admission to hospital was pretty much as described in the history she related, and which I have just detailed. She was kept quiet in a private ward for some three weeks, and during this time her pulse varied in frequency from 120 to 136 beats in the minute. Belladonna and digitalis were administered during this period. She was exceedingly tremulous, and her agitation and nervousness were so pronounced that she could scarcely speak intelligibly. The urine contained neither albumin nor sugar. Operation was performed on May 7th, a hypodermic injection consisting of morphine 1-6th gr. and atropine 1-100th gr. being given half an hour prior to the administration of the anæsthetic, which was chloroform. There was nothing unusual in the operation, which consisted in the removal of the right lobe, which was greatly enlarged, and with it almost the entire isthmus. The pulse for the subsequent 24 hours varied from 120 to 140, and the temperature rose to 101.4°. On the second day the temperature was normal, and the pulse fell to 120 again. Convalescence was uneventful, the drainage tube was removed on the third day, and the sutures on the sixth day. The pulse gradually fell in frequency until the tenth day, when she left for the convalescent home. On this day I found the record was 78 pulse beats, but, on counting it myself, it varied from 80 to 84 in the minute. The patient has since expressed herself to me as feeling better than she has felt for many years. The eyes are still prominent, but much less so than they were before operation. She has no palpitations, her muscular tremors are gone, and she is scarcely more nervous than any young girl would be whilst being medically examined.

(a) Paper read before the Surgical Section of the Royal Academy of Medicine in Ireland, February 28th, 1908.

Graves' disease, until comparatively recently, was generally looked upon as coming more within the province of the physician than the surgeon. I need scarcely trouble you with a list of the drugs usually prescribed. Phosphorus is probably the best of them. Naturally, we should have expected the somewhat fashionable animal extracts to have had their advocates. Not only have these been shown to be useless, but some of them, such as thyroid extract and ovarian preparations, have been shown to be positively dangerous. Cases treated from their initial stages by these preparations progressed rapidly from bad to worse. The beneficial effects ascribed to drugs would probably be more correctly attributed to the rest in bed and to the quiet to the nervous system generally.

More recently Lanz endeavoured to neutralise the poison in the patient's system by feeding his patients upon the milk of goats whose thyroid glands had been previously removed. He reported several cures. The outcome of this line of treatment was the production for the market of a powder of milk called rodogen. This powder supplies, or is supposed to supply, the principle conveyed by the milk of the thyroidectomised goats. The experience of other observers does not bear out the wonderful effects for these lines of treatment claimed by Lanz and his followers. In any case the treatment is not curative, but simply palliative. Professor Schlesinger, of Vienna, says his experience of the treatment of Graves' disease by the milk of thyroidectomised goats and by rodogen is negative, and not worth further consideration. The effects of treatment by injection of blood serum derived from sheep whose thyroid glands had been removed is thought to be more beneficial.

The operative treatment of this strange disease has undergone many transformations. Division of the isthmus of the thyroid gland, and even its excision, had their devotees some years ago. The operation of ligature of two or more of the thyroid arteries claimed its followers, but the most empirical of the operative procedures suggested and practised pretty extensively by some surgeons was that of sympathectomy on one or both sides of the neck. Considering the conflicting ideas that prevailed concerning the pathology and causation of the phenomena, it is not surprising that the effects of these various operative procedures were far from convincing physicians that operation provided better results than their eclectic drug treatment. In truth, the one seemed just as empirical as the other. Even at the present time there will be no difficulty in finding surgeons who still consider Graves' disease essentially a physician's disease so far as treatment is concerned. Quite recently Mr. Berry expressed himself strongly in the *British Medical Journal* in that direction. Considering the modern ideas respecting the pathology and causation of the phenomena of Graves' disease, Kocher, C. H. Mayo, and many others, whose experience is such as warrants them in drawing trustworthy deductions therefrom, state that thyroidectomy in some form or other is the proper line of treatment for this disease. Kocher says, by taking away the diseased gland in due time, one can cure even the severest cases of the disease, as one thus removes the source of the mischief by removing the organ in which the disease has its localisation. When, however, secondary changes have taken place in the fatty tissues of the orbits and in the cardiac muscle, etc., the complete re-establishment to normal conditions is hindered. The degree of amelioration of the symptoms, Kocher says, is in direct proportion to the amount of hypertrophied gland tissue removed or destroyed by the operation—that is to say, in direct proportion to the amount of diminution of the functions of the gland. The preliminary treatment consists in rest in bed with or without the administration of phosphorus or belladonna for some time before operation.

C. H. Mayo has adopted, as a preliminary to operation in severe cases a course of exposure to X-rays, and in some such cases has had X-rays applied to the remaining lobe after operation, and apparently with beneficial results.

The mortality of any or all of these operative procedures was naturally at first high, but surgeons whose experience is great in this branch of surgery state that the operative mortality of Graves' disease will be but little in excess of that following partial thyroidectomy for simple colloid goître, provided the operation is undertaken before the patient's heart, muscle, and system generally have become degenerated by the toxic poisons circulating in the blood. The latest report of Kocher's operations to which I had access showed that he had only one death in his last 52 thyroidectomies for Graves' disease, and that one was due to secondary hæmorrhage—a preventible condition. C. H. Mayo, in his last report, states that he had only two deaths in his last 64 thyroidectomies for Graves' disease. In considering the question of mortality, before deciding upon operation one should consider whether the particular case is one primarily of Graves' disease, or whether the phenomena of Graves' disease have developed secondarily in a patient who had been the subject of an ordinary colloid goître for some considerable time before, as the mortality, so far as I am able to learn, seems much less after operation for secondarily developed Graves' disease, while the prognosis as regards complete and permanent cure after operation can be given with greater certainty.

The mortality after thyroidectomy for Graves' disease has been attributed to shock, to a combination of symptoms to which the name of acute thyroidism has been applied, to acute tetany and to the effects of general anæsthesia, as well as to pneumonia, sepsis and such accidental conditions. In five cases of death from acute thyroidism reported by one surgeon, albuminuria was present in all before operation. The condition of acute thyroidism has been attributed to the absorption of thyreotoxins, which escaped into the wound after division of the isthmus of the gland; to the absorption of toxic blood serum from the wound, or serum containing thyroid secretion in suspension, or to rough handling of the gland during operation forcing a considerable quantity of thyreotoxins into the circulation.

To obviate as far as possible the risk of this complication, one should handle the gland gently and expose it freely before actually handling it at all. Free drainage should be provided for 24 to 48 hours, and as little raw gland surface should be left exposed in the wound as possible.

If there is anything which increases absorption in a wound or gland, it is loss of blood; consequently one should endeavour to prevent this absorption by introducing a considerable quantity of saline solution immediately after the operation. Should some toxic absorption have already taken place, the free administration of saline solution would dilute the poison and at the same time stimulate the kidneys to eliminate it rapidly.

To what extent the removal of, or destruction of the parathyroids in the performance of thyroidectomy for Graves' disease plays a part in the subsequent mortality is at present uncertain.

Their removal or destruction seems to be accountable for the acute tetany which occasionally causes death after thyroidectomy.

Halstead believes that the surgery of Graves' disease centres in the problem of removing the greater portion of the thyroid gland without sacrifice of the parathyroid glandules. This can be done by following the *technique* recently described by C. H. Mayo. It consists in peeling the posterior capsule off the lateral lobe during its removal, thus leaving that portion of capsule with the parathyroids on its posterior aspect intact.

As medical treatment is generally considered useless, and as surgical treatment is shown to be curative by men of experience such as Kocher and C. H. Mayo in early cases, and of pronounced benefit even in advanced cases, surely, it is not asking too much of physicians who see these cases first to ask them to try the effects of surgical interference more frequently than they have hitherto done, and at an early period in the course of the disease.

OPERATING THEATRES.

VICTORIA HOSPITAL FOR CHILDREN.

Inguinal Hernia, with Presence in the Sac of an Appendix which had been Subject to an Attack of Appendicitis.—Mr. Joseph Cunning operated on a boy, æt. 3, who was suffering from right inguinal hernia. The patient had worn a truss for about a year, but as the hernia was still present, it was considered there was no prospect of its cure by aything but operative measures. At the operaion an incision was made over the inguinal canal; the fibres of the external oblique were slit up to the internal ring, and the sac was then isolated from the structures of the cord. On opening the sac it was found that the appendix was present in and was adherent to the sac. The adhesions were separated and the appendix pulled down. There were many adhesions between the appendix and the ileum, and between the appendix and the cæcum; these were separated, the meso-appendix ligatured, and the appendix removed by the purse-string method. The sac was then ligatured and removed. The internal oblique and the conjoint tendon were sutured to the deep part of Poupart's ligament behind the cord, and the external oblique was sutured in front of the cord. Mr. Cunning then remarked that nothing was known regarding the undoubted attack of appendicitis which this child had evidently been the subject of. This, however, was not remarkable, seeing how often attacks of appendicitis received the name of stomach-ache, colic, indigestion, etc. It was fortunate, he thought, in this case that the cæcum came down freely into the sac, for it enabled him to remove the appendix without enlarging the ordinary hernia incision. He had once before operated on what seemed strangulated hernia, but, on opening the sac, its contents were found to be pus and non-strangulated intestine, while at the upper end of the inguinal canal was found an acutely inflamed and perforated appendix. The intestine in this case was gently reduced and left lying within the abdomen at the site of the internal ring after gauze packing had been introduced to shut off the rest of the abdominal cavity. The patient made a good recovery. He remembered also another case about two years ago of strangulated hernia in a female infant, æt. 1½, in which the strangulated contents proved to be the tube and ovary, and the strangulation was of such a degree that he considered it advisable to ligature and remove the tube and ovary, and then suture the inguinal canal. With regard to the radical cure of hernia in children, he considered that the mere removal of the sac was sufficient to restore the inguinal canal to as good a condition as that of a normal unruptured person, and that the ordinary methods of repair of the inguinal canal such as were used in adults are not really necessary, though he still employed a few stitches as a precautionary measure. The difference between a hernia in a child and one in an adult was that the internal oblique muscle which is so important in the prevention of protrusion, is normal in a child, whereas in an adult who has had a hernia for a long time the muscle is stretched, and very often distinct intervals are found between its fibres.

The convalescence of the child operated on was uneventful.

Small-pox on a Clyde Steamer.

On arrival of the Anchor Liner *Olympia* off Greenock, on April 5th, it was reported that on the voyage from Bombay to the Clyde three cases of small-pox had occurred on board.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

Meeting held Friday, March 27th, 1908.

The President, Sir Henry Swanzy, in the Chair.

TUBERCULAR JOINT DISEASE TREATED BY DENYS' TUBERCULIN.

Dr. Frank Dunne exhibited two patients suffering from this disease. A man, æt. 39, suffering from tubercular ulcer of lower third of leg and ankle-joint for five years, also several sinuses on both arms. An X-ray photograph showed extensive matting and pulping of bones of tarsus. All discharge ceased early in September last, and the patient had good use of his foot and both arms. The second patient, a girl, æt. 20, suffered from tubercular wrist for about three years, and both ankles for over two years. The wrist was scraped with little improvement. When treatment commenced this patient was very much run down. Temperature, 100-102°; pulse, 100; weight, 6st. 3lb. All discharge ceased early in June and temperature has not been above normal since. . X-ray photograph shows matting and pulping of every bone in wrist-joint, yet the girl has good use of the hand, and can walk perfectly. In both these cases treatment lasted for about a year. The man gained 1st. 9lb. in weight, and the girl 3st. 6lb. In both cases about fifty injections were given.

The Chairman said his practice had been confined to Koch's tuberculin, T. R. Denys' tuberculin appeared to be a very effective preparation, and he would like to know some details as to the method, and the indications as to dosage.

Mr. Lentaigne: It was a mistake to think that tuberculosis had not been cured in the past. He had seen numbers of cases that had got well of themselves. Recently he had had a large number of cases of complete cure, the time of which was measured by months, not by years, as in the cases exhibited. While expressing his appreciation of the good work done by Dr. Dunne, still he believed that the results would have been more quickly attained by surgical assistance. He himself was assisting surgical treatment by tuberculin, and he had found that Koch's tuberculin had not to be given so often as Denys'. Perfect cure had been obtained by gauging the injections by the opsonic index, but it was a difficult method, and he had seen no increased negative phase produced by calculating in a rough way the time of the negative phase of the previous injection. If the disease was found to persist or recur—and no one could say that the cases exhibited would not recur—they should look to the surroundings of the patient, as the question of environment was of great importance.

Professor McWeeney said the method for obtaining Denys' and Koch's tuberculin was the same up to a certain stage. Both grew the tubercle bacillus on the surface of a broth containing 5 per cent. of glycerine, and filtered off the bacilli. But Koch's method from that point consisted in evaporating the liquor of the culture to one-fifth of its original bulk, while Denys' used it without reducing it in volume. The difference, then, was that Denys' contained presumably toxic and presumably therapeutic materials which were easily destructible; these would be destroyed by boiling, in Koch's. The latter was more concentrated than Denys', but he was not aware of any difference in the dosage. Nowadays the tendency was to have a small dosage, and to avoid producing a reaction in a rise of temperature; in Koch's old system a rise was considered necessary. He had lately been working with tuberculin in ophthalmo-reaction. He used Koch's old tuberculin diluted to the strength of 2 per cent. This provided material for hundreds of patients at a cost of 8s. 6d. One drop produced the desired result. Contemporaneously with this he used the cutaneous reaction by inoculating both arms, the right with a drop of 25 per cent. of the old tuberculin and the left with 3 per cent. boric-acid solution. In a couple of cases he thought he noticed a marked therapeutic result from the method in the absorption of a pleural effusion, and in two other cases there was a distinct improvement in the symptoms. As the result of his experience of the opsonic index, he stated deliberately that, in his hands at least, he had never been able to convince himself that the errors of experiment did not outweigh the very slight differences from the normal obtained by means of the method, and he did not think he would attach any importance to opsonic indices obtained otherwise than by Wright himself, his immediate assistants, or those who worked for a prolonged period under his immediate supervision.

Mr. **M'Ardle** said that, while the theory with regard to the influence of tuberculin might be discussed by scientists, it was their duty, as practising surgeons, to take heed of what really happened. It would be impossible to carry out the serum treatment in many cases if they were obliged to have some one capable of taking the index at their elbow all the time. The treatment of the cases before them had been carried on in what might be called a haphazard way, but he had seen cases where, with the persistent employment of tuberculin, the patient rapidly put on flesh. He had seen laparotomies, for instance, carried out without beneficial effect, and after the injection of tuberculin the patients recovered, and were now quite well. He had seen a vast improvement in some of Dr. Dunne's cases—cases which were apparently hopeless —under the influence of tuberculin. But while tuberculin exerted a beneficial influence in such cases it exerted no influence, but a harmful one, once abscess formation had occurred.

Dr. **Dunne**, in reply, said he had no hope of being able to use the opsonic index, as he had too many patients, and too little assistance, to be able to do so. He was guided, as to the dosage, by the effect of the injection on the patient. That might be a temperature or a local reaction, but as much as possible he avoided a temperature reaction. If there was marked reaction he either left a longer interval or reduced the dose. He quite agreed that operative treatment would, in some cases, materially hasten recovery. He had about 90 cases under tuberculin treatment, and he found that he got the best results with small doses at short intervals. After three and a half years of using tuberculin he was firmly convinced that, as far as their present knowledge went, there was no treatment anything like equal to it for tuberculous affections, no matter where situated.

DIAGNOSIS OF IMPACTED CALCULUS IN THE URETER.

Mr. C. **Arthur Ball** read a paper on this subject, and gave an account of a case in which an erroneous diagnosis of impacted calculus in the ureter was made even with the assistance of an excellent radiograph, taken with a shadowgraph bougie *in situ*. The case was that of a man who had been operated on elsewhere six months previously for renal calculus. Since the operation all the urine from that kidney came through a fistula in the loin. A shadow by the X-rays of a supposed stone was found, apparently in the ureter; this was verified by several radiographs, and the relation to the ureter established by use of shadowgraph bougie. The ureter was exposed by an extraperitoneal iliac incision, but no stone was present. The ureter was dilated, and the final result was satisfactory. The origin of the shadow, which is still present, has not been established. Mr. Ball said the mistake could only have been avoided by a stereoscopic radiograph taken with a shadowgraph bougie *in situ*, and that in future he intended to make use of this method in all similar cases.

Mr. **M'Ardle** said they were accustomed to hear only of successes in the statistics of surgery generally, but Mr. Ball had followed the line taken by those who had placed surgery on a firm footing. The case was one of exceeding difficulty; the examination was carried out with extreme care, and the only thing in doubt was the "spot on the sun," which it would require time to determine. The paper was an exposition of the dangers of jumping at conclusions with regard to urinary troubles

Mr. **Wheeler** said the case had been formerly in his hands, and two X-ray photographs verified the diagnosis of renal calculus. After the stones were removed a catheter was passed into the bladder, and every care was taken to see that no calculus remained in the ureter. The urinary fistula gave him trouble, which he put down to using silk in order to get a firmer cicatrix and prevent a lumbar hernia; but the silk became infected, and bits came away. The shadow in Mr. Ball's skiagraph had developed since the man was under his care.

Dr. **Harvey** said the diagnosis was a very natural one, but, since the result was not what was anticipated, it would be interesting to see in what way the diagnosis could have been avoided. The shadow on the photograph was evidently some substance which was denser in the centre than at the periphery; that was not generally the case in urethral stone, nor was it oval. He understood that no urine was passing from the ureter, and in passing the urethral catheter it would appear to him natural to expect the catheter to be stopped by the stone.

Dr. **Lane Joynt** mentioned a case in which a shadow appeared in the neighbourhood of the base of the lung, and could not be explained, as the patient had no evidence of any lung trouble or history of old phthisis. Ultimately a diagnosis was made of calcification of the pleura. He quoted also a case of a deformed elbow —from an injury twenty-five years previously—in which a soft mass, like a hernia of the muscles round the forearm, gave a dense shadow like iodoform, though there was no history of any such drug having been used in the treatment.

Mr. **Gunn** said the line of the ureter varied a good deal, and it was difficult to conclude whether the shadow was really in the line of the ureter or not.

Mr. **Ball**, in reply, said the stone might not cause obstruction to the passage of the bougie, as it might act as a kind of ball-valve, and might be pushed upwards into the dilated ureter. There were no symptoms connected with the appendix. He would try and get a stereoscopic photograph.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held at Sheffield, March 27th, 1908.

The President, Dr. A. J. **Wallace** (Liverpool) in the Chair.

A **vote** of condolence to Mrs. William Walter, of Manchester, on the death of Dr. Walter, was carried.

Dr. **Miles Phillips** (Sheffield) exhibited a specimen of uterus bicornis unicollis, with atresia of the external os and absence of the vagina. The patient was 16 years of age, and had enjoyed good health up to October, 1907, when she began to suffer from pain in the right iliac region, and fever. She had never menstruated. Examination revealed a normally developed vulva, but there was no vaginal orifice, and per rectum a rounded, smooth, hard swelling, the size of a duck's egg, occupied the middle of the pelvic cavity. Under anæsthesia the lower pole of the tumour was reached by an easy perineal dissection, but the thickness of its wall resembled a uterine rather than a vaginal collection of fluid. The abdomen was therefore opened, and it was seen that the tumour consisted of the right enlarged horn of a bicornute uterus, together with a distended right Fallopian tube. The left cornu was rudimentary, and the Fallopian tube patent in only half its length. The uterus and appendages were extirpated, except the normal left ovary, which was saved. Recovery was complete and uneventful.

Dr. **Lloyd Roberts** (Manchester) showed a vaginal fibroma removed from a patient, æt. 46, who had had six pregnancies. The labours had always been difficult. She complained of painful and difficult micturition and an irregular sanious vaginal discharge. The tumour, which had a sessile attachment to the left vaginal fornix, was removed by enucleation.

Dr. **Briggs** (Liverpool) communicated a case of ACUTE COMPLETE INVERSION OF THE UTERUS, manually reduced on the 20th day after labour. The patient was 28 years of age, 4 years married, and had

had 2 miscarriages. The labour had been slow on account of premature rupture of the membranes, and the delivery with forceps under chloroform had occupied two hours. During the third stage fundal pressure had been used on account of severe hæmorrhage. For three weeks there had been febrile disturbance with one definite rigor the day before admission to hospital, severe abdominal pain and vaginal bleeding, dribbling and incontinence of urine. Vaginal douching of lysol had been carried out, but no examination made till the 19th day, when she was sent into hospital under the care of Dr. Briggs. On examination under anæsthesia the inverted ulcerated uterus lay in the vagina, and the ring of cervix was faint and sharp. The uterine cup became palpable bimanually, and reduction was effected by 20 minutes continuous increasing pressure gradually exerted so as to lift the body of the uterus through the thin cervical ring without damage. A douche of sterilised water at 120° was then given, and repeated twice daily for 7 days. Convalescence was tardy, with febrile disturbance, but the patient left hospital 8 weeks after the reduction of the inverted uterus.

Drs. **Briggs** and **Edmiston** narrated a case of

SEVERE ACCIDENTAL HÆMORRHAGE

occurring in a patient, æt. 26, v.-para, with a history of previous easy labours. During her present pregnancy she had had a great deal of worry, and said that she remembered falling on one occasion, but without serious consequence. At 11.30 a.m., March 6th, three days short of the full term, she was seized with severe abdominal pain and vomiting. At 7.30 p.m. the collapse became grave. She was pallid, cold and restless, pulse thready, 152 per minute, temperature sub-normal. The physical signs of a tense tender full-term uterus were present. Fœtal heart sounds were inaudible. Vaginally, the cervix admitted two fingers, there was no bleeding, and the examining finger could reach neither placenta nor blood clot. The membranes were unruptured, and labour pains were absent. In this condition she was admitted to hospital, and Dr. Briggs ordered morphia ¼ gr., and atropine 1-100 gr., hypodermically at 9.30 p.m. The patient slept five hours, and at 8 a.m. (March 7th) the pulse had fallen to 120. The hypodermic injection was repeated in three hours on account of restlessness, and the patient slept at intervals. The os now admitted three fingers. Shortly after midnight, March 8th, pains became pronounced, and a speedy and spontaneous delivery was completed; 2½ lbs. of clot and about a pint of fluid blood were expelled. The fœtus, which had been dead about a week, weighed 7¾ lbs. At the end of the third stage the pulse was 156, but gradually fell until the eighth day, when it rose to 140, and the temperature to 102°. The involution of the uterus had been slow. On the tenth day an intra-uterine douche of sterile water at 118° was given. The temperature fell to 97.8°, and the pulse to 112, gradually assuming the normal level. The points of interest are the entire absence of bleeding, the large size of the retro-placental clot, and the success of the treatment adopted. The amount of blood-clot amongst Goodell's cases with recovery was never above 2 lbs. In this case the retro-placental clot weighed 2½ lbs.

Dr. **Miles Phillips** related a case of

CONCEALED HÆMORRHAGE

at the fifth month of pregnancy, treated by vaginal hysterotomy. The patient had had nine children, the last 1½ years ago. Menstruation was regular, but the three periods before Christmas, 1907, were less in amount than normal, and the two periods since Christmas consisted of smart floodings with hypogastric pain. The last had ceased three days before she was seen by Dr. Phillips. The abdominal tumour extended to within 1½ ins. of the umbilicus. No fœtal parts or movements could be felt, and no heart sounds heard. Threatened miscarriage was diagnosed, and complete rest in bed enjoined. A week later the hæmorrhage recurred, and the patient was admitted to hospital. She looked very ill, and complained of severe abdominal pain. The uterus now extended 1 in. above the umbilicus. The pulse was 96 per minute. A laminaria tent was introduced into the rigid cervix, and rectal salines given. Five hours later, as she seemed to be getting worse, it was decided to evacuate the uterus, and under anæsthesia a transverse incision was made in the anterior vaginal fornix, the bladder separated, and the rigid cervix incised in the mid-line as well as 1½ ins. of the lower uterine segment. A large amount of old and recent clot was evacuated by the finger, and the intact ovum reached on the left side of the fundus was delivered. The blood was apparently in the decidual cavity. The incision was closed by catgut sutures, and a gauze pack left in the uterus. Recovery was uneventful.

Dr. **Gemmell** (Liverpool) read a note on

PRIMARY CARCINOMA OF THE FALLOPIAN TUBE,

based on a recent case, in which there was a history of profuse, watery, offensive vaginal discharge in a nulliparous woman, æt. 45. The physical signs led to a diagnosis of multiple uterine fibroids, with chronic inflammatory disease of the right appendage. Laparotomy revealed double chronic inflammatory appendage disease, right hydrosalpinx and left pyosalpinx. Subsequent examination of the specimen demonstrated that the left tube which was closed at its fimbriated end, sausage-shaped, 3 ins. in diameter, contained pus and an enormously thickened mucosa forming a papillomatous growth. Microscopically this proved to be adeno-carcinoma. Both ovaries were normal; the right tube was in a condition of simple salpingitis.

HARVEIAN SOCIETY OF LONDON.

A MEETING of the Society was held on March 26th, at 8.30 p.m., at the Stafford Rooms, the President, Mr. D'Arcy Power, F.R.C.S., in the chair, when Sir Almroth Wright, M.D., F.R.S., delivered the Harveian Lecture on "Some Points in Connection with Therapeutic Immunisation." An abstract of this lecture will be found on page 424.

CENTRAL MIDWIVES BOARD.

MEETING HELD THURSDAY, APRIL 9TH, 1908.

The **President** in the Chair.

THE first business—viz., the election of Chairman and Treasurer, resulted in Dr. Champneys resuming the chair, and Mr. Fordham continuing his appointment as Treasurer.

The report of the Standing Committee dealt with sundry correspondence referring to instruction for midwives, Dr. Nepean Longridge suggesting that they should possess some knowledge of the warning symptoms of uterine cancer. The Chairman undertook to draft a leaflet on the subject. In reply to certain letters from the Secretary of the British Medical Association, commenting on the Board's reference, in its letter to the Privy Council, to the hostility existing in some districts between medical men and midwives, it was stated that the matter referred to was founded on communications to the Board, on communications which have appeared in the *British Medical Journal and Supplement*, in the medical Press in general, in the nursing Press, and on facts within the knowledge of the Board.

Applications for approval as teacher were granted to Elsie M. Inglis, M.B., W. H. Wright, M.D., and to C. Vere Nicoll, M.R.C.S., L.R.C.P., and G. B. Messenger, L.M., S.S.A., *pro hâc vice*.

With reference to the Board's resolution of March 19th, that some action be taken in the matter of payment of fees to medical men called to the assistance of midwives, it was agreed:—(1) That the Privy Council be asked to furnish the Board with a return showing the Boards of Guardians which have adopted the suggestions of the Local Government Board in the Circular of July 29th, 1907. (2) That it be referred to a meeting of the Standing Committee to frame a statement on the subject; and (3) That when the return has been furnished the Privy Council be asked to receive a deputation of the Board on the subject of the payment of the fees of medical practitioners summoned to assist midwives in emergencies.

The **Secretary** furnished the Board with a statement as to the results obtained from his inquiry—sent to all the County Councils and Borough Councils in

England and Wales—respecting the number of midwives practising within their areas. Although there are only 135 County and Borough Councils, the Secretary had had to deal with 276 Local Supervising Authorities, owing to several of the Councils having delegated their powers. Six out of this number had not replied to the inquiry at all; in some cases where the powers had been delegated they had been repudiated by the authority to whom they were delegated, so that in those districts the Midwives Act was not being worked at all. The returns obtained cannot be considered absolutely reliable, especially as regards Wales, where, for instance, Anglesey is reported to have only one practising midwife, and Cardigan three. The total number in England and Wales, according to the returns, is shown to be 10,000, which, as the Secretary pointed out, is considerably under the correct estimate.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 12th, 1908.

Hypertrophy of the Tonsils.

Medical treatment can, says Dr. Guisez, in the *Journal des Praticiens*, when the tonsils are not too enlarged, give good results. The following gargle relieves the inflammation and acts as a slight antiseptic:—

Phenic acid, 15 gr.
Menthol, 6 gr.
Glycerine, 2 oz.
Cherry laurel water, 5 oz.

A tablespoonful in a glass of warm water, used as a gargle morning and evening.

In children too young to gargle, the parts may be touched with a mixture containing iodine or resorcin. The general treatment should not be neglected; it consists in cod-liver oil, iodide preparations, and sulphurous or arsenical mineral waters. The above treatment only succeeds where the hypertrophy is soft and of recent date, or where surgical treatment is counter-indicated by hæmophilia; or, in the case of epidemic infection (grippe, eruptive fevers, diphtheria).

Before proceeding to operate, the variety of the affection should be exactly recognised. Soft tonsils bleed but little; fibrous tonsils, on the contrary, frequently bleed profusely, from the fact that the vessels remain patent after the section. The form of the tonsils also commands attention (pedunculated or sessile). The bistoury may be employed in the pedunculated form, and in the spongy form observed in children, on account of the little danger of hæmorrhage. The galvano-caustic snare in children when the tonsil is pedunculated, or in the pedunculated fibrous form of adults. Removal by piecemeal is the method usually followed to-day, and is applicable to every case.

Ablation of the tonsil by the bistoury should only be employed by experienced hands; the tonsil is seized in a forceps and cut across by one stroke of the knife. A better instrument is the tonsillotome, but it is only applicable to children.

Removal by the galvanic red-hot wire is also employed with success, without fear of hæmorrhage as the vessels are cauterised during the passage of the wire. But the best method, according to Dr. Guisez, is that of piecemeal ablation.

The operation should be done under general anæsthesia for children, or local anæsthesia for adults. For this latter the region is painted with cocaine (1—20), and the anæsthesia is completed by two injections of stovain (1—100) into each of the pillars. After the tonsil has been removed by pieces with the forceps, the patient is given ice to suck, while iced drinks are ordered for 24 hours.

Vegetations of the Genital Organs.

Of all the means employed for destruction of vegetations of the genital organs, resorcin is the most efficacious. When they are isolated and pedunculated, it is sufficient to apply powder, pure or moistened with a little water, and covered with a compress. The applications are made every day until the vegetation dries up. When these papilloma are sessile and generalised, the following preparation is used:—

Collodion, 3 oz.
Resorcin, 6 dr.

Before applying the mixture, the parts should be washed with ether to remove any humidity which would hinder the adhesion of the collodion. After the first application the vegetations begin to wither up, and generally two or three applications complete the treatment. To avoid relapse, the patient is recommended to wash the parts with a weak solution of resorcin (½—100), and to powder with:—

Carbonate of zinc, 2 dr.
Subnitrate of bismuth, 2 dr.
Resorcin, ½ dr.
Fuller's earth, 3 oz.

Treatment of Aortic Aneurysm.

The palliative treatment consists in rest, lacto-vegetarian diet, the ice-bag over the region of the aneurysm, and injections of morphia.

For the curative treatment, iodide of potassium or sodium, mercury (if syphilis is suspected), chloride of calcium and gelatine.

Chloride of calcium is a good coadjuvant, and should be given in 20-grain doses three times a day.

Gelatine should not be given by the mouth, as it is transformed into peptone in the stomach. Lancereaux proposed to administer it subcutaneously:—

Gelatine, 2½ dr.
Bicarb. of soda, 2½ dr.
Water, 1 quart.

This solution should be sterilised. From 2 to 6 oz. might be injected once a week, and for a long time.

GERMANY.

Berlin, April 12th, 1908.

At the Medizinische Gesellschaft, Hr. His read a paper on

Medicine and Over-culture.

He started from the point that "nervosity" was a very widespread disease, and brought it into dependence on our social and cultural conditions. He thought we lived in a state of over-culture. He looked on subjectivism as the sign of our times, and as dominating all the spheres of our culture. Without altogether denying the influence of heredity, he believed that as an ætiological factor it was much overestimated by many. Moebius saw the chief cause of it in the modern means of intercourse, on the one hand, our spiritual aspirations towards the true, and the neglect, associated with it, of intellect.

As a reaction from our over-culture, a striving for a return to simplicity and nature was noticeable, arising out of a repugnance to the present conditions of culture. From this arose the various "Nature" methods of treatment, which were of the ages, and which were again brought to light. The speaker glanced at the histories of other epochs in which a period of highest culture was followed by one of over-culture. The period of the later renaissance was an exception to this. From this, as well as from the depressions that followed the Thirty Years' War, as well as the downfall of Prussia at the commencement of the last century, we learnt that prosperity alone could not be "nervosity," but that something else belonged to it—viz., security, freedom from danger to body and life. Over-work played a lesser part. This was a relative term; with a constitutional disposition it might lead to the injury of the individual, but never to an epidemic outburst.

Those called to improve these conditions were the physicians, who must take the best they could for combating the disease wherever it might come from. The most important was psychical treatment. An object must be placed before the nervous, the weak-willed, however small the circle it might benefit, and when it was accomplished we should have put new life into his self-consciousness, have strengthened his will, and increased his pleasure in life. Valuable, as had been emphasised on many sides, as was the support of religion, it was not a question of "confession" or denomination, but of faith where one submitted to a higher will.

For obviating the security it would naturally be false in principle to wish to bring war and misery about us, but in the time of peace it behoved us to play at war. For this, military service was of the greatest advantage. All kinds of games and bodily exercises were also of great use. The speaker concluded by appealing to physicians to be not only the bodily but also the mental advisers of their patients; these, however, must be brought to see that their organisms not only consisted of different parts, but that they were complete entities, and that they should not run to a different specialist for each separate disease, but should place their trust in their family doctor.

At the Verein für Innere Medizin, Hr. Zinn related a case of

Pulmonary Metastases in a Case of Epithelioma of the Chorion.

The disease occurred in a woman, æt. 31, and ran a seven-weeks' course, with symptoms similar to those of miliary tuberculosis. She was admitted into hospital with hæmoptysis, cyanosis, dyspnœa, and moderate fever. For about four weeks the expectoration was hæmorrhagic, muco-hæmorrhagic, sometimes more purulent. There were attacks of exacerbated dyspnœa, fever, and cyanosis. There was slight dulness at the apices of the lungs, diffuse fine râles, the latter bilateral, later on. The menses had appeared two months before; vomiting was frequent, as in the first pregnancy. The uterus was two finger-breadths above the symphysis. The case was taken to be one of miliary tuberculosis. Four weeks after admission the first bleeding from the vagina took place. It was repeated, and was profuse at times. A number of rounded bluish growths the size of cherries were found in the vagina; some were broken down and bleeding. The uterus was the size of the fist, movable and anteflexed. A portion excised showed the characteristic signs of chorionic epithelioma. Operation on the gynæcological side was declined on account of the pulmonary symptoms. Improvement took place under treatment with Fowler's solution and atoxyl, but the patient died 3½ months later with symptoms of cerebral hæmorrhage.

At the autopsy the lungs showed numerous metastases the size of peas, and larger equally disseminated through the lungs. There were several nodules in the uterus, and a smaller one in the vagina. In the posterior lobe of the brain was a fresh hæmorrhage into a cerebral metastasis. The typical structure of chorionic epithelioma was seen in the microscopic preparations, both in the excised portion from the vagina and also from the metastases in the brain. In some of those in the lungs there were marked retrogressive changes—necroses—and but few typical tumour cells. A similar condition was present also on the uterus. There were plainly spontaneous processes of recovery in progress, such as had been described by many authors.

Of all tumours, chorionic epithelioma afforded the most frequent metastases in the lungs—in about 41 per cent. This was the result of the growth of the tumour into the maternal vessels. The frequent participation of the lungs without any sign from the genitals was of importance for the clinician. The diagnosis was difficult in such cases, but less so when there was early vaginal hæmorrhage. The patient had passed a vesicular mole two years before.

In view of the tendency to spontaneous recovery the treatment should be surgical, and the uterus should have been removed. Only in that way could the sources of the metastases have been cut off, and those in the lungs were not a contra-indication of operation.

AUSTRIA.

Vienna, April 12th, 1908.

Acromegalia.

Hochenegg presented a patient at the Gesellschaft, æt. 30, on whom he had operated for a tumour in the hypophysis. The patient suffered from a severe form of acromegalia when brought to hospital, but immediately after the removal of the tumour the acromegalia began rapidly to disappear.

Exner thought there was something wrong in the logic of this disease. It has been affirmed that the function of the hypophysis is lost when acromegalia appears. Now this operation must have destroyed, or at least partially destroyed, the function of the hypophysis; yet all the symptoms of acromegalia disappeared, which is a contradiction in terms.

Redlich said he looked upon the disease of acromegalia as a hyper-function of the hypophysis, and not a loss of function, as sometimes affirmed. In the light of extirpation curing the disease, this theory is easily understood.

Perennial Horns of the Deer.

Grosz next brought in a male deer, which he had castrated, with the horns peculiarly placed as if the animal had on a peruke or periwig. This he assured the members was the result of castration. In all his experiments he found the horns fell off the next week after the removal of the testes, this was supported by perennial imitations which gave the animal an appearance of wearing a periwig.

He next exhibited two horns, one taken from an animal he had castrated, the other taken from another whose testes had been destroyed by injury to the organ. Both of the horns resembled each other in appearance and constituents.

Khautz remarked that the formation of this peruke was not always the sequence of castration, and argued for an exception to the rule.

Tandler thought the principal characteristic of this peruke after castration was the formation of a covering integument that persisted and never was shed as in the healthy animal.

The Rays and Syphilitic Exanthemata.

Ehrmann showed a patient who had suffered from a persistent syphilitic papular exanthemata which he had cured with the ultra-violet rays. Photos confirmed his statements. He commenced with the right shoulder on February 25th and 26th; in the right groin on February 27th and 28th; and on the forearms on March 4th. Photos of the two sides were now shown, as well as those before application. The gummata, as well as the syphilides, had undergone absorption, and this after three or four applications, or within four days. He considers this an effectual cure for local syphilis.

He brought forward a patient he exhibited to the members in January last who was then suffering from erythrodermia exfoliativa, with a blood anomaly of 32 per cent. of eosinophile leucocytes with enormously enlarged glands. After four radiations of the inguinal region and two of the supra-clavicular glands the swellings subsided, and the cutaneous symptoms disappeared. The blood constituents are quite changed, and the eosinophile cells reduced to 27 per cent., and the mononuclear increased from 1.7 per cent. to 11 per cent.

Squamous Epithelial Carcinoma.

Menzel showed a patient with a perfectly initial primary squamous epithelial carcinoma of the soft palate about the base of the uvula. Around the hard area a few nodules could be found, giving an irregular appearance to the surface. The histology and diagnosis were determined from excised sections.

Lang thought many of these surfaces had flat cancerous growths which often healed spontaneously: others healed up in the centre, leaving the periphery as a source of infection.

Epilepsy and the Röntgen Rays.

Schuller reopened the discussion on the positive results of diagnosing epilepsy by means of the Röntgen rays, which he considered quite possible. Changes in both the soft and bony tissues could be observed. He divided epilepsy into four groups:—(1) Traumatic fissures, impressions and defects; (2) circumscribed or diffuse hyperostosis and osteoporosis, particularly that arising from syphilis; (3) asymmetry of cranium, both in contour and thickness; and (4) tumours or other processes producing increased pressure. The more recent additions to the diagnosis are an abnormal branching and serpentine movement of the arteria meningæ, and an excessive dilatation of the venæ diploëticæ, the latter having many variations, but distinct from the normal, and which is a guide to surgical interference, as these dilated vessels are difficult to check after being opened. All these changes appear in inter-cranial pressure, as they are always associated with tumours in the cerebrum. From the commencement of these changes the venæ diploëticæ appear to be the first vessels that are affected, and hence their diagnostic value in epilepsy.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Carnegie Trust.—The details of the second quinquennial scheme for the allocation of grants in aid of University endowment, which have been awaited with considerable interest, have now been made public. Of the income (£50,000) available, the demands made by grants in aid of research, and by the upkeep of the College of Physicians' Laboratory, will tend to increase: the trustees, therefore, have limited the expenditure on endowments to £40,000—a sum of £200,000 spread over five years. The previous decision of the trustees not to alienate permanently any of the sources of the income available is adhered to, but a part of the grant to each University not exceeding £1,000 may be treated by the body receiving it as income, and applied provisionally to the maintenance of the lectureships for which the Carnegie trustees are gradually, year by year, building up endowments. Coming to the individual claims of the several centres, the library grant has proved universally beneficial, and it is proposed to continue it (£1,000) to each of the four Universities. In St. Andrews and Dundee a number of endowments have been received since the last quinquennial allocation, and the trustees propose to contribute £1,000 towards the endowment fund of the Botanic Garden, £10,000 to complete the engineering department, and £500 for the equipment of the pathological laboratories; £5,000 each is to be devoted to lectureships in geology, history, and economics, with an annual grant of £300 additional in each case. The University of Glasgow, besides its library grant, asks for £13,500 to clear off debt on the departments of physiology, materia medica, forensic medicine, and public health; these the trustees have sanctioned. Sums varying from £1,500 to £7,500 are allocated towards the endowment of a Chair of Mercantile Law, and lectureships in English, French, German and Bacteriology. On the principle laid down above, provisional assistance in the way of annual income will also be afforded to these lectureships. The Glasgow and West of Scotland Technical College, and the Agricultural College, also receive substantial help from the fund. Speaking of the claims of the extramural medical schools, the trustees do not think that the results of the last quinquennial method—viz., the payment of subsidies to the teachers towards salaries of assistants, justify the continuance of the experiment. Special cases of this kind will be dealt with under the endowment of research. Anderson's Medical College, Glasgow, therefore, gets only a renewal of its £500 for equipment. The University of Aberdeen's needs, as far as buildings are concerned, will be met by an annual grant of £1,000. Various law, educational, and language chairs and lectureships fall to be endowed at a cost of £25,000. The University of Edinburgh is granted £6,000 to complete the physics buildings, £1,200 for fireproof room and library, £2,000 for apparatus, and £300 for cataloguing the anatomical museum. An endowment fund of £20,000 for lectureships is also allocated, and £13,000 is set aside for the extension of the departments of physiology, natural history, and pathology. Of extra-mural institutions, the Heriot-Watt College receives £2,000, and the School of Medicine of the Royal Colleges £250 a year, and the Medical College for Women £250 a year. A summary of the grants shows that during the ensuing five years St. Andrews will receive £37,500; Glasgow, £35,500; Aberdeen, £43,000, and Edinburgh, £58,000.

BELFAST.

The University Bill.—During the past week many meetings have been held, and many opinions expressed, on Mr. Birrell's University Bill. The point which promises to give most difficulty as regards Belfast is the affiliation of Magee College, "the one weak point of the scheme," as it has been called by a high educational authority in England. The academic opinion of Belfast is opposed to any such affiliation, and foresees all sorts of wirepulling to get other institutions affiliated. On the other hand, those interested in Magee College want it to be a constituent part of the new University, and not merely affiliated. The Higher Education Committee of the Presbyterian Church is considering the matter, but has not yet made a public pronouncement upon it. A meeting of the professors and lecturers at Queen's College was held in the College last week, when the President gave an account of the Bill and explained some of its clauses and how they would affect the College. After a discussion a series of resolutions was passed unanimously. The first expressed extreme gratification that an earnest attempt is to be made to settle the Irish University question on a permanent basis. The second was "That we rejoice that the provisions of the Bill ensure that the proposed new University in Belfast shall stand upon the same broad non-sectarian and academic basis on which Queen's College, Belfast, has worked since its establishment; that the University shall be free from religious tests and from all ecclesiastical control; that it is to be a free and completely self-governing University; and that public bodies, benefactors, professors, graduates, secondary teachers, women and students will be represented on its governing body." The third resolution was, "That in our opinion the elevation of this College to University rank will not only add much to the dignity of Belfast, making it a University city, but will give a great impetus to higher education here and throughout Ulster; that it will stimulate both teachers and students to show themselves worthy of the higher status now proposed to be granted by the Legislature; that it will excite much greater public interest in the College, and attract an increasing amount of public support from local benefactors; and that it will largely stimulate literary and scientific research, and promote the diffusion of knowledge and culture throughout the North of Ireland." The fourth and last resolution ordered these resolutions to be sent to various quarters. These give clearly and briefly the grounds on which the Bill has been so well received among the friends of the College.

The Treatment of Cerebro-Spinal Meningitis.—At a meeting of the Public Health Committee last week, the physician to the fever hospitals, Dr. Gardner Robb, reported that the treatment of cerebro-spinal meningitis by Flexner's serum was giving great satisfaction. Since its introduction last autumn the death-rate has been reduced from 75 per cent. down to 30 per cent. There is no corresponding decrease in the death-rate of cases outside not treated with the serum, and there seems no room for doubt that the credit must be given entirely to the new remedy. There are at present 16 cases of the affection in question in the Purdysburn Fever Hospital.

LETTERS TO THE EDITOR.

THE REFERENDUM OF THE BRITISH MEDICAL ASSOCIATION.

To the Editor of The Medical Press and Circular.

Sir,—It is a pity to enter into a controversy regarding the results of the voting on the Referendum as long as there is a prospect of coming to some amicable compromise, but "Nil Desperandum's" letter cannot be allowed to go unchallenged He is an instance of the want of study of the question which is really responsible for the apparent apathy among the members, for he confuses the object of the Referendum, and speaks of it as intended to "bring about reforms," and therefore "marking an era in the history of the Association." When even the Referendum itself is misunderstood in this absurd fashion, how can your correspondent be expected to know much of a really complicated document like the draft charter? The Referendum, according to Sir Victor Horsley and the other "reformers," was an "unconstitutional" and "illegal" procedure, but, in the opinion of those who are as competent to judge, was a dignified and indignant protest against the attempt on the part of certain men in the Association to capture the control of its affairs, without any means of checking their policy, however extravagant it might become. There is no intention to charge the members with indifference or want of intelligence, but the fact remains that, from want of time and inexperience of the business affairs of the Association, the bulk of the members know very little of the details of the Charter. Beyond the vague and often-repeated assertion that it is to be made more actively useful to the profession, they are apparently ready to take things on trust on the authority of a great man like Sir Victor Horsley. So your correspondent implies, but I doubt whether that clever surgeon will thank him for the prominence which he gives him. Statesmen have been known to wreck their party, and it is not worthy of a great profession to pin their faith to any man's sleeve. If we were afflicted with a 'family circle arrangement" in the Council, we are in danger of a still more select and autocratic oligarchy in the future government of the Association. I make no attack on Sir Victor Horsley or any man individually, and believe them, as I hope they believe me, to be actuated by purely disinterested motives.

The framers of the draft Charter have given an enormous amount of time and labour to the task, and have produced a splendid piece of work, for which they deserve our heartiest gratitude. But they are not infallible, and they may be too sanguine and even rash in their policy. At all events, I claim the right of individual judgment, and every instinct of prudence and caution rises up against the proposal to turn the Association into a medical trades union and a political faction. I see imminent danger, in these schemes, of internal dissension and external conflict which will neither make its financial position secure or its professional status respected.

Let us take a glance at the figures of the voting, and see what can be gleaned from them.

In the first place, it will be found that the majority is confined to England and Wales alone, and to the more populous parts of it. Everywhere else the vote is hostile to the "reformers," as your correspondent styles them. In Scotland the majority is decisively against—namely, 65 per cent. to 35 per cent. In Ireland the voting is more equal, being 54 per cent. against and 46 per cent. in favour. But a surprise comes from the Colonial Divisions, in whose supposed interests and at whose urgent request the draft Charter is being hurried on. With strange ingratitude the Colonial Divisions have gone dead against the "reformers," seven out of the ten which met being overwhelmingly hostile. No less than 70 per cent. of the votes cast were against the minutes. It will not do to waive aside in the airy fashion your optimistic correspondent affects to do the fact that the members of the Association are supremely indifferent to its business affairs. It is no sense of security in the profound wisdom of this or that leader that can account for such lamentable want of interest. Gallant little Wales came up to the scratch in splendid fashion by 8 out of 9 Divisions holding a meeting, and about 19 per cent. of the members attending (who belonged to these Divisions). Scotland comes next with 18 meetings out of a possible 22, and a voting strength of 13.8 per cent. England had 118 out of a possible 146, and an attendance of 12.5 at the meetings. Ireland showed very badly in the matter of meetings—viz., 5 out of a possible 14; but the attendance was not so bad—viz., 17.8. The Colonies are nearly as bad as Ireland, with 10 out of 32 possible meetings, and an attendance of only 8.6 of members. How are the abstention of members and the failure of Divisions to be accounted for? Meetings held for scientific purposes are not neglected in this fashion. Purely business matters have no attractions for our busy men, and they cannot afford the time to attend. Besides, the draft Charter is a hard document to grasp. Even the men who did attend had perforce to take their opinions from those who professed to understand it, for there was an extraordinary absence of individuality in the voting. In no fewer than 76 Divisions the voting was unanimous on one side or the other, and in 19 more was very nearly so. In only 23 Divisions was there anything like a healthy difference of opinion. This accounts largely for the result of the voting, for the "reformers" have a larger following in the representative meeting than their opponents, and big battalions tell. The delegates were exhorted to support their party, and the Divisions called upon to give a vote of confidence in their favour.

The voting has not been on the merits of the Charter at all, but a trial of strength between two parties, the smaller of which has been defeated. Let the victors beware how they act, for the real struggle is yet to come, and the rupture of the Association will be the result of any forcing tactics.

I am, Sir, yours truly,

"Festina Lente."

Edinburgh, April 8th, 1908.

THE QUESTION OF FEES.

To the Editor of The Medical Press and Circular.

Sir,—To the discussion of this important question, broached by a correspondent in your valuable paper of this week, I will, if you please, make a contribution. I assume that outside quacks, unqualified or fraudulent pretenders, are not included, and that we are considering only the ethics of remuneration among honourable professional men. Of course, there are quacks within the profession, but I believe they form a very small minority. And by a quack I mean a man who does not give the very first place to consideration of the welfare of his patient, but puts more or less in the foreground the thought of how much money he can extract from him. Men of this type are the subjects of moral obliquity approaching more or less, or even reaching, criminality; and, I repeat, I do not believe there can be many such among the members of our profession. It is, however, one thing to adopt the methods of a cynical, unscrupulous, and sordid money-grabber, and quite another thing to demand the fullest payment for devoted professional services. Then, next, what is a specialist? A specialist is one who, by knowledge, talents and accomplishments, has made himself conspicuously skilful in one or other department of medicine or surgery. What shall be the scale of remuneration for the real specialist, or, indeed, for any particular practitioner for whose services there may be more than the average demand—and it is only in these latter circumstances that he can, as a rule, obtain fees higher than the average—must surely be left for each individual practitioner to determine for himself. I would further urge that, assuming the specialist's skill to be of consummate excellence, no fee within the means of a patient, especially of a wealthy patient, can be considered exorbitant. All that the practitioner is called upon in fairness to do, is to inform his clients beforehand what are his fees, and particularly to leave no doubt when an unusually large fee will be called for. With this proviso it is certainly to the advantage of the profession, and in no way hurtful to the public interests, when a specialist demands the highest possible pecuniary reward for his services. He knows very well that there are a large number of men in the profession quite as able as he to deal with the ordinary cases he may reject, whilst by his rejection, by restricting his services to the few able to pay his high fees, he really helps to raise the scale of remuneration of all his brethren, who, although they may be less popular, are not much less skilful or deserving than he himself. Surely it must be for the advantage of the profession if the scale of pay for the most distinguished members is kept at the highest level. The world takes the profession at its own "price," and if there are more "five guinea men" at the top, there are likely to be fewer "eighteen-penny (including medicine) men" at the bottom. Much as I should like to append my name, there seem reasons, which I am sure you and your readers will appreciate, which compel me to withhold it, and to sign myself,

Yours truly,

A Specialist.

Cavendish Square, April 8th, 1908.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Conveyance of Whooping-Cough to Animals.—Macewen publishes (*British Medical Journal*, January 11th, 1908) the report of an experiment on the transference of whooping-cough to a cat. A healthy animal was chosen, and, being placed in confinement, was fed on sputum and vomit from patients suffering from uncomplicated whooping-cough, the material being mixed with milk. This feeding was maintained for seven days, and then the cat was fed with ordinary milk. A fortnight later the cat began to show signs of sickness, and at the end of a month it had developed a choky cough, which was always followed by vomiting. A little later the cough became spasmodic, and was accompanied by a definite whoop. During the spasms the animal became greatly distressed, and clung to the floor of its cage with its claws. The conclusion is justified that the infective material of whooping-cough exists in the sputum or vomit, or both. It is also suggested as possible that cats may act as agents for the distribution of the infection. R.

Pathogenesis of Acute Pancreatitis.—Williams and Busch (*Journal of Medical Research*, October, 1907) make suggestions, borne out by experiments on animals, as to the pathogenesis of acute pancreatitis. Starting from the observed association of acute pancreatitis with gall-stones, they suggest that some cases of pancreatitis may be due to regurgitation of duodenal contents into the diverticulum of Vater, the way having been opened by the passage of gall-stones. Attempts were made on the human cadaver to force the duodenal contents into the diverticulum of Vater, but without success, except in one subject out of nine. In this case the bile passages were dilated, the gall-bladder contained gall-stones, and a gall-stone was lodged in the cystic duct. In three animals out of ten, the introduction of duodenal contents to the pancreatic duct by injection produced pancreatitis, and in three others fat-necrosis. In several animals attempts were made to enlarge the diverticulum of Vater by forcing glass beads into it, with the result that more than half the animals experimented on developed fat-necrosis or pancreatitis. The authors further suggest that duodenal contents introduced to the pancreas produce pancreatitis by auto-digestion, as the necrotic pancreatic tissue seen in cases of acute hæmorrhagic and gangrenous pancreatitis closely resembles pancreatic tissue that has undergone auto-digestion. R.

Cancerous Growths.—Whipham publishes (*Journal of Pathology and Bacteriology*, January, 1908) a study of some 650 cases of cancerous growths which came under observation at St. George's Hospital in the course of seven and a-half years. 496 of the cases were carcinoma, 130 sarcoma, and 24 endothelioma. 268, or 44.3 per cent., of those affected were males; 362, or 55.7 per cent., females. This difference was due to the greater liability of the breasts and generative organs to be affected in women than in men. On the other hand, the alimentary tract was more frequently attacked in males—143 cases, as compared with 42. In 34 cases, or 5.2 per cent., there was a history of malignant disease in the family, and it is curious that in 28 of these the persons affected in one family were of the same sex in each case. In three instances cancer occurred in married couples. Two instances of cancer of the breast in the wife were associated with cancer of the liver and of the œsophagus in their respective husbands, while in the third instance the wife suffered from cancer of the tongue and the husband from cancer of the pancreas. An exciting cause was assigned in 145 cases, or 22.3 per cent., as follows: previous injury, 6.9 per cent.; irritation, inflammation, or ulcer, 10.1 per cent.; pre-existing tumour, 5.2 per cent. No cases of carcinoma were encountered under the age of 20, and only 2.6 per cent. under 30; the highest incidence, 30.2 per cent., was between the ages of 40 and 49, though the incidence in the following decade was very little less—29.6 per cent. Of sarcoma, 9.2 per cent. of the cases occurred under 20, the highest incidence, 23.9 per cent., being between 30 and 40. Of endothelioma, 4.1 per cent. occurred under 20, the highest incidence, 41.7 per cent., being between 50 and 60. It appears, therefore, that carcinomata and endotheliomata agree in reaching their maximum late in life. Dissemination of the primary growth occurred in 58 per cent. of the carcinomata, 36.1 per cent. of the sarcomata, and 50 per cent. of the endotheliomata. (This estimate must be far from complete, since many of the patients were alive at the time of writing, and many metastases are only discovered on the post-mortem table.) The author discusses the various theories of the mode of spread of cancer, and he believes that in many of his cases of carcinoma of the alimentary, respiratory, and genital tracts (22 in all) dissemination took place by direct implantation. He adds a complete tabular record of the cases, giving the primary seat, the nature of the growth, the occurrence of metastases, the results of treatment, and other particulars. R.

A Modified Opsonic Technique.—Veitch describes (*Journal of Pathology and Bacteriology*, January, 1908) a modified method of estimating the phagocytic activity of the blood. The essential difference from Wright's method is that he omits the washing and preparation of leucocytes. The materials used are two volumes of the patient's or control blood, two of 1.5 per cent. sodium citrate solution, and one of a suspension of the bacteria in 1.25 per cent. salt solution. These ingredients are measured and mixed in the usual way, incubated for 15 minutes, a film stained and examined. The author states that quite sufficient leucocytes are present. If immediate incubation is impossible, then only the blood and the citrate solution should be mixed at first, the bacterial emulsion being added immediately before incubation. The author has in several cases compared the results obtained by this method with those obtained at the same time by Wright's method, and the differences are negligible. The method certainly has many advantages in its ease of application. R.

Treatment of Actinomycosis by Vaccines.—Wynn (*British Medical Journal*, March 7th, 1908) publishes the report of a successful case of what is, we think, the first attempt to treat actinomycosis by a vaccine. The patient had actinomycosis of the lung and liver, which necessitated the removal of part of a rib in an attempt at drainage. A copious discharge of pus, containing the ray fungus, persisted, and the temperature continued pyrexial. Agar-cultures of less than 48 hours were adopted for the preparation of the vaccine. The growth was scraped off, sterilised, and dried for an hour at 60° C. It was then ground in an agate mortar with normal saline solution containing 10 per cent. glycerine. One-thousandth part of a milligram of the solid substance was used as a dose. The first injection was given three weeks after the operation, and resulted in an immediate improvement in the patient's condition, the pulse-rate and temperature settling to normal. In all six inoculations were given at intervals of ten days to a fortnight, the results being marked in every case. At the end of the treatment the patient was apparently in excellent health, and though a cavity remained in the lung, there was no sputum, and the breath was not offensive. Ten months later there had been no falling back. Attempts were made to keep opsonic observations, and the writer is confident that the index was raised by the treatment. R.

Papillary Cystadenoma of the Breast.—Greenough and Seminous (*Publications of the Massachusetts General Hospital*, June, 1907) publish a description of the above tumour, based on a study of 20 cases. The same tumour has been described under various names, of which some of the best known are adenoma, duct papilloma, and duct cancer. According to the writers, it is not an uncommon growth, and it involves, as a rule, the large ducts of the breast, and is therefore situated near the nipple. The typical structure is one or more cysts filled with papillary ingrowths springing from the wall. The papillary growths have a branching connective tissue stalk, containing blood-vessels, and supporting a luxuriant growth of epithelium in the form of villous projections and gland-like interlacing tubules. The epithelium shows no tendency to infiltrate the surrounding tissues. It varies in its appearance in different specimens, and even in different parts of the same specimen. The lining of the larger cysts is commonly flattened and of several layers, whereas that on the smaller cysts and on the papillary tufts is more columnar in shape. The degree of proliferation of epithelium varies greatly. The rate of growth is slow, but of the twenty cases three showed signs of adeno-carcinoma. No definite cause can be assigned, the tumour being independent of trauma and lactation, and occurring at all ages. One of the patients was a male. R.

The Cell-Islets of Langerhans.—Vincent and Thompson (*Biophysikal. Centralbl.*, February, 1908, p. 319) have examined the pancreas in several mammals, in birds, fish and amphibia, and report accurate details of their work. They have arrived at one important conclusion regarding the cell-islets of Langerhans, and that is that there is a constant upbuilding of the gland parenchyma out of these islets, and a subsequent breaking down of the parenchyma during gland activity. In the condition of inanition of the gland brought about after exhaustion of secretory power by the injection of secretin, there is a great increase in the number of the islands, followed later on, as the gland recovers, by an increasing preponderance of the ordinary gland acini. The authors, in consequence, conclude that the islets cannot be regarded as a tissue *sui generis*. As regards their function, no opinion is expressed. M.

Ranula of Unusual Size.—Dr. Bale reports a case of a patient in whom a ranula of very large size was present (*South African Med. Record*, March 10th, 1908, p. 68). The patient was a native girl, æt. 13, who came under notice complaining of a swelling in the neck which had been present for three years. The tumour occupied the right submaxillary region, and extended in a spindle-shaped form along the anterior margin of the right sterno-mastoid muscle down to the level of the cricoid cartilage. On opening the mouth a tumour was also found under the front of the tongue, and was readily proved to be in communication with the cervical swelling, inasmuch as pressure upon the one caused enlargement of the other. The cyst was eventually excised, and proved to be a large bi-lobed ranula containing glairy mucoid fluid of a reddish colour. M.

Primary Hæmangioma of Muscle.—Davis presents an important literary and clinical study of this subject, based upon one case of his own and five others that had been operated on in the Johns Hopkins surgical clinic (*Johns Hopkins Hospital Bulletin*, March, 1908, p. 74). He has been able to include in his review 153 cases in all—a number which shows that the condition cannot be regarded as extremely rare. His main conclusions are as follows:—Primary hæmangiomata of muscle are slowly growing tumours, usually congenital in origin. They occasionally follow trauma, and may occur in any striated muscle. Compressibility, change in size on raising or lowering the limb, and pain, are the three typical symptoms, although any one or all of them may be lacking. The skin over them is usually normal, and the tumours themselves are usually soft, but may be hard, smooth, or lobulated, movable or fixed, circumscribed or diffuse. They vary in size from a small nut to a child's head. There are two principal varieties—the simple, which is rare, and the cavernous, which is more common. On section the characteristic appearance of a blood-filled sponge, brownish-red in colour, is seen. Microscopically the typical picture is that of blood-filled spaces lined with endothelium, containing normal blood, and surrounded by walls of smooth muscle and connective tissue. Phleboliths are often present in the blood spaces, as well as in the dilated veins, and are thrombotic in origin. The only treatment of value is excision, which, if complete, is practically sure to cure the condition. M.

Polyserositis.—May reports a case of this interesting condition (*Ext. Centralbl. f. Inn. Med.*, April 4th, 1908, p. 343). The patient, a man, æt. 20, was admitted to hospital suffering from severe ascites. Nothing abnormal could be detected on examining the heart, and in consequence a diagnosis of tubercular peritonitis was arrived at. At the autopsy complete obliteration of the pericardial sac was found; the spleen was enlarged, with thickened capsule; the liver was reduced to one-half its normal size, was smooth and uniform, and had its serous covering enormously thickened. The general consistence of the liver also was increased. Neither the peritoneum nor the pleura was thickened. May considers the absence of pleural and peritoneal involvement should prevent one from considering this a true case of polyserositis, and is inclined to group it under the symptom complex described as a pericardial pseudo-liver-cirrhosis. M.

OBITUARY.

DR. ROBERT COWAN LEES, M.B., C.M.GLASG., F.F.P.S.

We regret to record the death of Dr. Robert Cowan Lees. Till quite recently he was discharging his usual professional duties, but he was prostrated by pneumonia, which culminated fatally early on April 3rd. He received his education in Glasgow, passing from school to the University, where he graduated in medicine in 1879. All through his professional career he was associated with Glasgow, and had many interests sincerely at heart. For some years he lectured on medicine in the Western Medical School. He was a frequent contributor to medical journals, and in 1885 he was elected a Fellow of the Faculty of Physicians and Surgeons. In the Volunteer movement he took an active part, attaining the rank of surgeon-major in the 1st Lanarkshire Rifle Volunteers. Apart from professional work, he found time to devote to public affairs. He was a Justice of the Peace, Chairman of the Park Ward Municipal Committee, and President of the College Division of the Conservative Association, succeeding in the latter office the late Professor Sir Thomas M'Call Anderson. Keenly alive to everything bearing upon his profession, he commanded the confidence of his patients, and his frank and generous temperament made him many loyal friends.

FRED J. MACPHAIL, L.S.A.

We regret to announce the death of Dr. Fred J. Macphail, medical officer at Winwick Asylum, Warrington, who died on April 6th. The deceased gentleman previous to his appointment at Winwick, was one of the best known Rugby footballers in the district, being a prominent member of the Liverpool Old Boys' Club. His father is the Rev. Dr. Macphail, who was pastor of Canning Street Presbyterian Church, Liverpool.

Medical News in Brief

Royal College of Surgeons of England.

At a quarterly meeting of the Council, held at the College last Thursday, the President and Vice-Presidents reported that, in pursuance of a resolution adopted by the Council at their last meeting, they had addressed the following letter to Sir Henry R. Swanzy, President of the Royal College of Surgeons in Ireland:—

The New Irish University Bill.—"At their meeting on March 12th the Council of this College had under consideration your letter calling attention to the proposed foundation of a new Irish University, and its probable effect upon the Royal College of Surgeons in Ireland; and we were desired by the Council to write and express to you the strong sense which they entertain as to the importance of maintaining in Ireland a Royal College of Surgeons, and the hope that in any Bill which is brought forward to establish a new Irish University, provision may be made to safeguard the interests of your College. The Royal College of Surgeons in Ireland, like its sister College in England, was founded with the object of promoting the study of surgery and regulating its practice for the benefit of the public, and we venture to think that the history and traditions of your College amply show that continuous effect has been given to this primary object of its foundation. We highly esteem the important services to surgical education rendered by your College through its school and examinations, and specially do we regard your Fellowship as of great value as a mark of surgical skill and knowledge; and we believe that in promoting the study of surgery, and maintaining a high standard of professional conduct among its practitioners, your College has been able to perform duties of great value to the State and public. We should, therefore, regard it as a misfortune, not only to the profession, but to the public, if legislation were introduced which should result in diminishing or impairing the functions now exercised by the Royal College of Surgeons in Ireland. The Council of this College sincerely trust that you may be successful in your appeal to His Majesty's Government, and that the Royal College of Surgeons in Ireland may be able to continue that career of usefulness which has won for it so much distinction in the past."

Primary Examinations for the Fellowship.—It was determined to inform the Deans of the Medical Faculties of the Universities of Leeds, Liverpool and Sheffield that the Council, having consulted the several medical schools in reference to the proposal to alter the dates of the primary examinations for the Fellowship, and having considered the various suggestions made, were of opinion that it is undesirable to make any change.

Mr. Arthur Keith was admitted as conservator of the museum. A vote of thanks was given to Mr. R. H. Burne for his services in carrying on the duties of conservator of the museum during the illness and since the death of Professor Stewart, and he was appointed Assistant Conservator. Mr. Burne has been anatomical assistant in the museum since 1892.

A vote of thanks was given to Mr. Edmund Owen for his services as visitor to the examinations of the Egyptian Medical School at Cairo. The Jacksonian Prize for the year 1907 was not awarded. The subject for the prize for the year 1909 will be, "The Treatment of Surgical Affections by Vaccines and Anti-Toxins." A report was received from Mr. J. Ward Cousins regarding the proceedings of the Central Midwives Board during the past year, and the thanks of the Council were given to him for his services as the representative of the College on the Board.

Mr. J. B. Dawson, M.B.Lond., having passed the required examinations and conformed to the by-laws, was admitted a Fellow of the College. Mr. T. J. Walker, Consulting Surgeon to the Peterborough Infirmary, and Mr. H. P. Keatinge, Director of the Egyptian Government Medical School at Cairo, were elected Fellows of the College as members of twenty years' standing. Messrs. K. D. Panton, Toronto University; R. K. Paterson, Kingston, Canada, and London Hospital; and G. C. E. Simpson, M.B., B.A., Cantab., were admitted members of the College.

The Senates of the Proposed New Irish Universities.—Forecast.

It is stated that the following will be nominated as members of the Senate of the proposed new University in Dublin:—Chancellor: Sir William Butler, K.C.B. Members of the Senate: The Most Rev. Dr. Walsh, Roman Catholic Archbishop of Dublin, and the Most Rev. Dr. Healy, Roman Catholic Archbishop of Tuam; Mr. J. S. McArdle, Dr. J. J. O'Carroll, and Dr. M. J. Cox. Among the seven Protestant members are Mr. Butcher, M.P., Dr. Douglas Hyde, and Mr. Stephen Gwynn, M.P.

In the case of Belfast the forecast is fuller, and is as follows:—Chancellor: The Earl of Shaftesbury. Pro-Chancellors: Sir Donald Currie, Sir Robert Hart. Vice-Chancellor: The President of the Queen's College. Crown Nominees: Right Honourable Robert Young, Mr. John Cooke (H.M.L., Londonderry), Dr. P. O'Connell. Staff Representatives: Professor Sir William Whitla, Professor M. F. Fitzgerald, Professor E. A. Letts, Professor T. Sinclair, Professor J. Park, and Professor S. Dill. Graduates' Representatives: Mr. Justice Dodd, Judge Shaw, Dr. J. Walton Browne (R.U.I. Senator), Professor M. Leitch (R.U.I. Senator), Professor Leebody (R.U.I. Senator), and Mr. R. T. Martin. Registrar: Professor Johnson Symington. Representatives of Benefactors: Sir Otto Jaffe, Mr. H. Musgrave, D.L.; Mr. F. Purser, F.T.C.D.; Dr. P. Redfern, Mr. R. Dodds, M.A. Local Representatives: The Lord Mayor (Sir Robert Anderson), President Chamber of Commerce (Sir Charles Brett), Chairman Royal Victoria Hospital (Sir William Crawford). Secondary School Representatives: Mr. R. M. Jones, M.A.; Principal Royal Academical Institution (probable).

The Late Dr. Connolly Norman.

A meeting was held on Thursday last in the Royal College of Physicians, Dublin, to consider the question of erecting a suitable memorial to the memory of the late Dr. Connolly Norman. The President of the College presided. Among those present were Sir Henry Swanzy, President of the College of Surgeons, Dr. Little, Sir Francis Cruise, Sir Thornley Stoker, Dr. Magee Finny, Dr. W. Dawson, Dr. Maxwell, Dr. J. O'Conor Donelan, Dr. Baker, Dr. Fleury, Dr. Cullinan, Rev. M. Taylor, J. R. O'Connell, Esq., LL.D., and Dr. Carroll. Dr. Little and Sir Francis Cruise expressed sympathy with the object of the meeting. Sir Henry Swanzy paid tribute to the memory of the late Dr. Connolly Norman. After some discussion an executive committee was appointed. Dr. Dawson and J. R. O'Connell, Esq., LL.D., were appointed treasurers, and Dr. Donelan and Dr. Fleury secretaries. The meeting then adjourned for a fortnight.

PASS LISTS.

Royal College of Surgeons in Ireland—Election of Examiners.

A meeting will be held on Tuesday, May 5th, at 4.30 p.m., to elect examiners.

"Graduates of any University which may be from time to time recognised by the College shall be eligible for election as Examiners in the subjects of General Education. All the other Examiners shall be Fellows or Licentiates of the College, or Professors or Lecturers in any School of Medicine recognised by the College."

Candidates are requested to lodge their applications in writing with the Registrar, at the College, on or before Tuesday, April 28th, at 10 a.m.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

The following candidates have passed the first Professional Examination, April, 1908:—T. D. Condell, N. S. Deane, T. Dillon, W. H. Johnston, J. Kearney, J. E. J. Roche Kelly, W. Lumley, F. P. McDermott, L. O'Donovan, P. Walsh, V. White.

The offices of the Committee of Management will be closed from April 16th to 20th, 1908 (inclusive).

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

VIRIDIS.—The question of the origin of the green colouring of oysters has agitated people for quite a century, but MM. Puysegur and Bornet, by careful experiments, showed in 1877 that it was caused by the blue diatomea, which served as food for the oysters. Oysters purchased at Arcachon or in Brittany are placed in ponds dug out in the clay. There the oysters either "work" or "sulk." An oyster "at work" opens and closes its valves from time to time, sets in movement numberless vibratile filaments, thus causing a whirlpool, which drags into its stomach the water with a multitude of small particles and Diatoms. At the same time as it becomes green the oyster fattens, its flesh becomes more delicate. The fattening process is more or less slow; it occupies at least a season. The oysters that "sulk" remain closed, because some unfavourable circumstance disturbs them. If their situation improves, they get to "work"; if not, they die.

LESSEE.—You have to pay the house duty yourself, but the land lord is bound to allow you to deduct it from the next payment of rent.

OBSTETRICS.—The matter of midwifery instruction is a very serious question which will have to be settled definitely before long. We fail to agree about present-day teaching. We may deal with the matter shortly.

HUJUS.—We should be very glad to know more of the circumstances. Could you send us a cutting from the local press? We will be most happy to take your part if we find the circumstances warrant our doing so.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 15TH.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m.: Mr. J. Strachan: On Dendritic Growths of Copper Oxide in Paper. Mr. F. Enock: Nature's Protection of Insect Life (illustrated by lantern slides in three-colour photography.)

SOCIETY OF TROPICAL MEDICINE AND HYGIENE (20, Hanover Square, W.).—8.30 p.m.: Adjourned Discussion on Dr. Prout's paper on the Rôle of Filaria in the Production of Disease. Dr. Prout: On an Unusual Cause of Dysenteric Diarrhœa in the Tropics. Dr. T. P. Macdonald (North Queensland): Tropical Lands and White Races.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. T. P. Legg: Clinique (Surgical.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Dermatological (Dr. G. N. Meachen); Ophthalmological (Mr. R. P. Brooks). 3 p.m.: Demonstration on Fevers (at the North-Eastern Fever Hospital, St. Ann's Road, N.): Dr. F. Thomson.

Appointments.

BAIRD, HARVEY, M.D., Ch.B.Edin., Assistant Medical Officer at the Cardiff Mental Hospital.

CALDWELL, M. F., M.B., B.Ch.Irel., Junior Assistant Medical Officer at the Cardiff Mental Hospital.

DOWNES, HAROLD, M.B., L.R.C.P.Edin., Medical Superintendent to Benenden Sanatorium.

FORDE, T. A. MUNRO, M.R.C.S., L.R.C.P.Lond., Honorary Senior Surgeon to the Royal Hospital, Portsmouth.

GRIFFITHS, EVAN JOHN, M.B., Ch.B.Edin., Medical Officer for the Inspection of School Children by the Pontypridd Education Committee.

HEBBLETHWAITE, A. G., M.R.C.S., L.R.C.P.Lond., Honorary Physician to the Keighley Victoria Hospital.

LAWRIE, D., M.B., M.S.Glasg., Assistant Medical Inspector of Schools for the Glastonbury District of Somerset.

NASH, J. T. C., M.D., C.M.Edin., D.P.H.Cantab., Medical Officer of Health to the Norfolk County Council.

PAGE, H. M., F.R.C.S.Eng., Honorary Anæsthetist to Guy's Hospital.

STEVENSON, T. H. C., M.D. State Med. Lond., Chief Medical Inspector of Schools for Somerset.

Vacancies.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, apartments, attendance, and washing. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

Borough of Southend-on-Sea.—Medical Officer of Health. Salary, £550 per annum. Applications to William H. Snow, Town Clerk, Southend-on-Sea.

Camberwell House Asylum, London, S.E.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent.

County Borough of Southampton.—Assistant Medical Officer of Health. Salary, £150 per annum, with residence, board, and washing. Applications to the Town Clerk, Town Clerk's Office, Municipal Offices, Southampton.

Borough of Bootle.—Hospital for Infectious Diseases.—Resident Medical Officer. Salary, £120 per annum, with board, washing, and apartments at the Hospital. Applications to the Chairman of the Health Committee, Town Hall, Bootle.

Births.

FOX.—On April 7th, at 63, Grosvenor Street, London, the wife of Wilfrid Fox, M.D.—a son.

HAYWARD.—On April 9th. at 23, The Grange, Wimbledon, the wife of John Arthur Hayward, M.D., F.R.C.S.—a daughter.

HILLYER.—On April 11th, at Heathcote, East Grinstead, the wife of W. Henry Hillyer, M.D., D.P.H.,—a son.

NITCH.—On April 10th, at 69 Harley Street, London, the wife of Cyril A. R. Nitch, M.S., F.R.C.S.—a son.

PAVITT.—On April 9th, at 19, Crediton Road, Hampstead, the wife of Percy G. Pavitt, M.R.C.S., L.R.C.P.Lond., L.D.S., —son.

Marriages.

GRINDROD—CARR.—On April 13th, at St. Pancras Church, London, John Townly Grindrod, M.A., Cantab., of Blackpool (formerly of Liverpool), to May Louise Ashdown, only daughter of Thomas Carr, M.D., and Mrs. Carr, of Blackpool.

JAMISON—HEYWORTH.—On April 9th, at All Saints', Ennismore Gardens, London, Reginald Jamison, F.R.C.S., of 80, New Cavendish Street, London, son of the late Arthur Jamison, M.D., to Eanswythe, daughter of the late Colonel Lawrence Heyworth, and of Mrs. Heyworth, of Colne Priory, Earls Colne.

MAXWELL—CLARK.—On April 7th, at St. Mary Abbots, Kensington, Herbert Bowen Maxwell, M.R.C.S., L.R.C.P., to Elsie Constable Clark, younger daughter of the late Andrew Clark, Esq., of Glasgow, and Mrs. Clark, of 67 Castletown Road, West Kensington.

OXENDALE—PALMER.—On April 9th, at St. George's Church, Tufnell Park, London, by the Rev. G. E. Asker, M.A., Thomas Trevor Ranson Oxendale, elder son of the late Thomas Lowson Oxendale, M.D., of Heighington, Darlington, to Esther Caroline Palmer, eldest daughter of James Buckland Palmer, of 194, Brecknock Road, London.

Deaths.

BROWNE.—On April 9th, of heart failure after operation, Oswald Auchinleck Browne, M.D., F.R.C.S., of 7, Upper Wimpole Street, London.

GARTH.—On April 10th, in Calcutta, Henry Charles Garth, M.B., Edin. fourth son of the late Right Honble. Sir R. Garth, aged 47 years. (By cable.)

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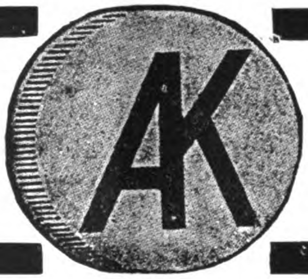

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, APRIL 22, 1908. No. 17.

NOTES AND COMMENTS.

Advance Australia. THE proprietors of proprietary medicines have been stirred to frantic efforts to stay what is described as the "fanatical" legislation proposed by the Commonwealth Government of Australia. No one who has read the report of the Commission appointed to inquire into the trade is in the least surprised that the Government is prepared to take strong measures to prevent the fraudulent business which masquerades under the pretence of trade secrets, and we are glad to see that it seems inclined to push its proposals through without sacrificing the principles at stake. We confess to having but little sympathy with trade secrets in connection with means for the relieving of human misery or the saving of human life, even in respect of legitimate preparations. Drug manufacture should be conducted on scientific chemical principles, and there should be no secrets in scientific work. It is one thing that medical men should be able to insist on patients having the preparations of some firm in whose products they have confidence, and quite another that the price of a certain drug should be enhanced because it is manufactured on a secret principle which is kept private for the benefit of some individual. There are, fortunately, plenty of respectable, high-class firms which are content to take their stand on the purity and quality of their goods, without claiming any secret for themselves.

Trade Secrets. THE trade secret myth under which the quack medicine vendor sells his common-place mixtures and pills is one that is entitled to no respect from honest men, and we hope all the importunities of the trade will not affect the decision of the Commonwealth Ministers. The basic principle of the proposed legislation is the disclosure of the contents of quack medicines on the label, and the trade recognise this as the death-blow of their business. So far, the Minister of Customs, on whom falls the responsibility of shaping the Bill, is only prepared to recommend as an exemption those goods which the Governor-General in Council is satisfied would, by disclosure, suffer in a legitimate way, without protecting the public. This exception we think unfortunate, as it would devolve entirely on the administrators of the Act as to what preparation would and would not be included, and knowing something of the pressure which powerful interests can bring to bear on officials, we cannot help thinking the Government would best protect their population by making no exceptions. The interesting lesson these facts suggest is that the evil of the quack medicine trade is recognised in our great dependency and is being earnestly grappled with, in the face of the Press and all other interests, while in England the question is not even a live one with our Ministry. The conduct of the Licensing Bill through the House of Commons would be child's play compared with the passage of a Bill to do away with the swindling preparations foisted on the poor by means of advertisements in newspapers and magazines of all descriptions.

A Nerve Specialist. IN the High Court last week an action was brought by a gentleman to recover some £500 lent to a lady on the security of her income, which was derived from her profession of a "nerve specialist." Evidence given by a solicitor who negotiated the business that the lady told him her income from this source was £2,000 a year, £800 of which was net. Various charges and counter-charges were made, but eventually the jury found for the plaintiff. It is rather disappointing that the facts as to this practice of "nerve specialism" did not come out at the trial, or at any rate were not reported, for it is wonderful to reflect how this large income was made so steadily and so safely as to be regarded as security for money advanced. What sort of treatment does this type of "nerve specialism" involve? And how are clients obtained? It might help some struggling medical brethren to know, as the ordinary practice of the profession seldom shows such figures. The case, at any rate, suggests the inadvisability of the growing practice of medical men calling themselves "specialists," as the term has no legal significance, and can be appropriated by "nerve specialists," "canine specialists," *et hoc genus omne*, with impunity.

Kissing not by Favour. THE London County Council, in their wisdom, have issued a notice to the effect that "Kiss-in-the-ring," and other kissing games, are to be discontinued in the Council Schools and in the non-provided schools for which they are responsible. "On medical grounds the practice is considered undesirable," runs the order. At the risk of being considered old-fashioned we cannot restrain a sigh that a pastime so popular and so exhilarating should be relegated to the limbo of unhygienic things, and we feel almost inclined to beg the authorities to consider the restrictions which a strictly hygienic life would entail. Is it not possible that the banishment of poetry and display of the affections from the narrow round of the London urchin's existence, might not conduce to a state of materialism and ill-mannerism even more perilous to the State than a putative risk of infection? The too-aseptic child might, it seems to us, become as sterile to the growth of kindly sentiments and light heartedness as to the growth of noxious microbes, and we know that in banishing the baleful bacteria we also banish the friendly ones. At any rate, we shall watch with attention the infectious disease returns for London, and if it does not show a fall as the result of the new Order in Council, we shall be inclined to put in a plea for the re-establishment of those pleasant amenities which combine a slight risk of infection with the cultivation of that inestimable possession, the *joie de vivre*. After all, as Stevenson has said, the first duty of man is to be happy.

Quare Fremuerunt.

The reasons for drinking were discussed last week in a thoughtful paper by Dr. Stanley Atkinson, read before the Society for the Study of Inebriety, and the author ended his arguments by a quotation from Dr. Mott, to the effect that the causes of drinking are infinitely varied, being intimately bound up within the temper and character of man. Indeed, the list of causes seems to cover each possible state of consciousness and its precise antithesis, fear, courage, sympathy, aversion, joy, sorrow, love, hatred, and so on. The list fully bore out another very apt citation from a medical author of 1700, Dr. Henry Aldridge, to the effect that

"There are five reasons why men drink;
Good wine, a friend, and being dry,
Or lest you should be by-and-by,
Or any other reason why."

Two hundred years of thinking and drinking do not, therefore, seem to have advanced knowledge of the causation of drunkenness very far. The reason why men drink apparently is because they like to, and the argument would therefore seem to be that either the opportunities for indulging their taste should be limited, or that they should be taught to like not to. The discouraging result of most attempts at temperance legislation hitherto is due, we fear, to the fact that the poor man does not care to be "robbed of his beer," and that he will continue in that dislike till the desire for beer is removed by the substitution of better leanings.

LEADING ARTICLES.

THE PRESENT POSITION OF THE MEDICAL PRACTITIONER.

The position of the average medical practitioner with regard to the struggle for existence appears to be at present in a somewhat acute stage of precariousness. There is reason to believe that he shares to a great extent in a commercial depression that is affecting most ranks of society. Yet even in times of national prosperity it is more than doubtful that he obtains the amount of emolument from his life-work to which his professional skill and services are entitled. A perusal of some of the earlier volumes of medical journalism will show that the grievance is no new one, although it probably has reached its acme at the commencement of the twentieth century. There can be little doubt that, in spite of prizes here and there, the average medical practitioner does not obtain an income adequate to recompense him for the years of careful study and of hard, conscientious, and highly technical and responsible work which come as a part of his vocation. It has often been urged that the chief reason for the inadequacy of income is the overcrowding of the profession, but that view is hardly borne out by the facts of the case. If we may accept some recently published statistics, there are in the United Kingdom some 34,907 qualified men and women to about 43,000,000 population. This would give one medical practitioner to about every 1,230 of the population of the British islands. Further statistics show that the average for the whole of Europe is one medical man to every 2,033. These figures may for present purposes be received as approximately correct. They do not represent an excessively undue proportion of medical attendants when we take into account the large number of medical men engaged in consulting and special practice, and another large section whose services are required by the State for army, navy, poor-law, and other public services. Viewed in this way, there appears not to be an undue number of medical men in the United Kingdom; and the restricted nature of their incomes appears to be due, not to the fact of competition in their own ranks as of competition from without. The State, which demands prolonged and careful training and stringent examination tests before it will grant the legal medical qualification, yet takes no steps to protect the community from the evils of quacks and quackery. The result is that all kinds of charlatanry are rampant to an extent that has never been hitherto equalled in the annals of civilisation. There needs little argument to show that all this means the diversion into alien channels of what would otherwise be a legitimate source of income for qualified medical men. Nor is there any need for the medical profession to be shy of admitting this phase of the problem of their diminished and diminishing competency. Finance is a material and inevitable condition of existence common to all professions, learned or otherwise; and, because the work performed by a medical man is essentially of a humane character, there is no obligation on his side to abandon the reciprocal due whereby his existence is maintained. There are various quarters from which comes a faint promise of relief. Thus in recent years great medical organisations have sprung into existence, and in some of them various extra-mural and intra-mural problems have become the subject of serious discussion. Even the General Medical Council has shown some slight awakening to the isolation of their position as regards the vital wants and aspirations of the medical profession. To increase the direct representation upon the Council, to enlarge its powers so as to render it a body capable of defending the rights of medical practitioners in a manner more or less analogous to the functions favoured by the Incorporated Law Society, is a point of desirable reform that will secure the cordial approval of the majority of practitioners. But, after all said and done, the cardinal principle of all future amelioration of the lot of medical men lies in the recognition of the duty of the State to protect the safety of the subject by the prevention of irregular medical practice. One of the steps advocated strenuously by The Medical Press and Circular has been the appointment of a Royal Commission upon quacks and quackery, a proposal that has been most ably advocated by Mr. H. Sewill. There could hardly be a more potent instrument for the education of the public or a more efficient means of securing data for legislative action. Were the medical profession generally to adopt this item as a leading part of their policy, there would be a prospect of the appointment of such a Commission in a not remote future. Meanwhile, it is the duty of those who wish for reform in the present condition of professional life to educate the public on these matters and others of a cognate character.

CURRENT TOPICS.

Visitors in Hospitals—A Fatality.

An unfortunate occurrence last week at the Royal Hospital for Incurables in Dublin—an excellently-managed institution—is a painful example of the evil wrought by ignorant but well-meaning folk. A patient, hopelessly ill of consumption, was found one morning in a comatose condition, having concealed near him an empty chlorodyne bottle and a flask of sulphonal tablets. Being roused with difficulty, he stated that the drugs had been brought to him by a lady visitor whose name he refused to give. In spite of treatment, the patient died some hours later, and there was no doubt his death was due to the drugs. The governors of the hospital have a stringent rule against visitors bringing any presents to patients without these passing through the hands of the lady superintendent, but everyone who knows anything of hospital management knows how difficult it is to see that such a rule is rigorously obeyed, especially in the case of small articles. The incident is an example of the dangers of self-drugging, to which we are well accustomed, though it is not often that the fatality occurs in the case of a patient in a hospital. It is appalling that well-intentioned people, like the lady who is responsible for this poor man's death, will interfere with their ignorant advice even with patients for whose sorry need provision is made.

Falmouth and its Poor.

The extraordinary meanness of some public authorities in dealing with their medical officers is past comprehension. It appears that the Falmouth Board of Guardians pays the medical officer to the workhouse the princely sum of £20 per annum, out of which medicines have to be supplied. After this the parson of the "Deserted Village" would presumably deem himself more than passing rich with £40 and no out-of-pocket expenses. The Local Government Board have very properly interfered, and tried to show this shabby authority how little it appreciates its duties to the poor, whose official guardian it is. One of the inspectors, Mr. Preston Thomas, was told off to make representations to the Board, and he pointed out to it that this salary worked out at 7s. 8d. a week, and if the cost of drugs was deducted, the medical man would only clear 5s. or 6s. a week. "About the amount a boy was paid for scaring crows," said the Inspector, and he added "that it was not reasonable to expect an officer to carry out his many duties for such remuneration." The effect of this admonition was that a motion ws made that on the present officer vacating his position the salary should be raised to £35—perhaps as modest a proposal as was possible. But even this humble suggestion was flouted by the Falmouth Bumbles, and the old heartless sweating is to continue. Falmouth can hardly expect much recommendation as a health resort from medical practitioners when its authorities are so glaringly and fatuously unjust in their public dealings.

Dairyman's Diagnosis.

British law, although in the main of monumental soundness, is nevertheless riddled with much foolishness. Take the matter of milk, which is fenced around by a perfect maze of contradictory and defective legislative compromises. To attempt to review the whole situation would be to write a volume, but a few words may be said on one phase of the question in order to illustrate our original proposition. It is provided that it shall be unlawful for any cowkeeper or dairyman to allow any person suffering from any dangerous infectious disorder to be engaged in the production, storage, or distribution of the milk. Unfortunately, the first diagnosis in this case must be made by the dairyman, before calling in a medical man. A better plan would be for it to be rendered compulsory upon the dairyman to call in a medical attendant to every case of illness of persons in his employ. Should there be the slightest doubt as to the exact nature of the malady, the medical officer of health should be at once called in, with full powers to apply any necessary or desirable tests, bacteriological or otherwise, that may be indicated by advanced medical science. Were the whole of the Milk Acts to be drawn up on modern lines of public health administration there is little doubt that a vast amount of good would be conferred upon the community by the lessening of milk-borne maladies.

Ambulance Alarms.

The proper organisation of first aid is clearly a matter of importance to the modern citizen. Needless to say, the rapid and safe transport of injured persons is, in many instances, no less essential to successful treatment than the existence of a well-equipped hospital at the end of the journey. Ambulance stations are now available in London and some other large cities, while various hospital, municipal, and police services are also available for the same purpose. Recently it has been proposed to construct motor ambulances, each carrying a skilled attendant who would be able to apply first aid on the road to hospital. The ambulance centre, to be of any general service, must obviously be kept in touch with various parts of the district in which it lies by telephonic communication. So far as railway stations and large centres of industry are concerned, a good suggestion has been made by Dr. J. S. Rodgers, of Dundee, namely, that an ambulance alarm should be installed after the manner of a fire alarm. The call being made, the trained ambulance men would fall in at a given spot, just as those trained in fire-drill would rendezvous at the fire signal. The suggestion seems practical, and should be brought to the notice of the Ambulance Associations of the United Kingdom.

The Preventive Extermination of Rodents.

Science having demonstrated the part played by rats in the spread of plague, it is meet that science should point out the remedy for the evil. For various reasons the extermination of rats is a matter of great difficulty, although a host of contrivances have been called into requisition from time immemorial. The clumsy method of the time-honoured rat-catcher, and the wiles of the gin, however, will in future be discarded whenever extermination is attempted on any large scale. The old-fashioned phosphorus paste and other vermin poisons killed off a small number of rats in detail, but were dangerous to other animals, and rats soon learnt to avoid them. An ideal destructive agency would be some form of poison which would be greedily devoured by the rats themselves, which would spread infection through other exposed rodents, and would be harmless to other forms of lower animal life. Such an agent is thought to have been supplied by Dr. Danysz, of the Pasteur Institute, in the form of a virus, which is a bacteriological preparation conveying a fatal disease to which only rats and mice are susceptible. The culture is obtained from a variety of Loeffler's *bacillus typhimurium,* which affects house and field mice, but not rats. This virus has been laid down successfully in some of the London underground tube railways, where the rats had been in the habit of short-circuting electric currents by gnawing away the insulating sheaths, but in Australia experience has not been so favourable to its claims.

Sleeping Engine Drivers.

THE special report of the recent railway accident at Shrewsbury, whereby the lives of eighteen persons were lost, not to mention a large number of injuries in addition, points to a serious menace to the public safety. The only theory that can be formed, after a careful investigation of the facts of the case, is that the engine driver—and perhaps the fireman, also—was asleep at the time of the accident. There was no evidence whatever either of drunkenness or of incompetence, but there is a damning record of long hours of night work during the preceding week. Colonel Yorke, the Government official who held the inquiry, apparently entertained no doubt whatever upon this point. The matter, clearly, cannot be permitted to rest there. In the interests of the travelling public it will be necessary to institute some kind of control over the hours of railwaymen, not only of those engaged upon the engines, but also at the signals and along the lines and at the stations generally. The principle of fixed hours of labour has been repeatedly laid before Parliament in the case of the miners. How much more important is such a curtailment within what may be termed physiological limits required for the men to whose hands the safety of millions of our fellow-countrymen—not to mention ourselves—is entrusted every year. Were the hours of railway servants compulsorily reduced to a reasonable limit, and were a periodical medical examination instituted at the same time, there is every likelihood that the number of mysterious railway collisions would thenceforth be greatly reduced. It is to be hoped that Parliament will lose no time in enforcing the moral of the Shrewsbury disaster.

The English College of Surgeons Referendum

THE somewhat novel experiment of the Royal College of Surgeons of England, in referring the question of the admission of women to their diploma appears to be raising a good deal of interest amongst members. It will be remembered that the two questions referred ran as follows:

1. In your opinion, is it desirable that women should be admitted by examination as members of the College?
2. In your opinion, is it desirable that women, after admission to the membership, should be admitted by examination as Fellows of the College,

To these questions the members were asked to answer "Yes" or "No." It has been stated in certain quarters, however, that many members are prepared to answer only on conditions. It is further rumoured that an appeal is to be sent round to members by those who hold that view asking them to disregard the official request, and to send in their answers in their own form. In some sort of remote way this attitude, assuming that it really exists as reported, would appear to reflect the desire on the part of a majority of members to be allowed to share with the Fellows in the government of their own corporation. Be that as it may, it is somewhat curious that a situation of the kind should be rendered possible by the progressive action of the Council in adopting the Referendum, and in actually endeavouring to ascertain the wishes of members in a proposed step of vital importance to the future of the College. The incident suggests that there is, after all, no insuperable obstacle to the ultimate broadening of the basis of control of this ancient and illustrious corporation.

Domestic Preventive Medicine.

A PRACTICAL step has been taken by the Women's National Health Association of Ireland in an attempt to mitigate the sordid curse of tuberculosis amongst the poor. Lady Aberdeen has written from the Viceregal Lodge announcing that the visit of a nurse can be secured to the house of any patient suffering from the malady in question. In this way patients can be taught how to treat themselves, and how to prevent the infection being spread to other persons. A Samaritan Committee of the Dublin Branch of the Women's Association will follow up, so far as possible, with food, blankets, and other absolute necessaries of treatment. This scheme seems to be more rational and worthy of support than the founding of costly sanatoria, destined for the most part for the use of paying patients. The only effectual way of dealing with human tuberculosis is to deal with it in the home. It is abundantly clear that every case allowed to remain untended in a poor environment becomes a standing source of infection for all persons in his vicinity. Every such patient whose danger zone is curtailed or abolished by the Women's Association of Ireland is therefore a distinct gain to the community. Lady Aberdeen is to be congratulated upon the directness, the simplicity, and the practical and humane efficiency of her scheme.

"Style and Appearance" in Poor-law.

THE qualities that lead to sucessful practice are numerous, as the newly-qualified man is apt to discover to his cost when he plunges into the sea of professional life. Amongst other things, there can be little doubt that what is known as the "bedside manner" is not a little valuable to its fortunate possessor. There is no need here to attempt to analyse the qualities that contribute to that particular method, or to show that its underlying basis is one of politeness and good breeding, apart from professional virtues. But it certainly is a little startling to find a Board of Guardians insisting upon the necessity of "style and appearance" in selecting an assistant medical officer. The course hitherto adopted, we understand, has been to leave the selection of the candidate to the medical officer. Under the present arrangement, three candidates are to be interviewed by the Board. It is to be presumed that body, which clearly has the courage of its own opinions, will be guided in its choice not so much by the medical qualifications and experience of the candidates, as by their "style and experience." Under these circumstances it is conceivable that a short series of lessons in deportment might be of advantage to young medical men in search of appointments. Possibly a similar spirit may influence many other Boards of Guardians, inasmuch as their decisions are often of a most unexpected and puzzling nature.

Hospital Anæsthetists.

The question of the administration of anæsthetics in hospitals is likely to attract a considerable amount of attention in the near future. Owing to the absolute lack of trustworthy data it is impossible either to accept or to reject the views of certain leading anæsthetists who assert that fatalities are in the main due to the capabilities and experience of the individual administrator. In any case, it is the duty of hospital authorities to place patients on the safest possible footing. If it be necessary, for instance, that a general anæsthetic should be administered by a senior student or one of the medical staff, then it should be made an obligatory condition that (*a*) he should show that he has received a special technical training in anæsthetics, and (*b*) that he be always under skilled supervision. We note that at Guy's Hospital two new anæsthetists have been appointed. The good anæsthetist must be born as well as made. There are in this way many general practitioners who are excellent anæsthetists. The difficulty is how to find them, but they would certainly be admirably fitted as recruits for the large staff of anæsthetists required for all large hospitals. A small honorarium would have to be granted in return for their exacting work, and the question of pluck for the position might possibly be met by making the tenure of the post subject to a preliminary six months' trial.

Cerebro-Spinal Meningitis.

The recrudescence of "spotted fever" in some parts of Ireland warns us of the curiously stubborn nature of this disease. When once it has obtained a footing in a locality it is apt to recur again and again, long after it has apparently taken a final departure. Its passage from port to port, and from town to town can further be traced, as a rule, with unerring accuracy. The invasion of cerebro-spinal meningitis is usually heralded by one or two stray cases, and it may be some time before the inevitable epidemic follows. In our present state of knowledge it is impossible to take special preventive steps with any certainty that the disease is being directly attacked. On these grounds London, which has had a fair number of "herald" cases, must be held to be yet within the danger zone so far as epidemic cerebro-spinal meningitis is concerned. All medical men connected with hospitals will do well to bear that fact in mind. Out in the Hague, by the way, it is reported that the malady, which has hitherto appeared only in isolated cases, has broken out in epidemic form in a village near Utrecht, where several deaths have already occurred.

PERSONAL.

Sir R. Douglas Powell has been re-elected President of the Royal College of Physicians of London by a large majority.

Sir Frederick Treves has gone into his quarters at Thatched House, the royal residence at Richmond which was recently placed at his disposal.

Dr. T. C. Shaw, Lecturer on Psychological Medicine at St. Bartholomew's Hospital, has been elected President of the Society for the Study of Inebriety.

Dr. Waller and **Dr. Mears** have been respectively reappointed Director and Treasurer of the Physiological Laboratory of the University of London.

The Lord Chancellor has placed Dr. R. G. Nesbitt, Dr. H. Davis, sen., and Dr. J. C. Mackay on the Commission of the Peace for the County of Cornwall.

Dr. Wm. E. Fothergill, Lecturer on Midwifery, Victoria University, has been elected Honorary Assistant Gynæcological Surgeon to the Royal Infirmary, Manchester.

Dr. St. Clair Thomson has been appointed representative of the University of London at the International Laryngo-Rhinological Congress, to be held at Vienna.

Professor von Jacksch, of Vienna, is said to have discovered a method of preventing the burning of the skin which so often results from the operation of X-rays.

Dr. Dawson and **Dr. J. R. Connell, LL.D.**, have been appointed Treasurers, and Dr. Donelan and Dr. Fleury Secretaries of the Executive Committee formed to promote a memorial to the late Dr. Connolly Norman.

Mr. Christopher Martin, Surgeon to the Birmingham and Midland Hospital for Women, will give the Ingleby Lectures of the University of Birmingham on May 7th and 14th. His subject is "Myoma of the Uterus."

Dr. James Porter, who has been appointed Director-General of the Medical Department of the Royal Navy, saw much service in the Boer war, especially at Stormberg, Magersfontein and Belfast. He has recently been in command at Haslar Hospital.

The Council of the Incorporated Institute of Hygiene have decided to promote a special exhibition, illustrating the requirements of infant life and the care and health of children, which will be opened, under distinguished auspices, on June 15th, 1908.

Army Medical Service.

An examination of candidates for thirty commissions in the Royal Army Medical Corps will be held on July 29th and following days. Applications to compete should be made to the Secretary, War Office, London, not later than July 20th, on which date the list will be closed. Candidates who are over the regulated limit of age at the date of the examination will be permitted to deduct from their actual age any period of service in the field after October 1st, 1899, that they could reckon towards retired pay and gratuity, if such deduction will bring them within the age limit. The presence of candidates will be required in London from July 27th.

A Clinical Lecture

ON

INTERNAL SQUINT.

By PATRICK MAXWELL, M.D.Ed., F.R.C.S.I.,

Ophthalmic Surgeon to Jervis Street Hospital; Surgeon to the Royal Victoria Eye and Ear Hospital, Dublin.

Gentlemen,—There are three kinds of internal squint—mechanical, paralytic, concomitant.

1.—An internal squint may be caused by orbital tumour, inflammatory exhudation, or other mechanical condition. The diagnosis is not very difficult. If there is anything in the orbit sufficiently large to rotate the eye to one side, it will also push it forwards. The projection of the eye causes the lids to open widely, giving a characteristic staring appearance. The power of turning the eye outwards is usually completely lost, and movement in other directions is also much restricted.

2.—Internal squint due to paralysis or paresis of the external rectus muscle.—In this case the power of turning the eye outwards is lost or restricted, but movement in other directions is normal.

Let us suppose that the right external rectus is paralysed. Make the patient turn his face straight towards you, and tell him to look at the bridge of your nose. You will observe that the right eye squints inwards. In the position you have placed him he is, strictly speaking, not using any of his orbital muscles. What, then, rotates his eye in? We must remember that all healthy muscles are always in a state of slight contraction or tonicity. The orbital muscles are in pairs, and, under ordinary circumstances, balance one another. When the external rectus is paralysed, it has lost its tone, and is overcome by the internal. Now ask the patient, without moving his head, to follow your finger with his eyes. When he looks to the right the squint increases; when he looks to the left it decreases or vanishes altogether. This is because, in looking to the right, the external rectus of the right eye and internal rectus of the left are employed. The left eye moves normally, but the right cannot pass the middle line. On the other hand, when the patient looks to the left, the external rectus of the left eye, and internal rectus of the right, are employed. Both muscles are healthy, and the movement is properly performed.

Now ask the patient to look at some point a little below your chin. Hold your hand before his left eye (the sound one) in such a way that it cannot see the object, but you can look at both his eyes. Observe what happens. The right eye ceases to squint, and the left turns in. This is called the secondary squint. Often on removing your hand the eyes remain in this position for a time. On covering the left eye, the primary squint is at once restored. Make the squint alternate a few times from one eye to the other, and you will readily perceive that the amount of deviation in the left eye is the greater of the two. At first sight this seems contrary to expectation, but the explanation is simple enough. When he uses the left eye the squint in the right is caused only by the unbalanced tone of its internal rectus. But when he tries to use the right eye he finds that he must strongly exert the external rectus to get it to the middle line; that is, he must perform the movement of looking to the right. Now, in looking to the right, an equal impulse is given to the right external rectus and left internal rectus. Neither of them can be used alone. The right external rectus in this man responds feebly, or not at all, to the impulse, and therefore turns very little, the left internal rectus responds normally, and turns a great deal.

In the figure, A and A^1 represent the directions of the visual axes in a normal case. In paralysis of the right external rectus, the primary squint is represented by the angle A R B. If covering the left eye had made it revolve only through the angle A^1 L B^1, the primary and secondary squints would have been equal. But the left eye rotates through the angle A^1 L C, while the right rotates through B R A. Therefore the secondary squint equals the primary *plus* the difference in the mobility of the two eyes.

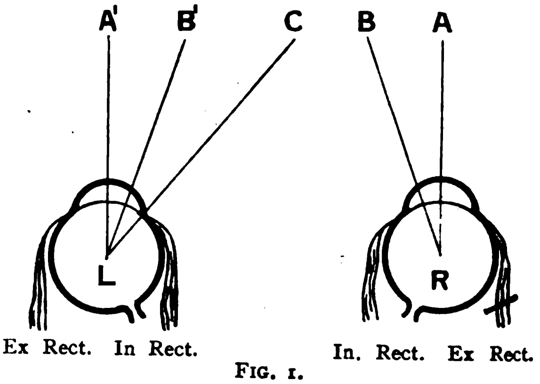

Fig. 1.

Sometimes the patient prefers to use the paralysed eye because its vision is better, or simply because it is the "master eye." He then produces a secondary squint in the sound one In such a case the patient and his friends think that the lesion is in the sound eye, and the medical adviser may make the same mistake unless he makes the squint alternate. The eye that squints *least* has the paralysis.

The patient complains of diplopia, or double vision. To reduce this as far as possible, he often carries his head turned to the paralysed side, which necessitates his turning the eyes the opposite way, reducing the squint thereby to a minimum.

Paralytic squint may come on at any age. There is often a history of syphilis, rheumatism, or tubercle.

3.—Concomitant convergent strabismus.—This is by far the commonest kind of squint. It is called concomitant because it does not increase or disappear when looking to one or other side, but *accompanies* the eye in a fixed degree in all its movements.

The vision of the squinting eye may be as good as that of the sound one, but is usually much worse. This may not be known by the patient or friends. It is well to point this out before performing an operation, otherwise it may be very naturally supposed that you have damaged the eye. Nothing can be seen by external or ophthalmoscopic examinations to account for the defect of vision. The primary and secondary squints are equal. In the vast majority of cases there is no diplopia, even where the vision of each eye taken separately is normal. In those rare cases where diplopia exists it does not trouble the patient, because it is only by a conscious effort that it can be perceived. This form of squint comes on in childhood, usually between the ages of 2 and 5 years. It is not associated with any constitutional disease. It is sometimes periodic—*i.e.*, it is only occasionally present, and comes on when the patient is trying to see anything accurately; or it may be alternating—*i.e.*, though always present, it is sometimes in one eye, sometimes in the other.

Donders made rational treatment possible by the discovery that internal squint is associated with hypermetropia. Fig. 2, though somewhat fanciful, will help you to follow the explanation. A pair of normal eyes, when looking at an object at six or more metres distance, will have their visual axes practically parallel, and will look along the lines D and D^1, but if the object is one metre distant, the visual axes will converge one metre angle. If the object is at half a metre, the eyes converge twice as much—*i.e.*, two metre angles, at one-third metre, three metre angle, and so on. Again, the normal or emmetropic eye is naturally focussed for distance, and requires to make no effort to see clearly. But, as the object approaches the eye, the latter must accommodate one diopter at one metre, two diopters at half-a-metre, and so on. It is therefore evident that to see an object clearly at any given distance the eyes must accommodate a certain number of diopters, and must at the same time converge the same number of metre angles Now movements that invariably occur together are governed by a common co-ordinating centre.

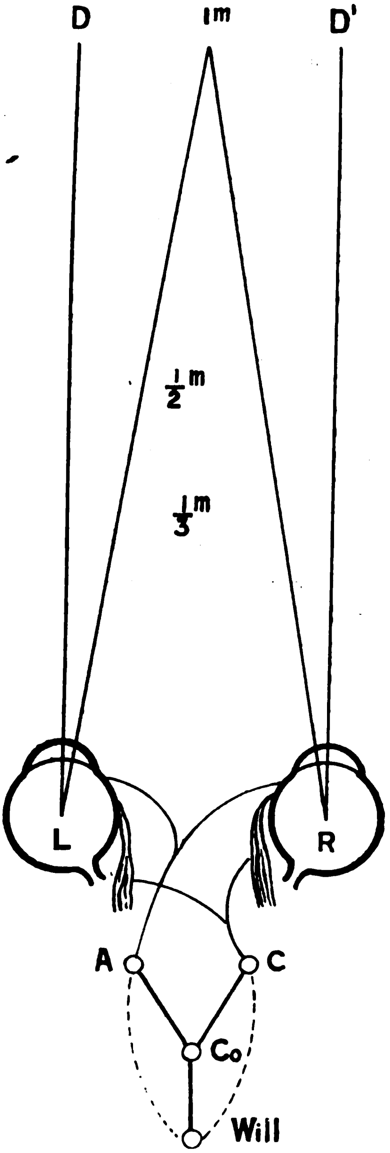

Fig. 2.

Now, if you "will" to look at a near object, an impulse passes from the cortex to the co-ordinating centre for near vision Co. It is here broken up into two impulses, which pass (1) to the centre for accommodation, A, and thence to the ciliary muscle, (2) to the centre of convergence, C, and thence to the internal recti of each eye.

Let us suppose that we are dealing with a case of hypermetropia, say, of three diopters. When looking at a distant object, it is necessary, if both eyes are to be employed simultaneously, that the visual axes must remain parallel. The converging centre must therefore remain passive. But as the accommodating centre is associated with it, it must also remain passive. The vision is consequently blurred because the image tends to fall behind the retina. Acute vision can only be obtained by focussing three diopters. But this necessitates a convergence of three metre angles—that is to say, the visual axes meet at one-third of a metre in front of the patient's face, and from thence diverge to either side of the object. The patient, while maintaining this convergence, can look to the right until the visual axis of the right eye cuts the object. The left eye now appears to be turned very much in, or he may look to the other side till the left eye looks at the object and the right appears turned in. If the vision of the two eyes is much the same, it is a matter of indifference which he uses, and the squint alternates. But if there is a difference, he selects the better eye to look with, and the squint becomes fixed in the other.

The patient is in this dilemma. If he is to retain the advantage of binocular vision he has to put up with blurred vision from insufficient focussing. But if he must see clearly he can only use one eye. For the first two or three years of life he adopts the former, but when he begins, as his mother says, to "notice" things, he prefers the latter. At first the squint is periodic. It then becomes more and more frequent till it is permanent. At the beginning it is entirely spasmodic, but ultimately, from the habitual faulty position, it becomes organic.

Donder's theory is proved by the effect of suitable convex glasses. These remove the necessity for excessive accommodation. Excessive convergence therefore ceases at the same time. In an early case a marked diminution of the squint is instantly produced by the proper spectacles, and it may completely disappear after wearing them continuously for a month or two. Cases of old standing, in which the squint has become organic, cannot be cured by glasses, but it is always diminished by their use. This is quite evident by measuring the angle before and after with the perimeter.

The interesting question now arises: Why do the great majority of hypermetropes not squint? There are several reasons:—

(1) The two dotted lines in Fig. 2 are meant to indicate that the will can reach either the centre for accommodation or for convergence, without going through the co-ordinating centre. Place two prisms of 12° in a trial frame, base inwards, and read through them at quarter-metre distance. You have to focus four diopters, but the direction of the light is so altered that your visual axes remain parallel. You are using the centre for accommodation alone. Your eyes after a time feel tired. The fatigue is due to the resistance which is offered by this unusual path in the brain. Conversely, if you put on a pair of strong convex glasses, which do away with the necessity of accommodation, you have to employ the centre for convergence alone. In this case also your eyes get tired. The amount of convergence or of accommodation that can be exerted independently of the other varies in different individuals. If a hypermetrope is able to exert the excess of accommodation required, and has the instinct for binocular vision, he is impelled to make the effort. An impulse by an unusual route at first passes with difficulty, but by constant repetition passes with increasing ease. The great majority of hypermetropes are able to make the effort, and thus avoid squinting, but many are never able to do so with perfect ease. They suffer from asthenopia, and require to use convex glasses.

(2) In the lower vertebrates, such as the fish, the visual axes diverge about 180°, so that each looks directly outwards. In the process of evolution they come to look more forwards, till in the higher mammals they are parallel when at rest, and can be made to converge for near objects. The orbits, however, in all, including man, remain somewhat divergent. Hansen Grut made a large number of observations in the dead subject, and found divergent strabismus very frequently in persons who had no squint during life.

The same has been observed in persons under deep narcosis. This condition of latent divergence is very common in hypermetropes. If a person has, let us say, three metre angles of divergence and three diopters of hypermetropia, he must employ three metre angles of convergence and three diopters of accommodation to obtain parallelism of axes and perfect retinal images. He can then proceed further with a proportional increase of each, to see near objects. But all this is easily done, because it is carried out by the normal mechanism of the co-ordinating centre. Both latent hypermetropia and latent divergence are, as a rule, masked by continuous muscular action. As it requires atropine to reveal the first, so chloroform will unmask the other.

(3) The binocular instinct: When one looks directly, with parallel axes, at a distant object, an image of it is produced on each macula, yet the mind perceives only one object. We say that the two images are mentally fused into one. If the object is now moved nearer along the axis of one eye, its image will still be formed on that macula, but the image in the other eye will be to the outer side of the macula. These two images cannot be fused, and diplopia is produced. In normal cases the dislike for diplopia, or the desire for fusion, is so imperative that before the individual is consciously aware of diplopia he has converged enough to bring both axes to bear on the object. However rapidly an object is moved, vertically, horizontally, or to and fro, if it is followed by *one* eye, it is followed by *both.* This instinct has been shown by Worth to have begun between the sixth and twelfth months, and it will overcome any tendency to squint from hypermetropia or any cause other than actual paralysis. Its development, however, is sometimes delayed. If a squint should come on at this stage, the patient never gets a chance of producing fusion, and the instinct is never acquired. If the squint is removed, the binocular instinct can be restored up to the sixth year.

(4) An incomplete power of suppression. All sensory impressions can be more or less suppressed, *e.g.*, in a Babel of conversation in a crowded room, one can converse with his neighbour, and, if sufficiently interested, will hear no one else. A patient with diplopia must give his *attention* to one image at a time. But the other image forces itself upon his notice, causing great confusion and distress. If an adult acquires diplopia, he can never completely suppress the false image as long as he lives. But children up to six years can very quickly learn to suppress. Though they may have fairly good vision in each eye separately (the other being covered), yet, when both are open, the squinting one is to all intents and purposes blind. After a time the act of suppression becomes so habitual that the patient is unable to avoid exercising it, even when the other eye is covered. Even in comparatively young children the vision of the squinting eye is often reduced to the counting of fingers at a metre or two. On the other hand, you may find cases much older in which the vision is very much better. The presence or absence in a greater or less degree of the power of suppression is therefore an important factor in determining whether a squint shall occur or not. If the squint is to remain untreated, this faculty is an advantage to the patient. But it is a most fatal gift to those whose eyes have been made practically straight, but in whom suppression has become a permanent habit. It, of course, renders binocular vision impossible.

Let us now pass briefly to treatment.

(1) In mechanical squints remove, if possible, the cause.

(2) A paralytic squint may resolve with or without the help of constitutional remedies even after six months. It is therefore safer to defer an operation till a year after the onset. The paralysed external rectus can then be advanced. This will help the patient to see single without having to turn his head so much to one side. But he will still have diplopia when looking to the paralysed side.

(3) In concomitant squint don't think of a tenotomy the moment you see the case. On the other hand, never send a child away "till it is old enough." The younger the child is, the more you can do for it.

Choose spectacles by retinoscopy under atropine, deducting half a diopter. Glasses should be worn constantly except in bed till the case is finished.

Prevent deterioration of sight in the squinting eye. Where the sight is already very bad, it may be wonderfully improved by bandaging the good eye for even a few days. It is usually sufficient to keep the good eye under atropine. The child is thus encouraged to use the bad eye. Its vision improves, and may even become the better of the two In this case the squint goes to the other eye. The atropine should then be stopped, to be resumed again in either eye as required.

The angle of the squint should be measured at the first visit and at intervals of a month or so afterwards. As long as it keeps decreasing, trust to the spectacles, and prevent loss of sight in the bad eye.

When no further improvement seems likely, an operation should be performed.

The space at my disposal is now exhausted, but I would advise all who would undertake the cure of squint to consult some special work on the subject. I know of no better guide than "Worth on Squint." His method of fusion training should be specially studied.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Albert Robin, M.D., of the Paris Academy of Medicine. Subject: "The Medical Treatment of Phlebitis."*

ORIGINAL PAPERS.

ON ARREST OF
POST-PARTUM HÆMORRHAGE.

By Dr. G. de G. GRIFFITH,

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I wish to bring under prominent notice a method of treatment recently begun to be referred to, which I have practised since the sixties, without once having had to abandon it for any other. Before I commenced, I remember we used to follow the then plans resorted to, some of which were subsequently changed for others, as one or more failed to check the hæmorrhage. I need not here recount the many methods, but will immediately state the treatment to which I would call attention.

It is the *compression of the abdominal aorta above its bifurcation.* The compression may be made in two ways: one by laying the fingers of the left hand on the thumping aorta, and compressing it against the spine, the fingers being laid over one side of the aorta, and the thumb over the other, the right hand grasping the uterus and making it contract as much as possible. Sometimes it may be necessary to use the fingers of both hands with the thumbs on the opposite side, and thus compress the aorta against the spine, while also narrowing its calibre by pinching the vessel, the uterus not being held or compressed at all. In some instances I have let the person who was "controlling" the uterus in the ineffectual effort to stop the hæmorrhage before I arrived continue to grasp the organ till I had completely arrested the flow by the aortic compression.

In some cases the left hand, grasping in its hollow the uterus, the edge of the palm of the hand can compress the aorta against the spine, at the same time keeping the uterus contracted in the hollow of the hand, the blood supply to the bleeding part being thus shut off entirely, for all purposes of staunching the hæmorrhage. In many cases I have found catching the aorta between the fingers and thumb just above its bifurcation sufficient to arrest hæmorrhage.

For years I found the foregoing methods sufficient, but in one case to which I was called the hæmorrhage was very severe—had been, before I reached the patient—and as I did not succeed in stopping it at once, it was proposed to use Dr. Atthill's 120° hot water douching. While waiting for the hot water, it occurred to me that the cause of my failure was that the branches given off above the point where I was compressing were large enough to supply the uterus. I therefore shifted the fingers higher, with the happy result of arresting any further loss, except that which was in the uterine cavity and in the uterine sinuses. By thus cutting off the blood supply, there is no need of any other method being adopted to keep the blood to the brain and other vital organs in the upper part of the body except the lowering of the head. Indeed, in cases of almost fatal collapse from forms of hæmorrhage other than post-partum, I have compressed the aorta so that the passing of blood to the lower half of the body could not be felt by the fingers, and thus, as well as by rolling the aorta, when pinched between finger and thumb—and so giving pain—revive the patient, when the pulse could not be felt at wrist, or temple, and but very feeble at carotids.

The question has been asked me: Will you use this plan in all forms of post-partum hæmorrhage? My reply is: Yes, in all forms, be it from uterine inertia, or from tears in the uterus, or any part of the genital tract. For years I have never given a dose of ergot, or any such drug, nor brought with me any means whatever of arresting hæmorrhage, knowing that all I needed were my hands, and not once has there been a failure—much more, a death—though I have been summoned when collapse was severe.

Some years ago, before his death, the late Mr. Cooke, of Westminster Hospital, whose anatomy school our lady students used to attend, on being told by them that I arrested hæmorrhage by compressing the aorta, said: "Oh, but if he arrests arterial, he will cause venous hæmorrhage, because he would be compressing this large vein"—showing them the vena cava. My reply was, and is, theoretically this may be so, clinically and practically it is not.

I have been asked, "Do you stop it at once?" "Yes, within half-an-hour or twenty minutes." When the compression is first applied, there will be some bleeding until you fix the aorta, and close it completely, and then the very irritation set up by compression or by pinching and rolling the aorta about, makes the uterus contract, and squeeze out any blood in its cavity or in its substance. I have always arrested it so quickly that I have never had to get anyone to relieve me because of being tired.

Here I may mention that the pulse at wrist, temples, or anywhere else, is no indication of the aortic pulsation. Sometimes the pulse at other parts can scarcely be felt, while the aorta is thumping violently. This holds good of other hæmorrhage than post-partum. Any severe rectal bleeding may in this way also be controlled, and were the femoral or other arteries of the leg bleeding, this compression would staunch the flow till the bleeding vessels were ligatured.

The compression after the birth of the child is exceedingly easy, the patient being on her back, and, if necessary, the knees well drawn up, the hand or hands are very readily buried in the abdominal cavity, where the aorta is plainly felt, as a rule pulsating vigorously; the intestines offer no obstacle to the compression, as some have said to me they would.

Before removing the fingers or the hands from the aorta, I lift one finger after another slowly—the vulva having been well dried by the nurse, and a clean diaper placed against the parts—and watch to see if the hæmorrhage be quite checked. If so, I cease the compression, but, if not, I renew it, till all loss has ceased.

I may here say that while exercising the compression the violent pulsating of the aorta seems to subside, as the pulses return to the various sites where usually felt.

Another method of arresting post-partum hæmorrhage I found also easy and effective—viz., following down the uterus into the pelvis, and grasping it for a while in this situation, and then, well burying the hand in the pelvic cavity behind the uterus, pushing the uterus as much as possible forward and compressing it against the pubes. In this way also I have arrested post-partum hæmorrhage readily and completely.

For years I have thus taught the ladies studying to be medical missionaries, and shown them that they need not be alarmed at the very worst forms of hæmorrhage if, in their very often isolated situations, they have no other appliances or help than their own hands.

Here I wish to cite a case of hæmorrhage from the carotid occurring after removal, by Dr. Wylie, of the Central London Throat and Ear Hospital, of tuberculous glands from the neck.

The hæmorrhage burst out while the patient was asleep, and evidently she was awoke by the loss. Putting her hand to the dressing, she found it soaked with blood, and woke up the nurse by her. I was sent for, and went at once with Dr. Price. The loss had been so sudden and so great that it seemed as though it would be fatal before the bleeding was staunched. The patient was unconscious, and in what seemed to be a fatal faint from heart-failure.

While Dr. Price undid the dressing and proceeded to stop the hæmorrhage, and while other restoratives were being got ready, I pinched the aorta high up above its bifurcation, and, knowing it gave pain, I rolled it about. The blood supply was shut off from the lower half of the body completely, and kept for heart and brain, and for cardiac and respiratory centres. The patient's pulse at the wrist came back, and she showed signs of feeling the pain I was giving her. She opened her eyes, and, in response to my question, "Do I pain you?" signified that I did.

By slow degrees she came to, and all immediate danger was averted. Had we not been thus enabled to act, the result must have been fatal.

In the most recent book on obstetrics, namely, "Rotunda Practical Midwifery," by Dr. Tweedie, the Master of the Rotunda Hospital, and Dr. Wrench, the Assistant Master, at p. 292, this mode of treatment is very briefly referred to under the head of "Other Methods of Stopping Severe Post-Partum Hæmorrhage:—

"(1) By compression of the aorta: You certainly can stop bleeding by direct pressure on the aorta from the abdomen. We have used this pressure in urgent cases, *when things were not ready*."

At p. 293 occur these few words: "If very urgent, either compress aorta or plunge the hand into uterus."

Dr. Jellett, ex-Assistant Master of the Rotunda Hospital, says in his book, "A Short Practice of Midwifery":—

"Compression of the aorta has also been recommended, and it is undoubtedly of value, if we have an assistant capable of performing it. It is of use while we are adopting local measures for checking the hæmorrhage, as it is at the uterus itself the bleeding must be finally checked."

Mr. Stanmore Bishop also advocates this method, and Dr. Fothergill confirms the value of the treatment in his "Manual of Midwifery," where he says:—

"The merits of this treatment possibly have not been tested by those whose teaching and opinions constitute obstetric 'authority.'"

SEXUAL HYPOCHONDRIASIS

AND AFFECTIONS OF THE MALE GENITAL ORGANS OTHER THAN VENEREAL.

By FREDERICK W. LOWNDES,

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Most medical practitioners are consulted from time to time by patients who complain of what they believe to be diseases more or less serious, or at least symptoms of such. These persons are found on careful examination to be in perfectly good health, their ailments being grossly exaggerated, or purely imaginary. They are the most unsatisfactory patients with whom we have to deal. Those practitioners who have for many years seen much of venereal diseases, are by a strange perversity consulted by persons who are firmly convinced that they are the victims of these diseases. Hence the terms "syphiliphobia" and "sexual hypochondriasis." Many years ago a surgeon came from a distance to ask my advice. He believed that he was suffering from syphilis, though he failed to give any history of infection, while there was absolutely no indication whatever of the disease. I failed to convince him of his error, and advised him to consult the late Mr. Berkeley Hill, who also failed to persuade him that he was wrong. He was in practice as a surgeon, and on all other points was perfectly rational. A patient whom I had treated for gleet went to America. He there saw a doctor, who treated him for syphilis, and also told him, after he had paid £20 in fees, that he would require six months more of treatment with additional expense. He decided to return to Liverpool and to see me. On learning his story, which he gave very clearly, I found that there was no proof of any primary infection, and no symptom of syphilis. He assured me that the doctor was a fully qualified one, with American degrees. Though he had perfect confidence in me, he was reluctant to believe that he was really free from the dread disease, so, as he was leaving for London, I advised him to consult Mr. Berkeley Hill. That gentleman afterwards wrote to me that he also had much trouble in reassuring my patient, whom he described as "erratic." He certainly was, in more senses than one. These cases are not numerous, and will probably become comparatively rare.

Sexual hypochondriasis comprises a very large class, both of maladies and patients. I will only notice the more important. Many patients refer their ailments to evil practices committed in boyhood. During the early part of last century it was customary for parents of the upper and middle class to send boys at the age of five to preparatory boarding schools. Among the boys there were some precocious ones, the precocity being unfortunate for him and other boys. The result was well expressed by one who spoke from sad experience. "I learned very little good and much that was very bad." The old Latin saying, *Humanum est errare*, is manifest in some boys yet in infancy. After leaving the preparatory school, these boys went to other boarding schools more distant. Thus parents and sons were separated from childhood to early manhood, with a few weeks' interval at Christmas and Midsummer. A probable reason for what now seems a most reprehensible form of education is, that in those days early marriages and large families were the rule, and not, as now, the exception. These patients are often very difficult to treat. They have read the bills and pamphlets of advertising quacks, whom they have also consulted, paying most exorbitant sums. They then consult a regular medical practitioner, who will, they hope, cure them for a small recompense or none at all. Many of these cases are greatly exaggerated, and a cure may be expected if the patient will follow advice and refrain from brooding over the past. In other cases it is too late; the patient will not settle down to any employment, and is a confirmed hypochondriac, if, indeed, his brain has not become affected. Some years ago an old friend sent me his son for advice. He had acquired evil habits at school; they had become ineradicable; he would not do any work; he spent all his time in consulting quacks, reading their literature, and his state was deplorable. A specialist in mental diseases had pronounced the case hopeless, and I was obliged to confirm this. He was sent to an asylum, where he died soon after. Very recently a man, æt. 35, came to consult me. He gave me a very candid history, but the expression of his face would have sufficed. His father called at my request, and stated that his son's conduct had almost ruined him. Time after time he had obtained employment for him, but it was soon given up, and the unhappy man remained idle at home, a curse to himself and to all around him. It was a sad, hopeless case, the worst features being the entire absence of any sense of shame on the son's part, and the want of all parental control on the part of the father. I have seen and heard of many other cases in adults. It has been suggested, and with much reason, that the evil habit may be regarded as symptomatic of softening or other form of brain disease. It ended so in several cases I saw in addition to the one I have mentioned, and I do not see why this more charitable view may not be the correct one.

More satisfactory patients are those who come to consult us as to the propriety of their becoming married. Some are young men who have hitherto led a continent life, and doubt their capacity to perform their marital duties. In most of the cases their fears are groundless, the genital organs being in a perfectly normal state, while the patient admits having erections and periodical nocturnal emissions. It is remarkable how timid these patients often are, and I cannot help regarding this as a probable explanation of the frequent suicides of bridegrooms-elect shortly before the day of their intended marriage. In other cases the patient has indulged more or less freely in promiscuous sexual intercourse, and feels uncertain whether he ought to marry. In all these cases much may be done by judicious advice and proper treatment. Those men who have led a continent life may be assured that such is the best preparation for marriage. As the late Sir James Paget stated in his lectures to students (a):—"Chastity does no harm to mind or body; its discipline is excellent; marriage can be safely waited for." The late Mr. William Acton, who for many years practised as a specialist in syphilis and venereal diseases, generally enjoined strict continence before marriage. I met him when he visited Liverpool in 1874, and in London in 1875, shortly before his sudden and lamented death. He had just completed and published the sixth and last edition of his work, "The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life." In the preface to this last edition he wrote:—"In conclusion, I would fain indulge the hope that the book may continue to exert, as I trust it has already exerted, some good practical influence upon public health and public morals." That this hope has been realised may be judged from the fact that, though 32 years have passed since the author's death, his book continues to be published and has a steady annual sale. It is still to be obtained from Messrs. J. and A. Churchill, of London, and will well repay perusal by both medical and lay readers. Since it was published I have always kept a copy to show to patients to whom I have recommended its purchase. Many men, young, middle-aged, and elderly, have adopted the suggestion, and have thanked me for it. It is specially useful for those men I have indicated as having led continent lives and who are contemplating marriage. They will find all the information they require, and good advice for their future life.

In the case of men who have not led a continent life, great care must be taken to ascertain whether they have suffered from syphilis, and, if so, whether it has been properly treated with mercury. Great caution must also be taken to ensure that a sufficiently long interval has elapsed since the last appearance of any symptoms of constitutional syphilis, as to make it absolutely impossible to infect the wife or unborn child. However incredible it may appear, I have been consulted by men with primary sores on their genitals who wished to have my sanction to their marriage. This was necessary in order to obtain a situation. It is needless to add that I not only refused my sanction to the marriage, but also to any suggestion made by patients for preventing infection. Proper treatment, perfect cure, and a sufficiently long interval—these, and these only, were the conditions with which I could be satisfied before giving my sanction.

It is pleasant to turn from these cases to those in which our consent may be freely given, and to see them followed by happy marriage.

I pass on to what is the most delicate and difficult point to be considered. In the paper previously referred to, Sir James Paget remarked:—"Many of your patients will ask you about sexual intercourse, and some will expect you to prescribe fornication." He proceeds:—"I would just as soon prescribe theft or lying or anything else that God has forbidden. If men will practise fornication or uncleanness, it must be of their own choice, and on their sole responsibility." These outspoken words of the illustrious surgeon who visited Liverpool at the opening of the Royal Infirmary in 1890, have been endorsed by many leading London and provincial physicians and surgeons. I give them because some clergymen and laymen have told me of some medical practitioners who have been so unwise as to give a contrary opinion. I can only express my conviction that this is very exceptional. It is unhappily too true that many of the men who consult us are not, owing to various causes, open to religious influence, and are unwilling to admit the possibility of living a chaste life. But however forlorn our hope may be we must do our duty. There is an old Lancashire word, "jannock," *i.e.*, downright, straightforward; and, as I have frequently told patients, it would not be "jannock" for me to recommend a course which might expose them to infection. That "continence hath its charms," negative and positive, is a truth known to none more than medical practitioners, who know the large number of men whom lust claims as its victims. There are more continent men than is generally believed, and I can remember even among that much abused class, medical students, many who lived perfectly pure lives.

(a) "Clinical Lectures and Essays, 1875," Sexual Hypochondriasis," p. 986.

The late Charles Kingsley is perhaps better remembered as the novelist than the learned divine, Canon of Westminster Abbey and Rector of Eversley. Yet no man was more bold and outspoken in his denunciation of vice than the author of "Westward Ho!" More than half a century ago he described the position of a young gentleman who had passed his youth at a public school and his manhood at one of the universities. No warning had been given unto him of the temptations to which he would be exposed. In his tale "Yeast," Kingsley observes:—"Love had been to him practically ground tabooed and carnal. What was to be expected? Just what happened—if woman's beauty had nothing holy in it, why should his fondness for it? Just what happens every day—that he had to sow his wild oats for himself and eat the fruit thereof and the dirt thereof also." The author proceeds to condemn strongly fathers of families and his own brother clergy for being to a large extent the cause of this. I need not repeat it, as the times have changed, and it is a far cry from the year 1851 to the present year. I have given priority, as was due, to the leading members of the profession to which I belong; next to the views of a prominent clergyman. I will add the words of the late Thomas Hughes, the learned member of Lincoln's Inn, best and most manly of all writers for boys and men. Following Kingsley ten years later, the author of "Tom Brown at Oxford" wrote: "In all the wide range of accepted British maxims there is none, take it for all in all, more thoroughly abominable than this one as to the sowing of wild oats. Look at it on what side you will and you can make nothing but a devil's maxim of it. What a man—be he young, old, or middle-aged—sows, *that*, and nothing else, shall he reap. The one only thing to do with wild oats is to put them carefully into the hottest part of the fire and get them burnt to dust, every seed of them. If you sow them, no matter in what ground, they will come up with long, tough roots like couch grass, and luxuriant stalks and leaves, as sure as there is a sun in heaven—a crop which it turns one's blood hot and cold to think of. The devil, too, whose special crop they are, will see that they thrive, and you and nobody else will have to reap them; and no common reaping will get them out of the soil, which must be dug down deep, again and again. Well for you if with all your care you can make the ground sweet again by your dying day."

Forty-six years have passed since these plain words of Thomas Hughes were written, and though great changes have taken place in our manners and morals since then, they will apply even to the present day. In bringing this subject before my professional brethren, and with more than forty years' experience as a surgeon, I am most anxious to keep the happy medium between optimism and pessimism. That there have been changes for the better in Liverpool within the last half century is a fact to which I can bear testimony. The "social evil" then existed to an extent, and in so aggressive a form, that it had to be suppressed. The state of morals was then very low among young men of all classes, and prostitution was rampant in the streets. In 1871 the provisions of the Vagrant Act against prostitues, which had fallen into abeyance, was reinforced, and the streets became more orderly. Brothels and houses of accommodation have been dealt with, and almost entirely suppressed. These changes cannot fail to have a good effect. There is also a better moral tone among young men of all classes, vice being no longer regarded as manly, its tendency to degrade men, even more than intemperance, being shown every day. There is also a great reduction in the prevalence, also in the severity of diseases, the result of "illicit" sexual intercourse. Young men in business, who wish to adopt the Latin motto "Excelsior," or the French *noblesse oblige*, can attend evening classes at the university and elsewhere. There are also the gymnasia and the volunteer drill for those who prefer an athletic life.

But while fully recognising all these improvements, for which we ought to be very grateful, I must not omit the other side and see what remains to be done. It is as remarkable as it is to be regretted that fathers do not warn their sons against what may lead to impurity. There is a growing tendency to keep boys at home in their early years, sending them to one of the excellent schools which Liverpool possesses, and of which we may be proud. In all homes where the ordinary decencies and proprieties of life are observed, cleanliness is the rule enforced by parents. The old jug and basin of former times is now replaced by the entire morning bath. Boys ought to be taught to wash their genital organs as much as their face and hands. Those who have a long and narrow prepuce should be circumcised, and I am glad to learn that this operation is more generally adopted. Those boys whose foreskin can be drawn back ought to be taught to do this, and to wash it thoroughly every morning and every night before going to bed. For want of this many boys annoy their parents, teachers, and others in authority by fingering their privates, owing to the irritation caused by the accumulation of the smegma. Some will urge the danger of directing boys' attention to their privates as likely to lead to evil. The danger consists not in cleanliness, but in dirt; not in the knowledge but in the ignorance of sexual subjects. There are among the profession and laity many who know by experience the untold misery and suffering caused by such ignorance. "If I had only known when a boy what I know now, when it is too late," has been said to me by men of all ages.

While I have not ignored the changes for the better in Liverpool, I cannot regard the present state of society without apprehensions for the future. Marriages are on the decline, and, as a necessary corollary, so also are births. To a large proportion of our male population marriage is impossible till middle age, while many can never marry at all. Single life has its honourable side as well as marriage. Many men have deferred or even renounced marriage in order to provide a home for father, mother, brothers, and sisters. All honour to them for it. Other men prefer to remain unmarried for good and sufficient reasons of their own. But the large proportion of unmarried men in this city is an element fraught with danger, and to this must be also added another. The "social evil" is now assuming the insidious and dangerous form of clandestine prostitution, while many girls and young women on the borderland between virtue and vice are to be seen in the streets every night under circumstances and amid surroundings terribly suggestive of a sad future for some, if not all of them. (*a*) I have written nothing to excuse or sanction what is immoral. I have the greatest sympathy for the many men who through no fault of their own but through dire necessity are practically denied the blessings of married life. Even more do I feel for the much larger proportion of women who remain unmarried, knowing as I do the truth of the words of a *confrère*, "The world is a very cold world for single women." It was in Liverpool that Felicia Hemans, the poetess, who gave to the world "The Happy Homes of England," first saw the light. I live in hope that the various causes which have led to the diminution of marriages and births may be removed. The English home with its

> "Life's darling divinities,
> Time-honoured children and wife"

has the merit of being an ancient institution. May we hope that it will be equally enduring?

(*a*) See Report of the Head Constable for 1906, pages 32 to 35.

ON ASCITES RELIEVED OR CURED BY PARACENTESIS. (*a*)

By FRANCIS HAWKINS, M.D., M.R.C.P.Lond.,

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Mr. President and Gentlemen,—In bringing before you the subject of ascites and its treatment by paracentesis, I cannot introduce to your notice that which is new as regards the method of treatment; indeed, from the very earliest times, paracentesis has been performed in cases of ascites. Erasistratus, of the Alexandrian School of Medicine, did not approve of this method of cure, for he thought the ascites arose from disease of the liver, and that so long as the liver was diseased the waters would accumulate again and again; but Aulus Cornelius Celsus, who flourished in the reigns of the Emperors Augustus and Tiberius, not only recommended that the fluid should be removed by paracentesis, but went a step further when he adds, "This is not a method of cure suitable to every case."

But I will leave a further consideration of these very early writers and come to the time of Sydenham, who, however, does not appear to have valued the operation of paracentesis as a method of cure, for he writes in 1683, "In my opinion—the operation of paracentesis, commonly called tapping, which some practitioners commend, is not less hazardous or more successful than blisters." It is here of interest to note that Sir Theodore Mayerne, a cotemporary of Sydenham, makes no mention in any of his works of paracentesis as a method of cure, or indeed as being performed in cases of ascites. In the days of the celebrated Mead—who, by the way, had his country seat near Windsor, to which he used to be driven in his carriage drawn by six horses—this operation had fallen into great disrepute. Mead states that physicians were often adverse to this operation because the abdomen fills up again, and because, if all the water is drawn off at once, the patient dies; but Mead also points out that such result may be prevented if a binder is placed around the abdomen and kept tight during the process. He records a case of a lady on whom this operation was performed in 1705. After being once tapped, the abdomen was covered with a flannel dipped in spirit of wine, and a bandage tightly applied; there was complete recovery. Mead also states that he knew of many cases whose lives were not only prolonged, but made easy. One of his patients left directions for the following to be placed on her tomb:—

"In LXVII. months she was tapped LXVI. times. Had taken away CCXL. gallons of water without ever repining at her case or ever fearing the operation."

Sharp also wrote in favour of the operation in 1729, and says that, "Though it does not often absolutely cure, yet it sometimes preserves life a great many years." But it is clear that the operation did not continue in favour, for we find Fothergill, in a paper read in 1768, saying that few patients can bear the name of tapping without apprehension or terror, and, further, he writes "That tapping has incurred some part of its disgrace from its being delayed till it could have no other effect than procuring a very short-lived hope to the patient." Fothergill advocated the operation being performed as early as possible, and he quotes cases when recovery had taken place after early paracentesis. Fothergill's paper, however, did not increase the reputation of the operation; but we find Heberden, in 1806, referring to the fact that "it is often necessary to let out the water of the ascites by tapping, but there have been very few instances when the water has not gathered again." Mason Good, in 1825, writes:—"We can often very advantageously draw it" (the ascitic effusion) "off at once by tapping"; and he adds, "various cases have fallen to his lot in which a radical cure has only been completed in this manner." Darwell, writing in 1833, was by no means in favour of the operation of paracentesis. He writes:—"We have frequently had patients tapped. . . . In all these instances, however, the effusion rapidly recurred, and, upon examination of several after death, the bowels were found adhering by old depositions of coagulable lymph." He, however, admits that recovery does take place in rare cases even after repeated tappings. Since this date many cases have been published. Hence Dr. Tanner, in 1854, in the case of a woman in the Hospital for Women in Soho Square, performed paracentesis four times, when there was no recurrence of fluid; the patient died two years later; and in 1859 Dr. Banks recorded a case of ascites where recovery occurred after tapping.

But there was at this time a strong disinclination to perform paracentesis. Flint, of New York, wrote in 1863 a paper entitled "A Clinical Report on Hydroperitoneum," based on an analysis of forty-six cases, proving that dropsical effusion may be removed, and a re-accumulation not occur for a greater or less period. In 1872 two papers appeared in the *Practitioner* on "The Treatment of Hepatic Dropsy," and the different views expressed at that time are of such interest that I venture to quote them. In the paper written by the late Dr. Basham, venesection from the arm, as also drug treatment, was recommended, and then, "when the urine becomes scanty, the breathing oppressed, the lower extremities anasarcous, and the loose tissues of the scrotum and penis infiltrated with fluid, the time has arrived for tapping." The other paper is by one still living, known, respected, and honoured by all—Dr. Frederick Roberts. He writes:—"I now come to the most important part of the paper, which is to advocate the early and, if necessary, repeated performance of paracentesis abdominis in appropriate cases of ascites. There cannot be a doubt that this operation is generally looked upon with much dread, and that it is only performed with the view of giving temporary relief, whereas it may be safely employed as a means of permanent cure so far as the ascites is concerned." Valuable as this paper was, it, I fear, did little more to bring the operation of paracentesis into good report than did the earlier writings of Mead or Fothergill, for though we find isolated cases published, notably by Dr. Lyons, of Dublin, and Dr. McCrea, of Belfast, yet Flint, writing again in 1883, thought it necessary to point out the objections held to early paracentesis, although he himself advocates it, and says that he had, ever since his first paper in 1863, pursued this course of treatment, and he adds the results have appeared to confirm its utility. Some nine years later Bristowe, in a paper read before the Medical Society of London, advocates early tapping in cases of ascites due to liver diseases without waiting for extreme distension, and he records several cases thus cured. Later in the same year Cheadle, in a paper "On the Prognosis and Treatment of Ascites," says that the only effectual plan of removing ascitic fluid in hepatic disease is by paracentesis, and he is convinced that the postponement of the operation until urgent symptoms arise is a grave error.

I will now bring to your notice some cases of ascites that have been under my own care, and when effusion of fluid has subsided after paracentesis. These cases have, with one exception, been under my observation for some years, and the results obtained will confirm the opinion and the teaching of Celsus, Mead, Fothergill, Flint, Frederick Roberts, Bristowe and Cheadle.

Case I.—Paracentesis performed once; patient in good health eleven years after.—F. G., æt. 21, a domestic servant, came under my care in December, 1895. She had always had good health until the previous September, when she had dragging pains between the umbilicus and the symphysis pubis whenever she lifted anything, and about December 3rd she noticed that the abdomen was getting larger. This enlargement gradually increased, and on December 20th she first noticed that her feet and legs were swollen and that she passed less urine. The bowels had always been regular; never any diarrhœa. The periods were also regular, the last having occurred one week before admission. There was an indefinite history of tuberculosis in the family.

She was dark-haired, well developed, and well nourished. The abdomen was greatly distended, more so anteriorly than laterally. The umbilicus was everted, and all the signs of free fluid within the

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(*a*) **A paper read before the Windsor and District Medical Society.**

abdominal cavity were present. On palpation there was general tenderness all over the abdomen. The heart sounds were normal, the pulse rate 128. The respirations were 28, and there was evidence of some slight œdema at the bases of the lungs. The feet and legs were œdematous. The urine had sp. gr. 1028, acid, with a trace of albumin. The temperature was 101°. Four days later paracentesis was performed, when 12 pints, 5 oz. of clear yellowish-green fluid, of sp. gr. 1025, neutral, with a slight deposit, showing strands of fibrin with a few blood corpuscles, was drawn off, and subsequently a bandage was tightly applied. The day following, on examination, nothing abnormal could be felt within the abdominal cavity. The examination, however, gave considerable pain. I then ordered that mercurial ointment should be rubbed over the abdominal wall, which was to be covered with a thick layer of cotton wool, and then a bandage to be tightly applied, a method of treatment handed down to us from the earliest time, even before the days of Celsus, who states that it originated with Tharrias, whose method was "to apply a discutient malagma and to bind upon it a napkin three times folded with a bandage not too tight." But to return to the case. The fluid did not re-accumulate. There was, however, from time to time severe abdominal pain, which was relieved by the application of an ice-bag. I will now ask you to note that in this case the temperature for four weeks varied from 101° to 102° in the evening, and from 97° to 98° in the morning. The sp. gr. of the urine in this case varied from 1020 to 1030, and on two occasions only—viz., January 21st and 24th, subsequent to the day of admission—was there a trace of albumin. After being under treatment four months, she was discharged. I saw this patient four months later, and could detect no sign of disease. It is now eleven years since paracentesis was performed. This patient is quite well, and has not been ill for a single day since her discharge. She has recently married.

Case II.—Paracentesis performed once; patient in good health fully nine years after.—S. G., a married woman, æt. 46. First came under my observation as an out-patient in May, 1897, complaining of sickness and diarrhœa. There was no evidence of organic disease, and under treatment these symptoms subsided. One month later she noticed that her feet and ankles were swollen, and three weeks later that the abdomen was increasing in size, and on July 27th, 1897, she again came to the hospital and was admitted as an in-patient. With the exception of having scarlet fever as a child she had never been ill. She had four children, the youngest being eleven years old. Her confinements had been normal, and her periods always regular. She had never suffered from epistaxis, hæmatemesis, or melæna. She had been addicted to drink for some time. She was tall, spare, with dark hair, and some slight vesicles over the face. The feet, ankles and legs up to the knees were somewhat œdematous. The abdomen was much distended and very tense, the skin being quite glossy. Palpation gave no pain. There was every evidence of free fluid within the abdominal cavity. The heart and lungs were normal. The urine was scanty, and contained neither blood nor albumin. The temperature was 99.6°. The day after admission she had an attack of vomiting. Twelve days later the œdema of the feet and legs had subsided; the urine was increased in quantity, sp. gr. 1010, with a trace of albumin. On August 20th, thirty-three days after admission, the fluid within the abdominal cavity showing no signs of subsiding, but rather the contrary, paracentesis was performed, and 8 pints, 12 oz., of a turbid, brownish fluid (*a*) was withdrawn. The abdomen was then tightly bandaged. The lower border of the liver was felt about one inch below the costal margin. The fluid did not re-accumulate. The urine increased in quantity, the sp. gr. varying from 1004 to 1010. There was a trace of albumin in most specimens examined, but not in all. The temperature varied from 97° to 99°. After being under treatment one month and eighteen days, she was discharged. In February, 1898, I again saw this patient, and the urine then contained blood and albumin. I have not seen this woman as a patient since, but I made inquiries in 1906, and found that since leaving the hospital she had been daily following her occupation as a charwoman, that she occasionally suffered from pains over the abdomen and slight attacks of epistaxis, and that she had to get up frequently during the night to micturate. She is still living, but has, since the death of her husband, given way to drink. It is now nine years and some months since paracentesis was performed.

Case III.—Paracentesis performed twenty-five times in fifteen months; patient in good health seven years after.—A single man, æt. 43, a gardener by occupation, who stated that he had not known what illness was until August, 1899, when he noticed that his feet were somewhat swollen, that he was losing flesh, his abdomen increasing in size, and that subsequently he had a difficulty in passing urine. On September 6th, 1899, he came under my observation. He had never been a heavy drinker, but had taken a small quantity of whisky every night. He had never suffered from venereal disease, nor vomiting, epistaxis, hæmatemesis, or melæna. He was a thin, spare man, with small dilated venules over the cheeks. His feet and legs were œdematous, there was some slight œdema of the chest wall, and some œdema over the sacrum. The abdomen was greatly distended, and there was every evidence of free fluid within the abdominal cavity. The heart sounds were normal, but there was some œdema of the bases of both lungs. He passed during the first 24 hours 19 oz. of urine, sp. gr. 1016. His temperature was 98°. On September 11th, five days after admission, paracentesis was performed, 23 pints, 16 oz., of clear, amber-coloured fluid being withdrawn. Nothing abnormal could be felt in the abdomen, and the liver dulness was about normal. On September 17th he was again tapped, and 19½ pints were withdrawn. Four days later the urine, which had gradually increased in quantity, was for the first time found to contain blood and albumin; sp. gr. was 1014. On September 30th paracentesis was again performed; 23 pints of fluid were removed; and on October 9th 25½ pints. After this he complained of shooting pains all over the abdomen, and the temperature rose to 99.6°. The œdema of the legs now began to subside; blood and albumin were constant in the urine. The fluid within the abdominal cavity having re-accumulated, paracentesis was again performed on October 25th; 36 pints were withdrawn; and 14 days later 23 pints, 15 oz. He now complained of severe colicky pains, which were relieved by carminatives and warm fomentations. He subsequently became so much better that he was allowed to get up, and go about the ward in a wheel-chair. On November 20th paracentesis was again performed, 29 pints of fluid being withdrawn. The œdema of the legs had now almost entirely disappeared. On December 5th paracentesis was repeated, and 23 pints, 17 oz. of fluid withdrawn. He had now been tapped eight times in four months, and he was so much better in himself that I decided to try the advice of Celsus and let him walk about. He was therefore discharged, being told to return to the hospital in a fortnight. He, however, returned in twelve days. There was now slight swelling of the feet and legs. The urine, sp. gr. 1020, contained a considerable quantity of albumin, but no blood. The fluid had re-accumulated within the abdominal cavity, so, seven days after re-admission, December 26th, 1899, paracentesis was again performed, 26 pints 13 ozs. of fluid being taken away. He expressed himself as feeling greatly relieved. All went on well till January 4th, 1900, when he complained of very severe abdominal pain, and only passed 10 oz. of urine, which contained a considerable quantity of blood. I ordered him to drink freely of distilled water, with the result that on the following day 45 oz. of urine, containing much blood, was passed. Five days after, the fluid having again accumulated, I tapped him once more, withdrawing 27 pints, 15 oz. The following day the urine contained no blood. A few days later he again had severe colicky pains, which were relieved by rhubarb and soda. On January 30th, 19 pints, 15 oz., and on February 20th 35 pints 5 oz. of fluid were removed,

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(*a*) No note was made of the sp. gr. of this fluid.

and two days later he was again discharged. But I must not take up your time with a detailed account of the subsequent admissions and tappings, as nothing further of any moment occurred; but I will content myself by stating that during a period extending over *one year and three months* in this case paracentesis was performed 25 times, and that he was finally discharged December 21st, 1900. Since then, for now over seven years, he has followed daily his occupation of a gardener, working from six in the morning till five in the evening, and during this time he has not once been ill. I have on a few occasions asked him to come and see me at the hospital, and I saw him only a few days ago, and on these occasions I have found the urine always to contain a trace of albumin, and the sp. gr. has been 1004 to 1010.

Case IV.—Paracentesis performed twice; patient in good health eight months after.—A married man, æt. 50, a foreman on the Great Western Railway, who has never been a drinking man, and had never been ill until five years ago, when he noticed that his feet and legs were slightly swollen. This lasted for three weeks. Since then he had not been ill, or given up work till August (1906), when he had pains in his legs, which subsequently became swollen, the left leg in particular, the right only slightly. Seven days later he had pains in the lower part of the abdomen, which he then noticed was much enlarged. He had vomited several times during the previous fourteen days, and on two occasions brought up blood, about an ounce each time. He was a thin, spare man, with some small venules over his cheeks. Both legs were œdematous, the left much more so than the right. The abdomen was much distended, the surface veins of the abdomen and chest being very distinct. There was free fluid within the abdominal cavity. The heart sounds were normal, but there was some œdema of the bases of both lungs; urine sp. gr. 1020, with a trace of albumin. Seven days after admission paracentesis was performed, and 19 pints of turbid yellow fluid (sp. gr. 1016) withdrawn. A few days later he complained of pains over the lower part of the abdomen. After paracentesis the œdema of the legs subsided. On September 4th paracentesis was again performed, when 12 pints, 18 oz. of fluid were withdrawn. There has been no return of the fluid, no œdema of the legs; on one occasion he vomited. The urine increased in quantity after paracentesis, and was then sp. gr. 1010, and contained a trace of albumin. Although only eight months have passed, I expect he will go on favourably for some time to come. (*a*)

I should just like to ask your attention to the temperature chart. You will note that for 38 days there was an evening rise and a morning fall, varying from 102.4° in the evening to 97.2° in the morning.

(To be concluded in our next.)

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Large Hydatid of the Liver—Operation.—Mr. James Berry operated on a man, æt. 50, who had been transferred from the medical wards on account of a large hydatid cyst of the liver. The patient had had very few symptoms beyond a feeling of discomfort in the epigastrium, and occasional vomiting. Some seven weeks ago diarrhœa became troublesome, and for this he came to the hospital. On admission, he was found to have a large rounded swelling in the region of the liver. The epigastric and the right hypochondriac regions were occupied by a small elastic prominent swelling pushing the lower right ribs forwards and outwards. There was no extension upwards of the liver dulness. There was no jaundice, no ascites, and no evidence of any disease above the diaphragm; there was nothing in the history of the case pointing to abscess of the liver. The man's general condition was good, and there was no elevation of temperature. At the usual weekly consultations it was generally agreed by the physicians and surgeons present that there was little or no doubt as to the diagnosis of a large hydatid of the liver. The operation was very simple, consisting merely, in the first place, of a vertical incision two inches long below the right costal margin and immediately over the most prominent part of the swelling. On cutting through the abdominal wall, a thick, tough layer of fibrous tissue was reached without the intervention of any visible liver tissue between it and the abdominal wall to which it was intimately adherent. On incising this fibrous layer, which was the ectocyst of the hydatid, many hundreds of hydatid cysts varying in size, from a pea to a plum, were turned out. These were all removed by sponging and irrigation. The vast cavity appeared to occupy almost the whole of the normal region of the liver. Under the microscope typical scolices were seen, some of which by their movements showed that they were still living at the time of examination. At the upper part of the cavity the diaphragm could easily be seen pulsating with each movement of the heart. A short glass tube, one inch and a half in diameter, and about the same length, was passed through the abdominal wall, and the whole cavity lightly packed with gauze. Mr. Berry said that a large, round, smooth elastic swelling in the region of the liver could scarcely be anything but a hydatid. He called attention to the fact that the patient had complained of very few symptoms, and was at first inclined to refuse operation. The dangers of leaving a hydatid of such large size, Mr. Berry pointed out, were that it would either burst or leak into the peritoneum, and thus set up peritonitis, or it would suppurate. The elasticity of the swelling in the present case, he said, was so marked that in all probability the hydatid was very near to the surface. The adhesions found between the abdominal wall and the tumour rendered packing of the peritoneal cavity unnecessary in this case. Indeed, the unobliterated peritoneum was not opened at all in the operation. Small hydatids, he remarked, might well be treated by immediate closure of the cavity in which they had been, but for very large hydatids or cysts like the present one, he thought packing and drainage the safer course. The wide, short glass tube, the use of which, he stated, he had learned from Mr. Rutherford Morison, was extremely useful in keeping open the mouth of the cavity, and so facilitating the introduction and the removal of gauze. Mr. Berry pointed out that it was not wise on the part of the surgeon to make any attempt at the operation to remove the ectocyst. The endocyst, on the contrary, usually presented itself in the form of a thick white membrane, easily detachable, and removable without any hæmorrhage, this being by no means the case with the outer fibrous layer constituting the ectocyst. This is always intimately adherent to the surrounding parts, and in the case of the liver, to large hepatic and portal veins; any attempt to remove it is sure to be followed by severe and even dangerous hæmorrhage. Some years ago, at another hospital, he had seen a foolish attempt made to remove the ectocyst, and the patient had died of hæmorrhage within a few hours of the operation. In the case he had just operated upon not a single drop of blood was lost excepting what actually came from the incision in the abdominal wall.

The after-course of the case was uneventful. The glass tube was discontinued eight days after the operation, the cavity having contracted up to a very small dimension. Five weeks after the operation there was still a small cavity remaining requiring daily dressing, but the patient was up and about, and quite well.

(a) I saw this patient quite recently, he was quite well. His liver was enlarged—firm and smooth border-urine, sp, gr, 1014. Trace of albumin.

TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held April 9th, 1908.

The President, Dr. **Herbert Spencer**, in the Chair.

Dr. **H. Macnaughton-Jones** read a short communication on the subject of

PRIMARY UNILATERAL TUBERCULOSIS OF THE FALLOPIAN TUBE.

He briefly reviewed the more recent ætiological and histological points bearing on tuberculosis of the female genitalia, dealing with the relative frequency with which the various organs are affected from the vulva to the ovary. The recurrence of primary tuberculosis in any of the genitalia is not common, but a unilateral primary tuberculosis is very rare. His communication dealt with primary unilateral tuberculosis of the Fallopian tube, of which he had met with two instances, and he had one case of primary tuberculosis of both tubes. In all these the rest of the genitalia were healthy. The details of the three were given, and all the removed tubes were shown, together with the microscopical sections. In the case which was the source of this communication, a tubercular pyosalpinx was removed 6½ years ago. She had one twin pregnancy and three other pregnancies since. He had recently to perform on this patient a cœliotomy, 39 days after labour, for an extensive septic perimetritis (the section of the matted adnexa was shown with the epidiascope). There was no evidence of tubercle. She was now perfectly well. All the five children were strong and healthy. Mr. Targett and Dr. Cuthbert Lockyer had made the reports. He had received replies from some 35 leading gynæcologists in the United Kingdom and abroad before bringing the case forward as to the records of such a condition. Only in seven of the home clinics were there records of such a lesion, and in but three of the foreign.

A short communication by Dr. **Kedarnath Das**, of Calcutta, on

THREE CASES OF CÆSAREAN HYSTERECTOMY FOR ATRESIA OF THE VAGINA

was read by the Honorary Secretary. Traumatism during labour in which instruments were used was the cause of the condition in each case. Two of the cases were complicated with vesico-vaginal fistulæ which had resisted attempts to close them, although in one case a recto-vaginal fistula had been closed. In the first case the mother died, probably from the infection of the peritoneum through the vesico-vaginal fistula. In this case the child lived. In the second case the mother lived, but a dead fœtus was removed from the uterus. In the third case both mother and child lived. The author drew attention to the frequency with which vesico-vaginal fistula occurred in India, the distressing nature of the condition, and the relief that can be given in the majority of cases by operation. The occurrence of conception under such peculiar circumstances, and the extra-peritoneal treatment of the stump in the third case, were also worthy of note.

Dr. C. **Nepean Longridge** read a short communication on the

CREATININ EXCRETION OF LYING-IN WOMEN

during the most active period of involution of the uterus. The paper was based on 90 estimations of creatinin, and 180 estimations of the total nitrogen in the urine. The patients were delivered in Queen Charlotte's Lying-in Hospital, and were kept upon a creatinin-free diet during the time they were under observation. The endogenous creatinin alone was estimated. It was found that the creatinin excretion maintained practically a level line, and is probably not increased by the involution of the uterus, a result which is in harmony with the recent work on creatinin excretion. By applying the conception of autolysis to the process of involution of the uterus, it was thought that a clearer idea of that process might be obtained. A very brief *résumé* of the main facts concerning autolysis was given, stress being laid on the fact that it is most rapid in an acid medium and in a bloodless organ. Dr. Longridge had observed that the wall of an autolysing uterus was acid in reaction, and considered that the rapidity of the first stage of involution was due to this fact, and to the fact that the uterus is anæmic during the first four or five days after delivery in a normal case. This anæmia is due to two factors, the retraction of the uterus and the effect of the kinking of the uterine arteries in reducing the blood pressure in them after delivery. Dr. Longridge thought that the conception of autolysis would help to explain many obscure points of uterine pathology, such as super-involution of the uterus, and the changes in fibroid tumours, and would lead to considerable clarification of our ideas in regard to the relation of the liver to the toxæmia of pregnancy.

A paper on a case of

INTRA-UTERINE DEATH OF THE FŒTUS

occurring in six consecutive pregnancies was read by Dr. **Herbert Williamson** and Dr. **Eardley Holland**. The case is recorded of a patient, æt. 24, who had given birth to two still-born children at the 26th and 28th weeks of gestation respectively. Careful examination of the patient and her husband failed to reveal any signs of syphilis, and no history of infection could be obtained. During the course of the next two years she gave birth to two more children, still-born, at the eighth month. In her fifth pregnancy the child was found to be alive in the 30th week, and the induction of premature labour was recommended. Three weeks later she was spontaneously delivered of a still-born child in Queen Charlotte's Hospital. Sections of the fœtal organs stained by Levaditi's method revealed the presence of the spirochæta pallida. She became pregnant again before the menses reappeared, and throughout this pregnancy was treated with small doses of mercury and iodide of potassium. When examined on October 17th the uterus reached to the costal margin, and the fœtal heart could be heard. It was believed that nine lunar months' gestation had been completed, and it was thought advisable to run no further risk, but to induce labour. Labour was induced on November 2nd, and she was delivered of living twins, a boy and a girl. Both children were obviously premature, and the amniotic sac of the female child contained an excess of liquor amnii. The children survived only a few days, and post-mortem neither showed syphilitic lesions nor could spirochætes be discovered in sections of the organs. The authors brought forward the case as a contribution towards the pathology of intra-uterine death, and stated their opinion that Levaditi's method of demonstrating the spirochæta pallida has given a new means of diagnosis and new indications for ante-natal treatment. They discussed briefly—(1) the evidence upon which it is claimed that the spirochæta pallida is the specific organism of syphilis, and (2) the reliability of Levaditi's method for demonstrating the presence of the organism.

Clinical Section.

Meeting held April 10th, 1908.

The President, Sir **Thomas Barlow**, Bart., in the Chair.

Dr. **Leonard Guthrie** and Mr. **Stephen Mayou** showed a boy, æt. 7, with left optic atrophy and right hemiplegia. He had been run over by a cab in July, 1906. He subsequently developed pneumothorax, and three days later became aphasic and hemiplegic on the right side, and blind in the left eye. The aphasia and hemiplegia had improved, but he was still blind in the left eye, and had complete atrophy of the left optic disc. No trace could be discovered of the left common carotid or its terminal branches, which were believed to be blocked, together with branches of the left middle cerebral and left arteria centralis retinæ.

Mr. **Charters Symonds** showed a patient, æt. 52, operated upon in 1904 for malignant disease of the larynx. Complete extirpation was carried out, with removal of the left thyro-hyoid and sterno-hyoid muscles, all surrounding fascia with lymphatics, and the left thyroid lobe. The trachea was attached to the skin above the sternum, and primary union obtained. Professor Gluck's device of inserting a rubber tube into the cannula, and thus carrying a current of air to the lips, enabled the patient to speak so that he could be heard at some distance, and could continue his duties.

Mr. W. S. **Handley** showed two cases of brawny arm of breast cancer which he had treated by the laying of four threads of white silk beneath the skin of the arm from the wrist to the soft tissues on the proximal side of the affected axillary glands and lymphatics. The œdema had disappeared, and the muscular power, previously lost, was gradually returning.

Dr. F. **Hawkins** (Reading) exhibited a man, æt. 43, never a heavy drinker, nor sufferer from venereal disease, who, in August 1899, had œdema of legs, chest wall, and sacral region, with much ascites; heart sounds normal, the urine sometimes containing blood and albumin. The abdomen was tapped 25 times in 15 months, the maximum amount of fluid withdrawn being 36 pints. Since 1900 he had had good health.

Dr. F. **Parkes Weber** showed a single woman, æt. 21, with symmetrical œdema of hands and feet of five or six weeks' standing in the feet, three weeks' duration in the hands; she had also diminished breathing, and voice sounds over the lower part of the left lung, especially in front and below the axilla. X-ray examination showed a shadow over this area; there was no cough or expectoration; slight anæmia, tested by blood count; the temperature was usually about 100° F.; the swelling and cyanosis of the extremities had diminished during rest in bed; the nature of the mediastinal affection was doubtful.

Dr. **Norman Moore** showed a patient, æt. 44, admitted two months ago to St. Bartholomew's Hospital with defective sight and symptoms of myxœdema. After continued administration of thyroid extract, the lethargy, slow speech, and other symptoms of myxœdema had disappeared. He could now walk well, and had no tremor of hands. But the remedy had not made any difference to the optic atrophy. Both discs were atrophied, the left more than the right. The visual field was not markedly contracted, but slightly so on the nasal side. He could perceive light with his left eye, and count objects with his right. Dr. Moore said that he knew of no other case of myxœdema combined with optic atrophy.

Dr. **Graham Forbes** and Dr. F. S. **Langmead** contributed a paper based on 12 cases of

FATAL LYMPHOCYTHÆMIA IN CHILDREN,

the ages ranging from 7 months to 11 years, ten being under 4 years. The disease had an indefinite onset, with increasing pallor and languor, and ranged from two weeks to three or four months, averaging five weeks in duration. Post-mortem examination showed enlarged lymphatic glands, punctate hæmorrhages on pericardium and pleuræ, enlarged spleen, liver and kidneys; no increase in the bone marrow. The disease was probably of microbic origin.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

Meeting held Friday, April 3rd, 1908.

Dr. Finny in the Chair.

DUODENAL ULCER: ITS DIAGNOSIS AND TREATMENT.

Mr. Mitchell (Belfast) read a communication on the above subject.. This was based on a series of nineteen cases which he had operated on during the previous year. Mr. Mitchell first emphasised the unrecognised frequency of the condition, and showed the urgent need for diagnosis, as it was a more serious condition than gastric ulcer, being much more liable to perforate and to lead to fatal hæmorrhage, and also less amenable to cure by medical means. He discussed the ætiology—the greater frequency in men (twenty-three to four of the present series)); hyperacidity as a factor in production; its connection with alcohol, etc. As prominent symptoms Mr. Mitchell placed (1) "hunger-pain"; (2) discomfort after food; (3) local tenderness above and to the right of the umbilicus; (4) hæmatemesis and melæna; (5) early dilatation of the stomach. The position and appearance of such ulcers were then described as they appeared in the living. Mr. Mitchell, in discussing the treatment, thought surgical means (at all events in chronic cases) were the only reliable and efficient method of treatment.

Dr. **Little** said his experience of duodenal ulcer had not been that it was so extensive as Mr. Mitchell indicated. He agreed that it was much more frequent in men than in women, and he had found it much more frequent among private than among hospital patients.

Dr. **Drury** said he had found that his patients who suffered from duodenal ulcer had less of actual pain than of discomfort.

Dr. **Dawson** referred to a case in which pain, occasionally of an acute variety, came on four or five hours after food. It was localised in the spine, and sometimes radiated towards the front on both sides, but there was no pain or tenderness in front of the abdomen. The first symptoms had been dilatation and then the pain; the hæmorrhage which followed was entirely gastric, and for a long time there was no melæna. After it, however, the ulcer was thought to be duodenal. Medical treatment failed, and an operation was successfully performed, when nothing was found in the appearance of the stomach or duodenum to indicate any morbid condition whatever.

Dr. **Moorhead** said they owed a debt of gratitude to Mr. Mitchell for emphasising the seriousness of the condition, and for assuring them that he could recommend operation with a free mind. Hyperchlorhydria had been a typical symptom in the cases of duodenal ulcer which he had seen.

Dr. **Peacocke** asked if the diagnosis of duodenal ulcer had been made by the symptom of "hunger-pain" practically alone, and if it had been confirmed.

Dr. **Bewley** said if the hunger-pain could be considered a proof of duodenal ulcer, the condition would have to be regarded, under the categories of severe and slight, as they found cases which were relieved by food and by medical treatment. Cases in which apparently absolute health preceded a copious hæmorrhage were not so uncommon, and he did not think the diagnosis was so absolutely clear as might be imagined.

Dr. **Cahill** said he had been able to diagnose duodenal ulcer through giving foods of different degrees of digestibility, such as beef and pork, and watching the time relation of the onset of pain.

Mr. **Wheeler** asked if the cases of perforation occurred without symptoms, and whether a diminution in the amount of hydrochloric acid would account for the want of symptoms prior to perforation.

Dr. **O'Carroll** said they might regard gastric cases—other than mere indiscretions—as being either mucogastric and associated with a diminution of acid secretion, or associated with an excess of acid secretion, or a necrotic or ulcerated condition. These three divisions would form a serviceable basis for diagnosis. They might assume that excess of acid was in many cases associated with ulceration in the stomach or duodenum. He hoped that they would in future be able to diagnose the condition at a stage that would prevent cases having to go to operation. Tests for acid were not always absolutely reliable, as in some cases the acidity of the stomach overstayed its emptying, and set up an ache which might be relieved by food. He agreed, of course, that if they could be sure of the diagnosis there should be operation on the spot.

Mr. **Mitchell**, in reply, said he agreed with Dr. O'Carroll's remarks, and had himself declined to operate in certain cases. While it was valuable to have an outstanding symptom that would give a direction to their thought, it would be a mistake to regard a single symptom as infallible. He had not, however, found a case of duodenal ulcer in which there was not "hunger-pain." His experience of the locality of the pain was varied, and he had not found any diminished hydrochloric acid. In reply to Mr. Wheeler he answered, No. The condition of duodenal ulcer might be commoner in the North than in Dublin; since March 5th he had been consulted by ten cases having typical signs, and in four operated on the ulcer was found.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, April 19th, 1908.

At the last meeting of the Medical Section of the Society for Vaterlandische Kultur a number of interesting cases were shown and described.

1. A case of

Epilepsy after Injury.

A young man, æt. 21, was kicked on the head by a horse eight years ago. For 15 months he had suffered from typical bilateral epileptic attacks. The forehead was trephined over the site of a bony depression and a bony process was removed. Along with this was found a lacuna larger in size than a bean, and in it was a cortical cyst the size of a pigeon's egg. Everything went on well after the operation, after which the patient had only two slight attacks.

2. Was a case of traumatic cerebral abscess, in which recovery had taken place.

3. Was a case of recovery after enormous

Prolapse of the Brain

after traumatic cerebral abscess. The patient, æt. 15, was only admitted into hospital a month after receipt of the injury. The opening in the skull was 2 cm. by 4 cm., a piece of brain, very much soiled and the size of the fist, was projecting. There were decubitus, fever, and paralysis of the whole of the right side. After the evacuation and cleansing of a large cerebral abscess, however, complete recovery took place. Even when shown there was spastic paralysis of the whole right half of the body remaining, but the patient could walk in a sort of ataxic fashion, and could make some use of his arms.

4. Was a case of

Meningitis with Formation of Gas.

The patient, a man, æt. 56, had been struck on the head with a stone, and for several days had shown signs of meningitis. The skull was extensively trephined, but this was not successful in saving the patient's life. The injury to the skull was inconsiderable and the dura was intact, but the latter on being incised was found to be covered with a greasy purulent layer with numerous gas bubbles. Although careful search was made the micro-organisms that caused the formation of the gas could not be discovered.

Other cases shown were one of successful extirpation of a cerebral tumour, one of extirpation of a sarcoma from the anterior central convolution. Here the diagnosis was made previous to the operation. The patient was a man, æt. 43, who began three months before with cramps, commencing in the left hand and passing up the arm to the left side of the head. These were followed later by paresis. Death took place 14 days after the operation from meningitis, which was favoured by metastatic cerebral sarcoma. At the operation Prof. Küttner, Breslau, laid great stress on careful arrest of hæmorrhage by stitching round, he removed the bones along with the tumours, drained through two small openings for 24 hours only, and sutured the wound, thus avoiding tamponade, which he rather considered favourable to secondary infection.

Another case was one of laminectomy, and the operation was performed on a patient who the year before had been kicked by a horse on the right side of the face. Some time afterwards distinct symptoms of myelitis appeared, about the region of the upper dorsal vertebræ—or there might be a tumour. The laminectomy was performed over the sixth and seventh cervical and first dorsal vertebræ. The result was negative. Recovery was uninterrupted, however. The speaker expressed the opinion that one could more readily do exploratory operations on the spinal cord than on the brain itself, as the deeper lying cord was less exposed to secondary infection.

Some cases of surgery of the stomach were also shown. There were two in which neither before operation nor at the operation could it be made quite certain whether the disease present was a hard, callous ulcer or was malignant. In such cases of doubt it was better to resect than to do gastrostomy. If the resection were performed with Graser's instrumentarium, with Murphy's button, and after Billroth's second method it was scarcely more dangerous than gastrostomy. If the stomach was so nearly normal as to afford no definite indications, the stools should be examined chemically for blood. In cases of epigastric hernia he always operated, as the stomach troubles associated with it were occasionally due to serious gastric disease.

Two cases of excessive flow of gastric juice were shown. A large quantity of clear, strongly acid fluid was brought up by vomiting, it was generally due to ulcer with or without stenosis of the pylorus. The enormous loss of fluid might lead even to dangerous drying-up of the body tissues. Gastroenterostomy acted favourably, even when there was no stenosis of the pylorus.

AUSTRIA.

Vienna, April 19th, 1908.

Syphilis and Morals.

Prof. Finger opened the inquiry promoted by the profession to combat syphilis at its source. He said this society was first proposed by Wolff, of Strassburg, at an international conference to consider the best way of eradicating leprosy, 1897. Two years later Havenith, of Brussels, after another international conference, succeeded in getting the Belgian Government to adopt certain moral regulations to limit the spread of disease, which have since been adopted in Germany, Austria and France.

Notwithstanding these efforts, the prudery of society still barred the way and prevented progress. To overcome this difficulty, the society adopted the next best method of obtaining expert knowledge from every quarter, and discussing it thoroughly in open conference, and pointing out the gravity of the disease and the daily destruction to life. Prof. Lang next demonstrated its dangerous infection, and how the micro-organisms are transmitted by razors and other utensils. Prompt treatment was a necessity, but good food, proper clothing, and comfortable dwellings were essential. Institutions, therefore, must be established to meet the social demands, for where the moralist fails the physician must commence. Prof. Noorden said that the last ten years had seen an enormous increase of sexual diseases and their consequences. Paralysis was now filling the lunatic asylums, and tabes our hospitals. Diseases of the circulation, heart, respiratory organs, blood and alimentary organs, were no exception to its ravages. One-half of the population in middle life suffered from arterial sclerosis due to syphilis. Every clinician knows the danger of neglecting the primary symptoms, which the patient is unwilling to divulge till the "quarternary" phenomena have set in and probably have undermined the health. Nothing is more tragic than the sight of homes wrecked with this morbid curse, and thence handed down to posterity.

Prof. Escherich followed with a jeremiad for the infant of the infected who innocently enters on a life of misery. He considers there should be a special institution provided for such victims. He divides this class into two divisions—venereal catarrh and genuine syphilis. The first are affected with diseases of the cornea and conjunctiva a few days after birth, which the "Hebammen" of Austria have strict injunctions to obey. The second division is the most serious, and one that is fast decimating the population of France.

From the point of view of psychiatry, Prof. Janregg said progressive paralysis was now recognised as an undeniable result of syphilis occurring within ten or twelve years after the primary effects. In the Austrian lunatic asylums at the present time there were 1,300 of these cases, and a very modest computation assumed an equal number treated at their own homes. This, he thought, comprehended 2 to 3 per cent. of all the syphilitic cases. Tabes spinalis was still more frequent amongst us.

Prof. Ehrmann devoted his attention to the transmission of the disease. The light cases were passed, and great damage done, while the severe cases were concealed till some serious illness arose, when human aid is hopeless. As a representative of the "Krankenkaisen" he considered 0.8 to 3 per cent. far too low for syphilitic diseases among the people, when we know positively that it is over 6 per cent. in the army and 3 per cent. in the militia. Statistics vary, however, as in the south of Hungary it is very prevalent, while the west Alplands have a very small number to record. Again, the calling has some influence on the transmission of the disease, as we find waiters and farm servants the greatest sufferers from the disease. Removal from the home life is a potent factor in the transmission. Our middle classes in this respect were very bad, while the housemaid who has often been blamed stands in a very respectable position, although recent examination of diseases of the nerve and vascular symptoms points to an increase. Isolation of the disease as practised on lepra in the seventeenth century would be the best way to eradicate the disease. Schiff said there was great difference in the frequency of the disease in various trades. He had under notice 300,000 tradesmen who were insured, and found that in the larger industries 16 in a thousand were laid off with diseases attributed to that disease. In some of the branches, however, it was double that number.

Brandweiner reported 7,417 cases, the half of whom were females, which came before him in five years at his clinic. From these he elicited that 67 per cent. were infected before 25 years of age, and 19 between 25 and 30, while the other 14 per cent. were later. Scherber announced that his experience of the disease showed that extra-genital transmission was greater in females than males, as the former was 3 to 4 per cent., while the latter was only 3 per cent. This varied in different localities, as in Russia we find it in many exceeding 70 or 80 per cent.

HUNGARY.

Budapest, April 18th, 1908.

At the recent meeting of the Royal Medical Society, Dr. Bárdos read a paper on

Menstrual Jaundice.

He remarked that he had a few cases of jaundice recurring with every menstruation, and he did not regard this condition as a separate disease, as others do. He had observed and described a case three years ago, and he was able to give the results of the autopsy, as the patient died of an inter-current disease. A calculus was found wedged in the common duct, which seemed to obstruct this passage completely, yet during life probably permitted the escape of sufficient bile to prevent stasis. With the congestion of the abdominal organs incident to menstruation, a true biliary stasis set in, so that some of the bile was readily absorbed by the lymphatics and icterus developed. Probably most cases reported depend, said Dr. Bárdos, on a similar cause, though there are no other, excepting one —that of Metzger's) autopsy records.

Cancerous Growth and Radium.

Dr. Holzwarth presented two patients before the Society, one of whom had a cancerous ulcer at the inner angle of the right eye. The treatment began December, 1906, weekly sittings, duration one hour. The bromide of radium was used; improvement was noticed after every application. For some reason the patient discontinued treatment after six weeks, with the result that the condition became worse, and the edges of the ulcer, that were in a fair way of cicatrisation, re-opened again. Treatment was instituted again, with the result that the ulcer that resisted obstinately treatment for five years is now healed completely. The second case was that of a cancer of the breast for which the patient was operated on twice— nine and three years ago. In this case applications were made three times a week, and after 26 sittings the tumour seems to have disappeared, and the patient regained perfect control of shoulder-joint (tumour located under left clavicle).

Radiotherapy in Trachoma.

Dr. Waldmann investigated the basis of success obtained and described by Cohn, of Breslau, with radium in the treatment of trachoma. Waldmann has, in fact, found a theoretical basis for the explanation of the success, inasmuch as it is assured by several investigators that the beneficial effect of radium on malignant growths is due to its power to decompose the lecithin which forms a substantial element of these growths. As the granulations of trachoma also contain a certain percentage of this substance, the effect thereon of radium becomes intelligible. The author picked out seven trachomatous cases of a most pronounced character; the amount of radium used was at first 1 mg., and later 10 mg.; time of exposure, five to ten minutes. The tube containing the radium was simply applied over the area treated, and slowly moved about without touching the surface. The results were really astonishing. Five of the seven eyes were entirely cured; the other two are in a fair way of becoming so. The absorption of the granules was not accompanied by any untoward effect. The number of sittings varied from eight to fourteen.

LETTERS TO THE EDITOR.

THE REFERENDUM OF THE BRITISH MEDICAL ASSOCIATION.

To the Editor of The Medical Press and Circular.

Sir,—Judging from the quality of his writing, it is evident that your correspondent, "Festina Lente," is a leading man. I am sorry he did not deal with the main fact of my letter, which appeared in your paper of March 25th. I pointed out that out of a membership of over 20,000, not more than 1,978 recorded their votes on the momentous question referred to them, in spite of the fact that the issues involved were as important as "Festina Lente" indicates, and that this importance had been urged upon the members literally by every possible means during a period of many months. What hope is there for the Association or for the profession if the only body capable of speaking in the voice of every class of practitioner remains dumb to the most urgent call. The position of the profession as a body in relation with the State is deplorable. Medical law, the reform of which, as you have so often shown, is of infinitely greater consequence to the people than to practitioners, remains entirely confused and ineffectual and not the smallest improvement is possible until the political position of the profession is improved by its united efforts. The British Medical Association, I repeat, has developed into a mere co-operative society for the publication of a medical journal—a journal supplied to subscribers at a low price, but produced at an enormous cost. I doubt if 1 per cent. of the members are aware of the amount of the Association's income which is absorbed by the *Journal*. If they do not care about the issues decided by the Referendum, it is not likely they will take the trouble to scrutinise the annual balance-sheet.

I am, Sir, yours truly,
An Obscure Practitioner.

April 15th, 1908.

To the Editor of The Medical Press and Circular.

Sir,—Outside criticism should be always welcome. Occasionally what appears to be such is but the repetition of *ex parte* statements of the loud-voiced adherents of one view. Pardon my saying that there is just such a fallacy underlying the remark that the result of the Referendum shows the "revolt of the Association against the government of the Council." The fallacy is that the representative meeting represents the Association more accurately than does the Central Council. The voting on the Referendum, for good and all, explodes this idea. There is the absolute fact that only 9 per cent. have attended these meetings. And we could not with confidence assert that larger numbers attend the annual meetings, which elect to the Representative Meeting. On the other hand, the members of the Central Council are elected by an open franchise, and about 30 per cent. do vote.

There can be no question as to which gives the more accurate representation.

The Representative Meeting is noisy, and its proceedings are fully reported. Its mode of conducting business is the laughing-stock of sensible men, and needed columns of apology from its Chairman. This is the sort of thing:—"Adjournment carried by 48 to 34. The Chairman appealed to members not to go away, as they had only a bare quorum. Dr. So-and-So said"—and the discussion and voting go on, although the meeting is theoretically adjourned!

The proposals of the last Representative Meeting are proposals for disfranchisement, and are the most deadly contrivance towards handing over affairs to a headstrong clique and a fickle mob.

The Central Council, parliament, or cabinet, whatever it may be called, is elected, not septennially, nor triennially, but annually, in the most careful manner, and is therefore in the closest touch with the members.

One cannot get over the plain fact that what is boasted of as the voice of the Association is only the voice of 9 per cent.; in fact, as any member who has attended a divisional meeting knows, an even fainter voice. Of course, I am referring throughout to matters of administration, finance, etc. On purely professional matters the representatives fairly represent the feeling of the profession in their district. But the Referendum does not apply to these matters.

The reasoning of your correspondent, "Nil Desperandum," will not hold water, but there can be no disputing the facts and conclusions of your other correspondent, "An Obscure Practitioner." He is, perhaps, extreme in saying that members care "absolutely nothing," but that is what it will come to if we have funds thrown about and constant excitement over such hare-brained schemes.

I am, Sir, yours truly,
Anti-Syphon.
Kensington, April 16th, 1908.

CENTRAL MIDWIVES' BOARD.

To the Editor of The Medical Press and Circular.

Sir,—At page 432 of your issue of April 15th, "referring to instruction for midwives, Dr. Nepean Longridge suggested that they should possess *some* knowledge of the warning symptoms of uterine cancer."

Allow me to say that all those whom we have trained—and we commenced to train in 1880—have been taught the names and uses of all the midwifery instruments, and those gynæcologic instruments required in the out-patient department, and during their midwifery term of learning see all the out-patients, and learn how to use the required instruments. I need hardly say how much this gynæcologic opportunity adds to their interest in their work, takes away much of the drudgery, and renders them very valuable workers hereafter, especially if they be engaged abroad as missionaries, and stationed far away, it may be, from any medical man or woman.

I am, Sir, yours truly,
G. de Gorrequer Griffith.

LAW AND MEDICINE.

To the Editor of The Medical Press and Circular.

Sir,—Your utterances on the question of the attitude of the Bench in its various grades towards the medical profession are always admirable; it is to be hoped that they are not allowed to escape the notice of the men they immediately concern. Once more to-day you justly give voice to the indignation that the educated medical man must feel when he recognises the contempt with which science in general, and medical science and its votaries particularly, are looked upon by law officers of the highest responsibility; and when he recognises that the contempt is based upon pure ignorance of science, its methods and its achievements. We must be thankful, however, for small mercies. We must be thankful that, although a judge may be handicapped in the efficient exercise of his high office owing to ignorance of science, it is no longer possible that he should combine with ignorance, which is commonly his misfortune rather than his fault, intellectual inferiority rendering him entirely unfit for his lofty position. The days are, of course, gone by when a member of the Bar, whose early career had served only to demonstrate his intellectual unfitness for any responsible judicial position, could be made a Judge of the High Court by means of jobbery. The times have almost, if not quite, gone when a Judge, becoming incapable through age and mental decay, should be allowed to cling on to the detriment of his Majesty's lieges. If our Judges are too often devoid of scientific knowledge, it is not they, but our system of national education that is to blame. It is not more than forty years ago since the representatives of our ancient Universities would have almost crucified or burnt at the stake the men of science who seemed to threaten the foundations of their cherished beliefs. Many of us cannot have forgotten the memorable occasion at Oxford when Bishop Wilberforce made his attack upon the scientists; and the castigation which he received at the hands of Huxley. Since that day they have buried Darwin in Westminster Abbey, they have recognised science at the Universities, and some of them have organised scientific departments of magnificent amplitude. But, in spite of this, the great proportion of our schoolboys are still educated without any knowledge of science. Science is still looked down upon or despised by the great bulk of those students whose ambition is a position in Parliament, in the Law, in the Church, or otherwise in the service of the State. It is not only on the Bench that the lack of scientific knowledge shows itself conspicuously, and to the injury of the commonwealth—the medical quack is not the only fraudulent pretender whose apotheosis seems possible even at the opening of the twentieth century.

I am, Sir, yours truly,
April 15th, 1908. A Surrey Doctor.

MEDICAL FEES.

To the Editor of The Medical Press and Circular.

Sir,—The remarks of your correspondent *àpropos* of the recent notorious "dentist fees' " case in the law courts, deserve the careful attention of all medical men. Why should such extremes in the scale of remuneration be found in this alone of all the learned professions? The fact is that the fees demanded by surgeons and specialists are as absurdly disproportionate as those paid to club and open surgery medical men are disgracefully sordid and inadequate. Can we not get at the root of this unclean thing and purge it away from the body of an honourable profession?

The lawyers have no difficulty in enforcing a fair scale of fees. What is possible to the Incorporated Law Society should not be beyond the wit of the General Medical Council. It will be answered that the real point is the powers of the Council, which are inadequate. Then why, in the name of Heaven, does the Council not take steps to obtain adequate powers for protection? Are we to be through the rest of the ages at the mercy of a group of self-seeking corporations, who govern the Council, *inter alia*, and care not a jot for the general practitioner? Is the question of fees too mean a matter for this august Council to consider? Oh! for a whiff of the common-sense that created the Incorporated Law Society!

I am, Sir, yours truly,
A Man of Moderate Fees.
Brighton, April 14th, 1908.

AUSTRALIA FOR THE SONS OF PROFESSIONAL MEN.

To the Editor of The Medical Press and Circular.

Sir,—It is a good many years since I resided in Great Britain, but even then the problem of "what to do with our boys" pressed heavily upon the parents of the professional classes. The Army and Navy were closed to those who had no private income; the clerical, legal, medical and other professions were overstocked; and the openings in commerce were only for those who had money or influential connections. And everything that I can learn points to an intensification of these conditions at the present day. The position, therefore, of the man who has sons about to leave school must be a very difficult one, when he is face to face with the question of how to give them a satisfactory start in life. It is in the hope of being able to do something to answer this question which prompts me to beg for some space in your columns.

For years many of the sons of professional men have emigrated to the United States or Canada. I come forward with the claim that Australia and New Zealand can offer opportunities superior to either of these two countries to industrious and persevering lads, who are prepared to accept rough and strenuous conditions for the sake of obtaining a competence in later life. I may say at once that there are no openings in our large towns. All the city occupations are filled to overflowing. But the Australian Bush is calling for thousands of willing hearts and hands to subdue it and make it fruitful.

The wealth of Australia is immense, and this is mostly due to the production of wool, wheat, sugar, butter, live stock and fruit—commodities for which there is a great and growing demand at prices that are likely to be maintained or increased. Life on the land, therefore, promises to him who approaches it in a spirit both scientific and practical the opportunity, not only for a healthy and natural existence, but the possibility of an independence. The glorious climate of Australia is all in its favour. Here there is no long, rigorous winter, and there exists a voluntary organisation—the Immigration League of Australia—whose chief object is to welcome newcomers and afford them advice and assistance.

The Executive Committee are prepared to give information about Australia and New Zealand to all who write to them, to arrange for the placing of lads at agricultural colleges or farms, to act generally *in loco parentis* towards them, and to see that they are not taken advantage of in any way. The League numbers among its members some of the leading men of Australia, and their desire is to help in the development of the continent, and retain the British emigrant under the flag of Empire.

We say, send your sons to us, and we will ensure them proper treatment and a fair start. We do not want ne'er-do-wells or failures. Experience proves that such do no better here than in the Old Country. But steady, industrious lads are bound to succeed here, and in many cases their parents might be induced to follow them out here, and prolong their lives in this incomparable climate. We invite parents to communicate with us at Bull's Chambers, Moore Street, Sydney, Australia, and we will give them full information, and send books and maps about Australia and New Zealand, and prospectuses of agricultural colleges and schools of mines. Some months' notice is needed to enable a lad to be entered at an agricultural college.

I am, Sir, yours truly,
RICHARD ARTHUR, M.D.Ed.,
President, Immigration League of Australasia.

OBITUARY.

J. D. ROBERTS, M.R.C.S.ENG., L.R.C.P.I.

WE regret to record the death of Dr. J. D. Roberts, of Barnoldswick, a prominent figure in the Yorkshire district, which took place on April 14th. He went to Barnoldswick 44 years ago from Bradford, and built up an extensive medical practice in the district. He was for over 40 years Medical Officer, a position which he recently resigned, and was chairman of a local weaving company. His age was 73. The deceased gentleman qualified as M.R.C.S. (England) so far back as 1863, and as L.R.C.P. (Ireland) in 1879.

REVIEWS OF BOOKS.

YEAR-BOOK OF PHARMACY. (*a*)

THE space at our command would not allow of anything like an exhaustive review of the wealth of information brought together, classified, and arranged in a manner admirabily suited for reference in this excellent Year-Book.

Within the five hundred pages, not counting the forty odd occupied by the exhaustive index, the reader will find the cream of both the foreign and home journals that has any relevancy to the progress of chemistry, materia medica, and pharmacy, as far as these subjects influence therapeutics.

As an example of the value of the book to the medical practitioner, we may instance the abstracts from French and German journals on urine, and those on ergot and ergotinine.

In the section dealing with the proceedings of the conference, Mr. W. H. Martindale's paper on "Pharmacy in Foreign Countries" will well repay reading, and the author was justly complimented on his "infinite capacity for taking pains."

The volume is one of a long series of annuals which have done much to keep the pharmacian and the physician familiar with the advance of the collateral sciences to medicine and is fully equal to the best of its predecessors.

THE MAJOR SYMPTOMS OF HYSTERIA. (*a*)

IT is meant as no disparagement to our neighbours across the Channel when we say that the French have fuller and more abundant opportunities of studying hysteria than those who practise among the phlegmatic Anglo-Saxons. The Gallic temperament, with its brightness, its volatility, and its enthusiasm, lends itself more readily a prey to the development of hysteria than does the matter-of-fact mentality of the true-born Briton. The best studies of the disease, at any rate, have been produced by French physicians, and in the line of Charcot and Luys comes Professor Janet, who contributes the chatty, interesting, and suggestive work before us. This book is really a republication of a series of fifteen lectures delivered before the Medical School of Harvard University on the occasion of the inauguration of its new buildings in 1906, and we warmly congratulate the author on having given to his subject a new and convincing turn. Professor Janet's definition of hysteria is one which it would be difficult to improve, and for the sake of those who do not know it, we give it here:—"Hysteria," he says, "is a form of mental depression characterised by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality." There we have the basis on which these charming lectures are built up, and we cordially invite all who are interested in the subject to give themselves the pleasure of reading them in their leisure moments, however scant.

SCHROTTER'S HYGIENE OF THE LUNG. (*b*)

THE object of this little book is to instruct the layman on the functions of the respiratory organs and on the importance which a free exercise of these functions possesses for the human organism. The subject matter is divided into three parts. The first deals very fully with the structure and functional activity of the lungs, the second with the care of the healthy lung, while the third is devoted to the consideration of pulmonary diseases. The book appeals, of course, to the educated reader, and in fact contains much that is of value to the medical man. The translation has been faithfully carried out, the author's meaning being in all cases accurately represented. A comparison with the original text at once proves this to be so. The illustrations have also been well reproduced, and add not a little to the value of a very useful and practical volume.

DURING the week ending April 11th there have been two deaths from plague at Accra and one at Dodowah. All other places have been free of plague.

(*a*) "Year-Book of Pharmacy from July 1st, 1906, to June 30th, 1907." With the Transactions of the British Pharmaceutical Conference at the Forty-fourth Annual Meeting held in Manchester, July, 1907. Editor of the Year-Book, J. O. Braithwaite. Editor of the Transactions, E. Saville Peck, M.A., Edmund Whyte, B.Sc., F.I.C. London: J. and A. Churchill. 1907.

(*a*) "The Major Symptoms of Hysteria." By Pierre Janet, M.D., Professor of Psychology in the College de France. New York: The Macmillan Co. London; Macmillan and Co., Ltd. 1907.

(*b*) "Hygiene of the Lung in Health and Disease." By Professor Dr. Leopold von Schrötter, Director of the Third Medical Clinic of the Vienna University. Translated by H. W. Arnutt, M.R.C.S., L.R.C.P., with 16 illustrations. London: Redman, Ltd.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Milroy's Disease.—Hope and French give an account of a family, several members of which were affected by a persistent hereditary œdema with acute exacerbations, a condition to which they propose to give the name "Milroy's Disease," after the name of the writer who first called attention to it (*Quarterly Medical Journal*, April, 1908, p. 312). The condition had first manifested itself in a male, five generations back, and had been or is present in thirteen members out of forty-two individuals comprising the five generations, and an account of whom could be obtained. Both males and females were amongst those who suffered, and it was noticeable that epilepsy and mental trouble was found amongst some of those members who escaped the hereditary complaint. The point in which the present cases resembles those previously described are given as follows, the summary forming a convenient account of the chief features of the disease:—(1) The œdema was restricted to the legs, and there was no traceable cause for it, general or local. (2) There was an absence of all pain in the pale swollen legs, and also a total absence of constitutional symptoms. (3) The strong family predisposition, with incidence in both males and females. (4) The œdema was very sharply limited at its upper level. (5) The œdema remained permanent from its first appearance. The writers' cases, however, differed from others in the occurrence of acute attacks accompanied by pain and increase of swelling. In none of them, moreover, was the œdema present at birth. The cause of the condition is discussed, but no satisfactory conclusion is arrived at, the authors leaning to the view that it is a vaso-motor neurosis and allied to such diseases as factitious urticaria and angio-neurotic œdema. M.

Cutaneous Diphtheria Reaction.—Schick (*Munch. Med. Woch.*, 1908, No. 10) has produced by inoculation of a diphtheria-toxin solution a cutaneous reaction somewhat similar to the tubercular cutaneous reaction, or more frequently a local pus vesicle. The reaction is specific and does not take place when toxin is ingested which has been previously neutralised in vitro by anti-toxin. Nor does it occur when a dose of anti-toxin of from 1,500-3,000 units has been given about 24 hours previous to the inoculation. As far as diagnosis is concerned the re-action is of little use, but the author hopes by accurate observation to arrive at new knowledge concerning the clinical course of diphtheria, and more especially to be led to a rational method of estimating the dosage of anti-toxin required in any particular case. M.

Pulmonary Complications following Anæsthesia.—Wright discusses this subject in the *Johns Hopkins Hospital Bulletin* (March, 1908, p. 89). Out of 9,000 patients anæsthetised in the gynæcological service of the Johns Hopkins Hospital prior to August, 1903, 29 patients developed pneumonia, and of these six died. From an analysis of the cases it seems likely that the duration of the anæsthesia is a most important factor in the production of post-anæsthetic pneumonia, as only four out of the 29 had been under the anæsthetic for less than an hour. Out of the 29 cases, 12 were diagnosed as lobar, and 17 as broncho-pneumonia. The lobar variety differs from lobar pneumonia seen in the medical wards as follows:—(1) The temperature as a rule is lower, and the curve shows more irregularities. (2) The duration is shorter, and there is rarely a true crisis. (3) Complications are rare. (4) Cough is not severe and the sputum is rarely blood-stained. (5) The pneumonia is often central, and physical signs develop late. The second or third day after operation is the common time for the development of symptoms. Other pulmonary complication met with are bronchitis, pulmonary abscess, lung emboli, serous pleurisy, and empyema. The causation of these various conditions is unknown, but most probably a combination of some of the following factors are operative:—(1) Irritant action of anæsthetic; (2) aspiration of mucus and vomit, and hypersecretion of mucus; (3) emboli; (4) extension of infection through sub-diaphragmatic space in cases of laparotomy; (5) limitation of lung expansion and lessened resistance of patient. M.

Action of Choline on Arterial Pressure.—Desgrez and Chevalier (*Compt. Rend.*, tome 146, p. 89) point out that choline injected intravenously in dogs, in a proportion of 5 milligrammes per kilo body weight, causes a fall of blood pressure up to 5 c.m. Hg. This first condition is soon passed, however, and is followed by a longer period lasting some hours, during which there is a diminution of pressure. Choline acts also as a direct antagonist to adrenalin, and it is possible to combine the two substances in such proportion that the effect of each on blood pressure is completely annulled. Choline is up to this the only substance normally present in the animal body of known chemical constitution which causes a fall in blood pressure. M.

Arterio-Sclerosis in Relation to Mental Disease.—Campbell ((*Amer. Journ. of Insanity*, January, 1908) states that though this condition is common among mental patients in advanced life, and often appears to be of little importance, yet there are some cases where it seems to be the central element in the clinical and anatomical picture. He divides the cases of mental disorder based on cerebral arterio-sclerosis into two main groups. In the first group the symptoms are less severe and more stationary, while the second group includes those more severe and progressive cases with a varied neurological picture and extreme reduction of mental activity. Certain cases described as melancholia, hypochondria, and neurasthenia can be better grouped on ætiological grounds as cases of arterio-sclerotic brain disorder, while in certain cases of dementia the arterio-sclerotic changes are obviously the most important element in the process. Campbell further suggests that "in certain cases of epilepsy with onset in late life, the convulsions and general symptomatology are closely related to arterio-sclerosis.

K.

Atoxyl in Syphilis.—Ward (*R.A.M.C. Journ.*, April, 1908) records the results of the treatment of syphilitic patients with this drug. The efficacy of this drug in the treatment of sleeping sickness suggested its trial in the case of syphilis, though various writers have described the gravest symptoms and consequences following the administration of the drug. Atoxyl is a proprietary word used to denote the special preparation of a German firm of manufacturers, but many preparations have been put on the market manufactured according to the chemical analysis. Ward suggests that the difference in the results obtained by different workers may be explained by a difference in these various preparations. The drug used in the cases under notice was that manufactured by Burroughs Wellcome and Co., and is described as "Sodium-para-amino-phenyl-arsonate," and in no case was any toxic symptom seen as a result of the treatment. When starting the treatment the drug was administered intramuscularly in doses of 6 grains every alternate day till the patient had received between 50 and 60 grains, but in the latter cases the dose was increased to 9 grains through a course of eight to ten injections. In all the cases the treatment was quickly followed by a disappearance of the symptoms, and this was especially marked in the cases of the lesions on the mucous surfaces. In the majority of the cases a period of eight to ten weeks elapsed before the patient returned with any active signs of the disease, which were, however, very slight and easily yielded to a second course of injections of 6 grains each. How many courses of injections are necessary to completely stamp out the disease, or how far the dose may safely be increased are points which are not yet settled, but there is sufficient evidence to show that the drug is a very valuable agent in the treatment of syphilis. Ward says "its immediate action on the lesions of early syphilis would appear to be quite equal to, if not better than, that of mercury." The drug is readily soluble in hot distilled water, and the injections are absolutely painless. Injection of the drug is never followed by salivation or spongy gums, and it appears to have a tonic and alterative effect. K.

Congenital Biliary Cirrhosis.—Griffith (*Archives of Pediatrics*, March, 1908) records a case of this rare condition. The child was admitted to hospital at the age of five months, and had, the parents stated, been jaundiced since birth. He had been under treatment for some time before admission to hospital, and though the jaundice had not varied the child's weight was stated, for a time to have increased. On admission to hospital the child was found to be deeply jaundiced and to have several purpuric spots on the scalp, the urine contained bile pigment, and the stools some dark material, apparently altered blood. The child died five weeks later, having continuously lost weight during his stay in hospital, in spite of the fact that there was no diarrhœa and food was well taken and retained. On post-mortem examination the liver and spleen were both found considerably enlarged. The gall-bladder was empty and collapsed, and the cystic duct completely obliterated. The right and left hepatic ducts were patulous, but as a partial examination only was permitted it was impossible to trace the common bile duct. Microscopical examination showed the typical lesions of biliary cirrhosis, there being an extensive increase of the periportal connective tissue with a proportionately great multiplication of bile ducts. "The hyperplastic connective tissue in some instances invaded the lobule, but was in general confined to the periphery. In the centre of the lobule there was some deposit of fibrous tissue of a younger and more cellular type." There was no evidence of congenital syphilis in the case. K.

Treatment of Chorea.—Koplik (*Med. Record*, February, 1908) considers the treatment of chorea minor, and lays great stress on the dangers of the indiscriminate use of Fowler's solution. He finds that it is the rule for patients treated with this drug to have albumin in the urine. Casts, and even blood, may be found. He finds that albumin appears before any other sign of toxic action of the drug, and should be the signal for stopping further use of it. He shows that Fowler's solution, on standing, becomes stronger, so that what is supposed to be a small dose of the drug is in reality a large one. Cases do as well without use of Fowler's solution. The treatment he recommends is modified rest cure, with some mild sedative, as trional, and, where needed, strychnine as a tonic. Hydrotherapy is always useful. Sodium salicylate may be tried, but should not be continued if not well borne. Digitalis should not be used. He believes that isolation and darkened rooms are not indicated, as children do much better with quiet companionship and fresh air. D.

Contribution to our Knowledge of Hyperacidity.—Balas (*Deut. Med. Woch.*, 1908) reports three cases of persistent uncomplicated hyperacidity of the stomach cured by gastro-enterostomy. In none of these three cases was there any evidence of stenosis of the pylorus or of ulcer. These results coincide with the Katzenstein theory that bile and pancreas secretion regurgitating into the stomach reduce the acidity through neutralisation, also through inhibition of the gastric secretion. Both these secretions were found in the stomachs of these three cases after operation. D.

Epidemic Poliomyelitis.—Sinkler (*Arch. of Diagnosis*, New York, 1908) produces an analysis of 274 additional cases, making a total of 509 with those already reported, which tend to support his conclusion (*Amer. Jour. Med. Sciences*, April, 1875) that a large majority of cases of poliomyelitis occurs during the summer months. In his series of 509, 418, or 82 per cent., occurred between June and October. The nature and progress of the disease indicate that it is clearly due to infection by a micro-organism developed during hot weather, and he refers to the fact that in an epidemic in Vermont in 1894 horses and birds were also affected. D.

Simplified Serum Differentiation of Syphilis.—Klausner (*Wien. Klin. Woch.*, February, 1908) announces that he has obtained constantly positive results in 31 cases of syphilis, and constantly negative results in 23 cases of non-syphilitic cutaneous affections with the simple diagnostic test he proposes. In a glass, 0.5 cm. in diameter, and 7 cm. tall, he mixes 0.2 c.c. of the patient's serum with 0.7 c.c. of distilled water. After thorough mixing, the glass is set aside at room temperature. In the course of about 15 hours a precipitate forms, in the syphilitic cases, from 2 to 4 mm. in depth, or flakes float in the fluid, gradually sinking to the bottom. The control glasses show no precipitation during this period. If a little precipitation occurs by the end of 24 hours, it is insignificant compared with the marked amount in the syphilitic serum. As the precipitate dissolves in physiologic salt solution and in acetic acid, he believes it to be formed of globulin, and that it may possibly prove to be characteristic of all processes accompanied by formation of anti-bodies. The reaction was positive also in 2 cases of severe croupous pneumonia and in 1 of typhoid, but by diluting the serum to 1 to 5, or 1 to 10, there was no further reaction in these cases, while the reaction occurred unmodified even with this dilution in the cases of syphilis. D.

Reduction of Ingestion of Fluids in Kidney Disease.—Widal (*Bull. de l'Acad. de Méd.*, Paris February, 1908) regards the scales as a most important aid in the treatment of patients with infiltration of the tissues. Systematic weighing not only informs the physician in regard to the visible œdema and its extent, but it reveals accumulation of fluid long before it becomes apparent externally. The fluctuation in the weight shows the necessity for supervision of the intake of fluids, and this is imperative, he thinks, in every case of interstitial nephritis, whether there is appreciable œdema or not. As a rule the patient can take care of two quarts of fluid, but in some cases he does much better if the amount ingested is reduced to three pints, or even one quart in the 24 hours. The diuresis has no significance unless it can be compared with the amount of fluids ingested. Restriction of the intake may prove useful in prophylaxis of further trouble in nephritis, and also in the course of cardiac affections with impending asystole. Even with adequate compensation the physician should never neglect the supervision of the amount of fluids to be allowed the patient. D.

MEDICAL NEWS IN BRIEF

Diphtheria in Schools.

AT a provincial sessional meeting of the Royal Sanitary Institute, held a few days since in Hull Town Hall, Dr. J. Wright Mason read a paper on "Diphtheria in Elementary Schools, and its Prevention." Having remarked that diphtheria is particularly a disease of the young, occurring principally between the ages of two and eight years, Dr. Mason said in the first years of life boys are more liable to die from the disease. This risk diminishes year by year, and in the third and fourth year it is transferred to the female side.

The greatest attack rate is generally between four and five years, children under one year being remarkably exempt, due possibly to their sleeping with their parents instead of with children. "There is no doubt," Dr. Mason added, "that school life plays an important part in the spread of diphtheria, and is also a factor in the increasing prevalence of the disease amongst our urban population. At the present time there is a large number of children under five years of age receiving instruction in elementary subjects, when the brain is not sufficiently developed to benefit by it. It has been stated that some £1,250,000 is annually expended on this unnecessary and, to my mind, educationally useless attendance."

Royal College of Surgeons of England.—The Admission of Women.

We are requested by the Secretary of the Royal College of Surgeons to publish the following:—

The President has been informed that an unauthorised circular is about to be issued to members of the College regarding the admission of women to the membership and fellowship, and that in this circular it is suggested that members should disregard the request of the Council that the answers to the questions in the official circular should be in the form of simply "Yes" or "No." It is hoped that members will not allow themselves to be misled by this unofficial circular, and that, with a view to avoiding confusion as regards the result of the poll, they will record their answers on the official balloting card in accordance with the instructions for voting contained thereon.

Infants' Health Exhibition.

The Council of the Incorporated Institute of Hygiene have decided to promote a special exhibition, illustrating the requirements of infant life and the care and health of children, which will be opened, under distinguished auspices, on June 15th. This exhibition is intended to demonstrate the progress of recent years in providing for the welfare, comfort and training of the child, and it is proposed to exhibit the latest improvements connected therewith. An attractive display is being organised, which will appeal strongly to mothers and the heads of families, as well as to members of the medical profession, matrons and nurses, while it will have special interest to school teachers, as the recent Act for the medical inspection of school children has drawn much attention to this important subject.

The King and Dr. Hall Edwards.

The following letter has been received by Mrs. Hall Edwards from the King, in reply to a letter of thanks which she wrote to his Majesty in acknowledgment of the pension granted to her husband from the Civil List.

"Biarritz, April 1st, 1908.

"Dear Madam,—I am commanded by the King to thank you for your letter, and to say that it has given his Majesty sincere pleasure to confer a Civil List pension upon your husband, whose services have been so extraordinarily self-sacrificing towards the advancement of science and the benefit of humanity. The King wishes you to express to your husband his deepest sympathy with him, together with the earnest hope that possibly his other hand may yet be saved.

"I remain, dear Madam, yours very faithfully,
"Arthur Davidson."

Queen's College, Belfast.—List of Prizewinners.

The following have been awarded prizes at the class examinations in medicine lately held:—Chemistry.—J. H. Beverland, H. M'Ilroy. Practical Chemistry.—Senior: Adam Anderson; Junior: Joseph Porter, Frederick W. M'K. Thomson, Robert M. Beath, B.A. Chemical Laboratory.—Kenneth C. G. Arbuthnot, Frances E. Blair. Anatomy.—Senior: William W. D. Thomson, William A. Berry, Robert A. Kerr, Harold Black. Junior: Thomas D. Graham, Frederick Crooks. Practical Anatomy.—Senior: Robert A. Kerr, William W. D. Thomson, Charles J. Simpson, Harold Black, Henry P. Malcolm, William O. Wilson, B.A. Second Year: William A. Berry, Robert J. M'Connell, William K. Calwell. First Year: Frederick Crooks, Thomas D. Graham. Physiology.—Senior: William A. Berry (Harold Black and Robert A. Kerr equal), Melville C. Irwin. Junior: Robert J. M'Connell, Thomas D. Graham, William M. O'Farrell, William M'M. Millar. Practical Physiology.—Charles J. Simpson, Robert A. Kerr (Harold Black and Frederick O. Clarke equal). Practical Histology.—William Wilson, (Norman B. Graham, B.A., and Robert J. M'Connell equal). Special Prize for Histology Demonstrations.—Charles J. Simpson, George Cooper. Materia Medica.—(Harold Black and Samuel E. A. Acheson equal), Melville C. Irwin, William A. Anderson. Special Mid-Session Prizes.—Harold Black, Samuel Edwin A. Acheson, William F. Algeo. Medicine.—Senior: (David S. Clarke, B.A., and Caroline J. Crawford equal), Caroline V. Lowe. Junior: William W. D. Thomson, Harold Black, William A. Anderson. Midwifery, Gynæcology, and Diseases of Children.—Alexander Patton, B.A., William Dickey (Alexander V. Craig and John James Gilmore equal). Surgery.—John James Gilmore, Alexander V. Craig, William Dickey. Ophthalmology and Otology.—John J. Gilmore (William Dickey and Alexander V. Craig equal). Sanitary Science.—Alexander V. Craig, John J. Gilmore.

PASS LISTS.

University of Durham Faculty of Medicine.

The following Degrees have been conferred during April, 1908:—

Doctor in Medicine.—James G. Gibb, M.B., B.S., Durh.; Sampson G. V. Harris, M.B., B.S., Durh.; Arthur H. Nott, M.B., Durh. (*in absentia*); John C. Pearce, M.B., B.S., Durh.; William T. Sewell, M.B., B.S., Durh.; Edward Tate, M.B., B.S., Durh.

Doctor in Medicine for Practitioners of Fifteen Years' Standing.—David Donald, L.R.C.P. and S., L.F.P.S., G.; B. W. N. Gowring, M.R.C.S., L.R.C.P.; Robert Hudson, L.M.R.C.P. and S., I.; Walter W. Nuttall, M.R.C.S., L.R.C.P.; Robert G. Reid, L.R.C.P. and S., L.F.P.S., G.

Master in Surgery (M.S.).—James G. Gibb, M.B., B.S., Durh., M.R.C.S.

Bachelor in Medicine (M.B.) and in Surgery (B.S.).—Ronald M. Davies, Helen M. Gurney, Arthur H. Hogg, Ernest L. Markham, Gertrude E. O'Brien, Charlotte Purnell, Elizabeth Patteson, Hubert Shield, Eric F. Waddington, Leslie H. Walker, James B. Williamson, John F. Young.

Bachelor in Hygiene (B.Hy.).—Robert Samuel Trotter, M.D., Aber.

And the following received the Diploma in Public Health (D.P.H.).—Samuel T. Cochrane, M.B., B.S., Durh.; Lilian M. Chesney, M.B., Ch.B., Ed.; Edward G. Dru Drury, M.D., B.S., Lond.; George P. Harlan, M.D., Ch.B., Glas.; Robert S. Trotter, M.D., Aber.

University of Aberdeen.

At the Graduation ceremonial on April 7th, 1908, the following degrees were conferred:—

Degree of Doctor of Medicine (M.D.).—William F. Croll, M.A., M.B., Ch.B. (with Honours); William S. Garden, M.B., Ch.B.; James Robertson, M.B., Ch.B.; Lieut.-Colonel Henry Thomson, M.B., C.M., I.M.S., Sanitary Commissioner for Madras, India.

Degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (Ch.B.).—James Watt, M.A. (with First Class Honours); Thomas C. Boyd, M.A. (with Second Class Honours).

Ordinary Degree.—John Anderson, Alex. A. Bisset, John Brown, Donald Buchanan, James B. Cruickshank, James G. Danson, George C. Davidson, Adam Gilchrist, James A. Hendry, M.A., B.Sc.; Edward Johnson, James W. Littlejohn, Wm. G. Macdonald, James D. Mackay, John F. Macleod, Rae McRae, Allan Massey, William Mearns, Arthur J. Milne, Thomas B. Nicholls, Ian Ogilvie, Arthur W. Pirie, Douglas Porter, John Rennie, Robert Ross, Andrew J. Shinnie, William A. Watson. Wm. G. Watt, Maurice J. Williamson, Douglas Wood.

Diploma in Public Health.—William Begg, M.B., Ch.B. (Aberd.); John H. Moir, M.B., Ch.B. (Aberd.); George Scott, M.B., C.M. (Aberd.), Lt.-Col. late R.A.M.C.

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

OMEGA.—Our correspondent is thanked for his communication. We have dealt with it editorially elsewhere.

VACCINE STATISTICAL TABLES.

WE have been asked by the Association for the Supply of Pure Vaccine Lymph, the well-known agents of Dr. Warlomont's calf vaccine, to insert a note as to their published statistics. For the March quarter of 1908 402 insertions have been made, with the satisfactory result of 367 typical first-rate and 35 secondary vesicles. Lest there should be any misconception as to the exact meaning of the 35 secondary vesicles, we are informed that two were accidental, there being two cases producing two typical and one secondary vesicles. The 33 remaining were produced from 11 cases of three insertions each by the same operator, using similar vaccine, and on a similar occasion. It is tolerably certain that the failure to develop first-rate vesicles in these 11 cases must have been due to a difference in personal susceptibility. In view of the long-established excellence of Dr. Warlomont's vaccine, we are pleased to explain what may at first sight appear to be a slight deficiency, but is, in reality, a high testimony to the trustworthiness of the vaccine.

B. C. (Woking).—The newspaper report has reached us from another source, and has been placed in the hands of our staff.

A SUFFRAGETTE CLINIC.

AN establishment has been set up in Berlin for a clinic conducted entirely by female doctors. The work of female doctors has been carried on hitherto under difficulties, though upwards of 200 operations are performed annually entirely by women. The new clinic, which is the result of persistent efforts, chiefly of Fraeuleins Franciska and Henriette Tiburtius, the former a doctor of medicine and the latter a doctor of dentistry, will be a kind of private hospital, where any Berlin woman doctor may bring her patients and treat them, and, if necessary, perform operations on them.

BRISTOLIAN.—If our correspondent will refer to our issue of February 26, 1908, he will find that the subject is discussed in our editorial columns.

Meetings of the Societies, Lectures, &c

WEDNESDAY, APRIL 22ND.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Diseases of the Skin (Dr. Meachen); Diseases of the Eye (Mr. Brooks).

THURSDAY, APRIL 23RD.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital Tottenham, N.).—2.30 p.m.: Medical Out-Patient Clinic (Dr. Whiting); X-Rays (Dr. Pirie).

FRIDAY, APRIL 24TH.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Operations. Medical Out-Patient Clinic (Dr. Auld): Diseases of the Eye (Mr. Brooks): 3 p.m.: Medical In-Patient Clinic (Dr. Leslie).

ROYAL SOCIETY OF MEDICINE (20, Hanover Square, W.—Electro-Therapeutical Section (Hon. Secretary: Reginald Morton): at 8.30 p.m. Paper: Dr. Reginald Morton: The Electrical Treatment of Atonic Conditions of the Digestive System.

Appointments.

DOMINY, GEORGE HERBERT, L.R.C.P.Lond., M.R.C.S., District Medical Officer by the Blandford (Dorset) Union.

FOTHERGILL, W. E., M.A., B.Sc., M.D., Honorary Assistant Gynæcological Surgeon to the Manchester Royal Infirmary.

HOLLANDER, BERNARD, M.D., M.R.C.S., L.R.C.P.Lond., Physician to the British Hospital for Mental Disorders and Brain Diseases, Camden Road, N.W.

JAMES, A. M. A., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Kingscliffe District of the County of Northampton.

LAWSON, J. WARD, M.R.C.S., L.R.C.P.Lond., Physician to the British Hospital for Mental Disorders and Brain Diseases, Camden Road, N.W.

MANSON, KENRED, M.B., B.S.Dunelm, House Physician to the Royal South Hants and Southampton Hospital.

NICHOLLS, A. R., M.R.C.S., L.R.C.P.Lond., Assistant Medical Inspector of Schools for the Langport District of Somerset.

PARSONS, J. F., M.R.C.S., L.S.A., Assistant Medical Inspector of Schools for the Frome District of Somerset.

POLLARD, G. S., M.R.C.S., L.R.C.P.Lond., Assistant Medical Inspector of Schools for the Frome District of Somerset.

SHIPWAY, F. E., M.D., B.C.Cantab., Honorary Anæsthetist to Guy's Hospital.

THOMAS, FRANK LESLIE, M.B., B.S.Lond., L.R.C.P.Lond., M.R.C.S., District Medical Officer and Medical Officer to the Workhouse by the Barnstaple (Devon) Board of Guardians.

WALTER, R. H., M.B., M.S.Edin., has been appointed Assistant Medical Inspector of Schools for the Yeovil District of Somerset.

WILLIAMS, CHISHOLM, F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.Lond., Medical Officer to the X-Ray Department at St. John's Hospital for Diseases of the Skin, Leicester Square, London.

Vacancies.

Borough of Bootle.—Hospital for Infectious Diseases.—Resident Medical Officer. Salary, £120 per annum, with board, washing, and apartments at the Hospital. Applications to the Chairman of the Health Committee, Town Hall, Bootle.

Borough of Southend-on-Sea.—Medical Officer of Health. Salary, £550 per annum. Applications to William H. Snow, Town Clerk, Southend-on-Sea.

County Borough of Preston.—Schools Medical Officer. Salary, £250 per annum. Applications to Alfred Howarth, Town Clerk, Town Hall, Preston.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

Prince of Wales General Hospital.—House Surgeon, Salary £75 per annum; House Physician, Salary £75 per annum; Junior House Surgeon, Salary £40 per annum; Junior House Physician, Salary £40 per annum. Each appointment with residence, board and laundry. Immediate application to Fredk. W. Drewett, Director. (See Advt.)

Staffordshire County Asylum at Stafford.—Second Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—Assistant Casualty Medical Officer for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Physician for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications addressed to the Secretary. (See Advt.)

Births.

NICOLL.—On April 17th, at 22, Abingdon Villas, Kensington, the wife of Charles Vere Nicoll, M.R.C.S., L.R.C.P.Lond., of the above address and Iverna Court, W.—a son.

QUIRKE.—On April 10th, at 308, Lillie Road, S.W., the wife of John J. Quirke, M.R.C.S., L.R.C.P., of a son.

WALKER.—On April 14th, at 35, Westgate, Peterborough, the wife of R. Alec Walker, M.B., F.R.C.S., of a son.

Marriages.

CARRICK—MURRAY.—On April 15th, at the United Free Church, Sanquhar, Peter Carrick, M.A., M.B., Ch.B., of Blackheath, London, to Kathleen Macintyre, eldest daughter of William Murray, J.P., Agent British Linen Bank, Sanquhar.

MACKAY—CROMMELIN BROWN.—By Spanish Law, at Huelva, Spain (the domicile of the bridegroom), and afterwards, on the 13th April, at the Langham Hotel, London, by the Rev. David Macdonald, B.D., of Manchester, William Alexander Mackay, F.R.C.S., and M.D.Edin., to Louisa Emily Crommelin Brown, daughter of the late John Crommelin Brown, of the Indian Civil Service.

Deaths.

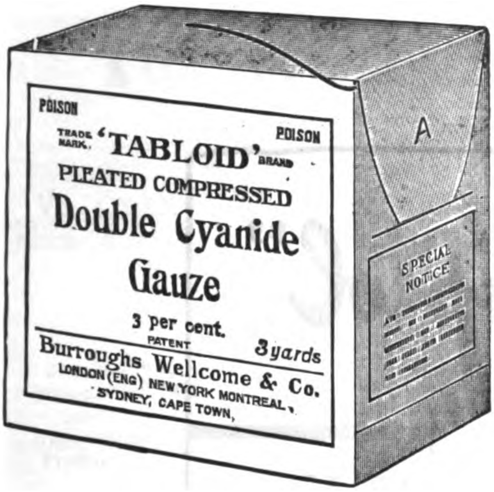
KNOX.—On April 15th, at his residence, Summerhill, Kingstown, Francis Blake Knox, L.R.C.S.I., L.K.Q.C.T.I., son of the late Captain F. Blake Knox, 5th Dragoon Guards.

PECHEY-PHIPSON.—On April 14th, at 29, Grimston Gardens, Folkestone, Mary Edith Pechey-Phipson, M.D., formerly Chief Physician of the Cama and Allbless Hospitals, Bombay, wife of Herbert M. Phipson.

RUSSELL.—On April 15th, at 17, Canynge Road, Clifton, Elizabeth Mary, widow of the late John Russell, M.R.C.S., of Clifton, Bristol, aged 77 years.

SPICER.—On April 15th, at Granada, Spain, Florence, the beloved wife of W. T. Holmes Spicer, F.R.C.S., 5, Wimpole Street, London.

WALKER.—On April 13th (midnight), at Wolverton, Beckenham, Joseph Walker, M.D., M.R.C.S.Eng., L.D.S., late of 22, Grosvenor Street, London, W., in his 83rd year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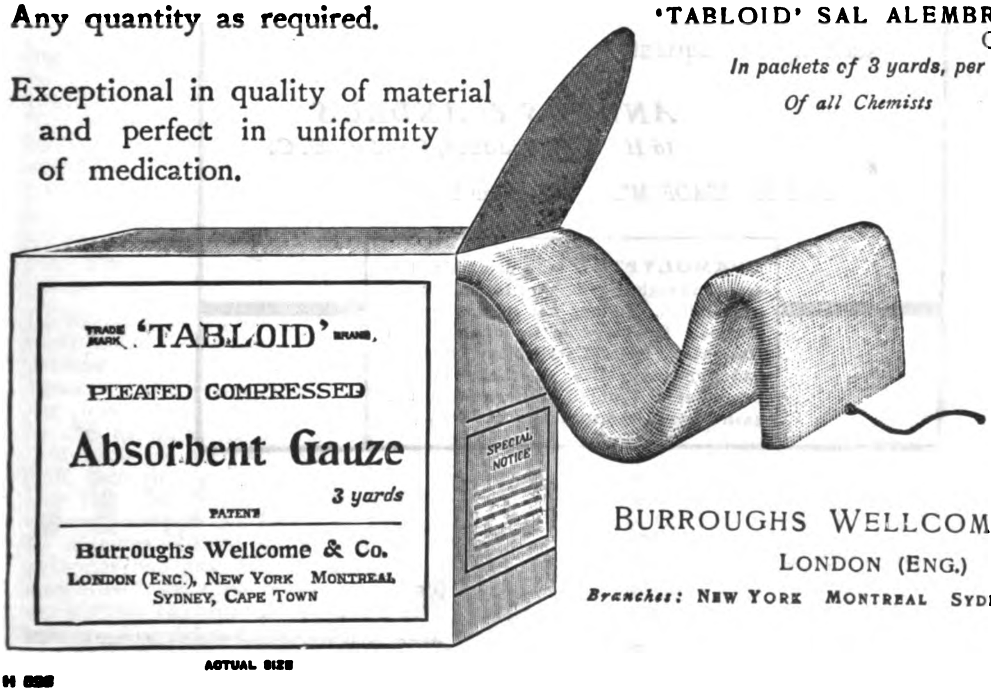
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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Criminal Prosecution and Unqualified Practice.

AT the risk, we fear, of wearying our readers, we have contended over and over again that, even with the present laws, a vigorous administration can do much to prevent fraudulent quackery, and we have lamented with almost tiresome iteration the supineness of the Treasury and chief constables in following up and prosecuting charlatans. The well-known Brighton case showed how easily possible it is to get these rogues punished if a well-worked-up and well-directed case be presented at assizes. Last week another prosecution on similar lines was undertaken. A man named Mortimer, who, it is alleged, has been practising in Exeter under the style of "Dr. Mortimer, U.S.A., Medical Specialist," was charged with fraudulently obtaining sums of money varying from £1 12s. to £4 from various persons. Counsel, in opening the case, said the people defrauded were of the poorest class of society, who, on account of illness, had been ready to listen to any quack who promised them relief. It appeared that Mortimer issued a bill which was circulated in the town, describing himself as "The Great American Doctor, Prof. Mortimer (Berkeley College, Boston, U.S.A.)," and detailing how he had "devoted a life-time study of every disease that affects and afflicts humanity," and had "equipped himself with every modern appliance for the diagnosing of every disease in existence." This bill went on to state, among much of a similar character, that "Prof. Mortimer wishes it to be known that he has no patent cure-alls to sell—no quackery, but offers you the advice of a renowned medical specialist."

The Fine Line.

IN outlining the prisoner's offence, counsel said that the plan adopted was the same with all patients, namely, first to frighten them and then to allay their fears by saying he would work a cure, always insisting on having cash down before the treatment was begun. A guarantee was given that the money would be refunded if the desired effect was not produced, but the prisoner only seems to have stayed a fortnight in the town. Some of the medicine was analysed and found to consist principally of water with a little colouring matter and sal volatile. At the hearing the first case broke down, but a number of others were proceeded with, and evidence was given by a detective from Swansea to the effect that the prisoner had practised in that town as a "medical specialist" for three weeks, and stood committed on similar charges for offences perpetrated in that town. The defence raised by the prisoner was to the effect that any man could practice medicine and surgery in England, and that his treatment was legitimate and *bonâ fide*. He hoped to bring witnesses on his behalf, failing which the Recorder said he would commit him for trial. At this stage of the case we are precluded from comment, but we cannot but express our pleasure that the police authorities are setting to work on these cases of unqualified practitioners, as such proceedings are manifestly in the public interest, if only for their educative influence.

Stiffening of the Brain.

DR. FREYBERGER continues the pathologist of election in South-West London, and we await the day when he will be placarded in the papers as "the celebrated specialist," or on the lines which the journals, by common consent, have adopted with regard to Mr. Pepper, "the famous expert, Professor Freyberger." But whether specialist or not, Dr. Freyberger's word passes apparently for gospel with the coroners who delight in his evidence. At Lambeth, last week, an inquest was held on a 17-months' baby who had died at St. Thomas's Hospital soon after the operation of trephining. The hospital pathologists were, presumably, considered incompetent to do the work which it is their life's business to do, namely, to give an expert opinion on the cause of death, and so Dr. Freyberger was resorted to. This gentleman said that he found the left side of the brain smaller than the right; the brain substance very stiff, resembling a cheesy substance; whilst in the cavities were hard nodules. On the right side some of these had run together into a hard, gristly mass. "Death," he continued, "was due to shock following the operation whilst the child was suffering from stiffening of the brain." To him said the Coroner: "Is this disease you have described common?" "No," answered Dr. Freyberger, "very rare." Here at last we are on common ground with Dr. Freyberger; "stiffening of the brain," in our experience, or in his, is certainly rare. But one cannot help the reflection whether it is worth while to get a gentleman from Regent's Park to Lambeth to say so.

Dr. Kerr and Medical Inspection.

WHEN Dr. Kerr speaks on school hygiene he reminds us of the trout among the minnows. With all due deference to medical officers of health and philanthropic people who are interested in children, the administration of the new Act should be, and can only effectively be, carried out by persons of certain qualifications, and however advantageous a knowledge of sanitary conditions may be, public health accomplishments, in the ordinarily-accepted sense of the term, do not necessarily connote any fitness at all for the inspection of children. At the recent conference of the National Association of Teachers, Dr. Kerr read a paper on "The Medical Inspection and Treatment of Children," in which he showed up the impracticability of many of the arrangements which are being rushed into by the authorities of one kind and another. "Medical inspection," he said, "was not the weighing and measuring of every child in England. That would be pure waste of money, without use educationally or medically . . . . and the recording of most childish complaints was not worth the trouble." These are very wise words which we are glad to see spoken so faithfully. It appears that education authorities, having been bidden from Whitehall to put medical inspection under the medical officer of health, have jumped to the conclusion that a cheap junior is good enough for the work, and that inspection is the sort of formal business that anyone can carry out, anthropometrical results being the chief aim and object of the system.

The System and its Future.

Now, as Dr. Kerr showed, the inspection should be devoted to the picking out of children with defects, ocular, mental, and so on, but that the school doctor should have a far more extended function than this, namely, that of studying the conditions of school work, of educational methods and routine, and of premises and apparatus. It is is obvious that, to give sound advice in these matters, a medical man, besides his technical knowledge, and besides some special knowledge of children, must be thoroughly *au fait* with the methods of education, and be in a very distinct degree a man of special qualifications. Such work has, indeed, no concern with the purely sanitary department, and requires a man of a type which can only be catered for by a public service. In our minds, the ideal should not be the subordination of the school doctor to the medical officer of health, but his amalgamation with the certifying factory surgeon, whose work in many respects is similar to his, as an independent public officer, free from the influences of local prejudice and independent of petty authorities. The Board of Education, however, have ruled otherwise, and, presumably, only bankruptcy of the present system can effect any change.

"Still They Come."

It is interesting, as a comment on the conditions of medical practice, to note that at the recent election of a medical officer of schools for Brighton no less than seventy-three candidates presented themselves. The salary of the post was only £300 a year, rising, at the discretion of the Education Committee, to £500, and presumably carried no extra emolument of any kind in the shape of pension, and so on. Yet for it there was an influx of applications such as one would have expected if the salary had been £1,000, rising to £1,500. The candidates, too, were of a high level of excellence, not mere disappointed "wasters" or adventurers. It seems, then, that the earning powers of brilliant members of the profession of the age of 30 or thereabouts may be put down at something below £300 a year, without anything much in the way of prospects. If any parents are thinking of putting their sons into the profession, they would do well to take note of the fact. Time was when an appointment of £300 a year was considered a pleasing addition to a practice; now it looks like being the be-all and end-all of medical existence. And the cry is, "Still they come."

It is a curious fact, noted from various parts of the United Kingdom, that an unusual amount of Eustachian deafness has been associated with the recent prevalence of influenza. Fortunately, the deafness is limited to weeks, or in some instances to two or even three months' duration.

LEADING ARTICLES.

THE RESEARCH DEFENCE SOCIETY.

The foundation of the Research Defence Society, under powerful auspices, marks a new stage in an old-standing social controversy. Hitherto the anti-vivisectionists have been permitted practically to work their own sweet will without let or hindrance. Now and then, it is true, there has been a public discussion, but it cannot be said that the whole case for comparative research has ever been authoritatively presented by those best qualified to speak. The only exception to that general statement was the expert evidence given in the action for libel in which the Hon. Stephen Coleridge was mulcted in heavy damages. The crushing blow inflicted by that lawsuit has been followed by a second Royal Commission, in which the anti-vivisectionists who have come forward have been subjected to a rigorous cross-examination as to the grounds of their statements. The wild rhetoric of the platform and the pamphlet is apt to cut a sorry figure beneath that kind of ordeal, and this was conspicuously the case in the present instance. In the most recently published report of the Royal Commission on Vivisection, an anti-vivisectionist, who had been engaged in practice as a qualified medical man for fifteen years, was taken over some of his statements in a book entitled "A View from Within." One passage described an experiment at University College upon a dog, which was kept alive by artificial respiration through a tracheotomy wound: "At each stroke of the bellows," he wrote, "a little ether was pumped in with the air—a much feebler blast than that used at Strasburg." It seems hardly credible that any person who had undergone any sort of scientific training could advance a definite statement of that kind, depending solely for his information upon his own unaided senses of sight and smell, and upon memory of what he had seen at Strasburg on a previous occasion. Yet such appears to be the inevitable deduction from the published evidence. Moreover, the witness further admitted he had not inquired from either of the professors present as to the amount of ether used. The same writer began by saying that his book was written to inform the public of what went on in the laboratories. He had worked for several months in various Continental laboratories, but never in an English one. In his book he wrote: "My knowledge of what is done on the Continent, and my studies of the *Journal of Physiology*, which details some of the experiments carried on in this country, prove to me absolutely that vivisection in Great Britain is not different in nature or scope to what it is on the Continent." In evidence he suggested that it was probable, judging from human nature, that the (English) vivisector did not always take care to see that the animal was properly anæsthetised, believing as he did that the animal felt little pain. Yet this witness was compelled to admit he had not a single fact to lay before the Commission in support of that belief, although, at the same time, he adhered to his opinion that the existing Act had had no influence whatever upon the practice of vivisection. We have adverted to the Commission because it affords a striking instance of the general value of the average anti-vivisectionist's intellectual methods. Before the test of logical examination his so-called facts, his propositions, and his conclusions are, as a rule, found to be grotesque and worthless. It is to be hoped that the work begun by the two Commissions that have sat on the subject will henceforth be continued by a Society which includes amongst its members many of the most distinguished names in the social and scientific life of the United Kingdom. The number of eminent medical men is overwhelming, a fact that is of immense significance when contrasted with the scanty handful of medical practitioners who can be claimed by the anti-vivisectionist party, and of those we do not recall the name of any sngle one of established scientific standing. The President of the Society is Lord Cromer, and its Secretary, Mr. Stephen Paget, who has for many years played the part of a virile protagonist in the championship of reason and of knowledge against the attacks of blind sentimentalism and prejudice. The keynote of the new body may be gathered from the opening sentence of its recently-issued circular, which runs :—" A Society has been formed, with the name of the Research Defence Society, to make known the facts as to experiments on animals in this country; the immense importance to the welfare of mankind of such experiments; and the great saving of human life and health directly attributable to them." The letter will be found printed in full elsewhere in our present issue. We cannot doubt that the Society will be joined by a large additional number of medical men.

AMERICAN MEDICAL LITERATURE.

We are all accustomed to the new spelling which characterises many, and, indeed, the majority of American works on medicine, and we have perforce to accept it with all its nerve-grating effect. We are not, however, as yet so accustomed to the absolute disregard of all the elementary principles of grammar which also is beginning to characterise these works. We have before us the last edition of our very excellent contemporary, *Surgery, Gynæcology, and Obstetrics*, a journal which always contains something new and interesting. To an English reader, however, the value of many of its articles is greatly impaired by the fault to which we have alluded. Isolated mistakes or solecisms in grammar may be made, and often are made, by the most experienced and careful of writers, but the continuous flow of illiteracy which characterises many American articles can only be the result of an entire contempt for what we may call, for want of a better name, the amenities of literature. This contempt is already manifest in the case of American orthography and etymology, and it is now coming to a climax in the case of grammar. Should it continue to make its present rapid progress, there can be little doubt that in a short time the American language, as spoken and written in one State, will become unintelligible, not alone to the British, but even to the inhabitants of the neighbouring States. Here are a few extracts from the journal to which we have alluded. In an article on "Breech Presentation" we are informed that "breeches in primiparæ are common"; that "breech presentations in contracted pelvis should have an early Cæsarean section"; and that "the material for this paper is 250 cases of breech deliveries." In an article on the "Supports of the Uterus," we are told that "the abdominal contents in an elastic sac are composed of liquid, gaseous, semi-liquid, semi-solid, and solid material of variable quantities." In an article on the "Abdominal Incision" we read that "this" (a particular form of incision) "gives a very firm closure, but does not give the access to the pathology that Pfannenstiel's incision does for the lower pelvis." In an editorial article we read that "the patient will require the constant attendance of an accoucheur, and the liquid will require to be let out at first indication of undesirable action." With so much contempt for literary amenities on the part of the respective authors, it is not strange that the printers should be similarly affected. Thus we find that the word "knowledge" is divided thus—knowl-edge; "alkaline" is spelt "alculine"; the expression "seven months' gestation" is printed without an apostrophe. Still, on the whole, the American printer, like the American artist, is vastly superior in *technique* to the American author. We do not bring forward these criticisms in any unfriendly or carping spirit, but simply because we want to emphasise the general disorder which is bound to creep into any subject once we begin to disregard rule. In America the President tries to alter the established orthography in the case of Government documents at Washington, and, as a result, Dr. Double Dash, in Nebraska, considers that he can pitchfork his words into sentences, irrespective of any guiding rules, so long as the sharp American intellect can deduce a meaning from them. There must be men in America who dislike and condemn this growing form of neglect, and if they would save the literature of their country from dropping apart into as many dialects as there are States, or even districts, they must speak at once.

CURRENT TOPICS.

Mr. Coroner Troutbeck on Anæsthetics.

In the near future it seems more than likely that a good deal of attention will be given to the subject of deaths under anaesthetics. Some recent remarks on this point by Mr. Troutbeck, the Coroner for Westminster, are worthy of careful consideration. He said that everyone who read the voluminous criticisms that were going on in the Press, both medical and lay, would see that there was an immense variety of opinion on the subject of anæsthetics. The function of coroners and juries was not to determine what was the best course for a doctor or an anæsthetist to pursue. That was the business of those gentlemen, and what coroners and juries had to satisfy themselves on was whether the cases were approached by persons who possessed the requisite skill, and whether death occurred in spite of their skill. It was obvious that they had to rely mainly on the evidence of persons whose conduct they were inquiring into, and the only possible check they could have was that a post-mortem examination should be made by some one who was not connected with any particular hospital and the medical men there. True, it was not a great check, because the important evidence came from those who were connected with the life of the patient and who were present at his death. Still, it was a check. There is a good, solid substratum of common sense in Mr. Troutbeck's remarks. Were it not that he invariably displays a profound distrust of the competency of the general practitioner to perform post-mortem examinations and to give evidence at inquests, we should endorse his views readily enough. As it is, most medical men will suspect him of special pleading on behalf of his "expert" henchman, Dr. Freyberger.

Proposed Memorial to the Late Professor Annandale.

IT is well that lasting memorials should be founded in memory of those of our brethren who have attained professional distinction in the battle of life. In the field of medicine the crown of honour is bestowed only upon those who have shown both strength and courage through many years of arduous toil. It has been proposed to establish such a memorial in the case of the late Professor Annandale, the well-known Professor of Clinical Surgery in the University of Edinburgh. Many friends and former pupils in all parts of the world will be glad of an opportunity of testifying their regard to their former teacher. The proposal is, briefly, that a fund should be raised for the purpose of awarding a gold medal annually to the best student in clinical surgery at the final examination, to be known as "The Annandale Gold Medal in Clinical Surgery." In addition to this, it is thought that a bust of the late Professor should be placed in the lecture theatre of the Royal Infirmary, Edinburgh, so long associated with his teaching. As the late Professor Annandale identified himself so closely and for so many years with the athletic life of the University, it has been suggested that, if there should be any surplus after providing for these objects, it might be devoted to some memorial in connection with the athletic club. The Committee have appointed Mr. H. M. D. Watson, C.A., 13, Rutland Square, Edinburgh, as Secretary and Treasurer.

Nursing Home Expenses.

THE desire to grow rich rapidly has presumably overtaken the average proprietor of the nursing home. At any rate, the fees charged in many of these institutions are on a scale that may fairly be characterised as extortionate, while a few deserve a stronger epithet. In forming any estimate of what is a fair remuneration for that kind of accommodation, there are, of course, a number of things to be taken into consideration. A properly equipped nursing home cannot be carried on without a large and competent staff, and a good many expenses in various directions, to say nothing of the initial outlay upon furniture and fittings. Nor will any reasonable person grumble at a fair charge, which would not drive persons of moderate means into the voluntary hospitals, where they occupy beds that were meant for the use of the poor. The excessive charge of the nursing homes and the large fees of the surgeons are leading to complaints from the public on all hands. To meet the difficulty it has been suggested that paying hospitals should be established on the basis adopted in almost every large town in the United States and Canada. There any degree of accommodation can be secured, varying from a luxurious suite of rooms for the millionaire to the single room or even the cubicle for those of moderate means. Some such adaptation of nursing home charges to the purse of the patients is absolutely necessary if justice is to be done to the poor, to the hospitals, to the sick public, and to the medical profession.

Schools for Defective Children.

IT would be hard to find a more conspicuous instance of the humane tendencies of modern times than the way in which defective children are cared for by the State. Last week the Chairman of the London Education Committee opened a special school for that class of children in the poorest part of Whitechapel. In declaring the school open, the Chairman said that that was the twenty-eighth school for physically defective and the eighty-seventh for mentally defective children. Though the ground was by no means covered, yet they were making good progress. More would be done in future to develop the trade side of the instruction. Dressmaking classes were to be started for the girls, and various trade classes for the boys; and the Committee was doing its best to find out the best things to teach the children. Under a proper scheme of education it may be hoped that many physically defective children may be rendered productive and self-supporting members of society. In such an event the money of the ratepayers will be well spent, although it will be hard to convince some of them of the justification of conveying the children to and fro daily in horsed vehicles and ambulances.

Health Reform in Ireland.

FEW philanthropic societies have such a successful record of work performed in the first year of their existence as the Women's National Health Association of Ireland, of which Her Excellency the Countess of Aberdeen is the active President. The first annual report presented at the meeting of the General Council last week in Dublin gave evidence not only of an enormous amount of energetic educational work performed and in progress, but of considerable solid results of that work. The Tuberculous Exhibition which was held in Dublin in October last has since visited, or arrangements have been made that it should visit, some fifty other towns in the country. The interest taken in the exhibition, and in the lectures delivered in connection with it, has shown itself in action by an increase in the number of open windows, by a decrease in the habit of spitting, by increased care as to the purity of the milk supply, and by increased activity on the part of public bodies in the direction of providing hospital treatment for consumptive patients. The activities of the Association, however, are not confined to the campaign against tuberculosis, for it has also taken up seriously the subject of infant mortality, with which it hopes to deal more effectively during the present year. We trust that in this direction, as in the other, its efforts may be fraught with success.

Country Practitioners and Vaccination Fees.

THE value of local organisation on the part of medical men has been repeatedly demonstrated of late in various parts of the kingdom, notably, amongst others, at Coventry and Sheffield. The rural medical officers of the Scarborough Poor-law Union are following suit, and have practically gone "on strike." The reason of their discontent is the recent decision of the guardians reducing vaccination fees to the absolute minimum stipulated in the Local Government Board order on the subject. A return to the old scale is demanded by the rural vaccination officers. Their contention appears to be reasonable, inasmuch as they are often called upon to travel long distances. One of them, for instance, mentioned that he had to pay visits at distances of six and seven miles, and part of his district included the hilliest part of Yorkshire. Under these circumstances it is easy to see why they should decline fees which might be considered adequate in the case of urban vaccination officers in the town. The matter is under the consideration of the Scarborough Guardians, and it is to be hoped that the firm attitude taken by the local country practitioners will be crowned with success.

Administration of Midwives Act.

The report of the Gloucester County Council Medical Officer of Health as to the administration of the Midwives Act in 1907 has been presented to the local authority. The total number of certified midwives on the Register was 361; some 18 to 20 are still required for districts at present unprovided. There is no certified midwife in nine out of a total of fourteen workhouses. The number of notices requiring medical help was 400, as against 399 and 256 in 1906 and 1905 respectively. A good deal of practical supervision and instruction appears to have been given. The report is of much interest, inasmuch as it drew marked attention to the dearth of certified women and the difficulty of obtaining their services in country districts. The fact appears to be now getting more generally recognised that under the most favourable conditions as to age and regular employment, the living to be made from the occupation in question is meagre in the extreme. Indeed, it is in many cases impossible to make a bare subsistence wage even when the midwife is clever and capable enough to eke out her income from work of other kinds. Sir John Dorington, speaking at the Gloucester Council, said that, although the Act was, perhaps, necessary in towns, it was inapplicable in the case of villages and hamlets, and he feared a very great disaster, a very sad and lamentable state of things, would be brought about by the inability of the local authorities to make the required provision. This severe criticism appears to be based on somewhat substantial grounds.

The Notification of Measles.

The high death-rate from measles has long been the despair of sanitarians. Although a mild disease, under proper conditions of care and treatment, it becomes a veritable scourge in the houses of the poor, who assume that, being a mild disease, it wants neither nursing nor medical attention. The ætiology of the malady is still so uncertain that it is difficult to conjecture in what direction the ultimate control of measles will be, for some day or other scientific medicine will undoubtedly attain a mastery over that as of all other zymotic diseases. Possibly the identification of the specific pathogenic micro-organism will be followed by the successful introduction of a curative vaccine or serum. Meanwhile, the early infectiveness of the disorder has baffled all the attempts of sanitary authorities to check the ravages of one of the most disastrous of all the exanthemata. Notification has not proved of much good, possibly because it has been applied only within restricted areas. In the case of hydrophobia muzzling was of little use until it was made universal throughout the kingdom. Meanwhile, those local authorities that have had the courage to apply the principle of notification deserve the thanks of the community. Some twenty years ago Coatbridge tried the experiment for seven years, but the Council found results not commensurate with the cost. However, it has been decided to extend for two years a recent brief period of compulsory notification of measles in the district. This public spirited action will be watched with interest in many quarters.

PERSONAL.

The King of Denmark and the Royal Family were present at the inauguration of a clinic for internal diseases opened in connection with the Finsen Medical Light Institute.

The salary of Dr. Michael J. Nolan, Medical Superintendent of the Down District Asylum, Downpatrick, has been raised from £700 to £900 a year.

A dangerous attack was made on Dr. Civel, of Brest, while seeing patients at the hospital in that town; one of them suddenly fired at him with a revolver. Fortunately, the bullet missed its aim, but struck another patient in the room.

Two well-known foreign medical men passed away last week in the persons of Dr. von Schrötter, Professor of Medicine in the University of Vienna, the distinguished laryngologist, and Dr. F. Terrier, Professor of Clinical Surgery in the Paris Faculty of Medicine.

A memorial is on foot to perpetuate the memory of Prof. Annandale, by the establishment of a gold medal in Clinical Surgery and a bust to be placed in the Royal Infirmary, Edinburgh. The Memorial Committee includes Sir William Turner and Mr. I. M. Cutterill.

The seventy-sixth annual meeting of the British Medical Association is to be held at Sheffield in July, 1908. Mr. Simeon Snell, F.R.C.S.Edin., ophthalmic surgeon, Royal Infirmary, Sheffield, is the president-elect, and the hon. local secretary is Mr. Sinclair White, M.Ch., F.R.C.S., Ranmoor, Sheffield.

Mr. J. J. Walker, M.R.C.S., of Peterborough, and Professor H. P. Keatinge, Director of the Government Medical School at Cairo, have been elected Fellows of the Royal College of Surgeons of England without eamination, in recognition of their distinction in surgery.

A handsome presentation was made at the Sutton Coldfield Medical Dispensary on April 15th to Dr. A. H. Evans, on the occasion of his retiring from his duties in connection with this institution. It took the form of a handsomely chased and inscribed silver cake-dish, and was handed to him by the President, Mr. E. J. Brookes, on behalf of over a hundred of the doctor's dispensary patients.

A tragic accident has marked the opening of the climbing season in Cumberland. The victim was a medical student, Mr. David Howard Caine, son of the late Mr. W. S. Caine, M.P. He was paying a visit to Wastdale Head, having done a little unpretentious climbing last year. He arrived at Wastwater Hotel, and left the next morning about 11 o'clock ostensibly for a walk. He appears to have been last seen going up towards Burnthwaite on April 13th, and nothing further was heard of him until his body was found on Wednesday afternoon.

A Clinical Lecture

ON

THE MEDICAL TREATMENT OF PHLEBITIS.

By PROFESSOR ALBERT ROBIN, M.D.,

Of the Paris Academy of Medicine.

[Specially Reported for this Journal.]

Even in affections the ætiology and pathogenesis of which are well known to us, ætiological and pathogenetic therapeusis runs often only along parallel lines, the morbid state which we wish to modify running its own course independently of the determining cause. Still we must always direct our attention to the ætiological factors when accessible, because their persistence tends to aggravate the morbid state resulting therefrom. Such is the case in phlebitis.

The infective origin of phlebitis is generally admitted, whether medical, puerperal, or surgical. Even *phlegmasia alba dolens* must be included, thus bringing it into a general category, the constituent elements of which are distinguished from each other by the mode of infection, the nature of the infection, the severity, the extent and the soil which are of capital importance from a nosological point of view, but, save in respect of the soil, hardly bear upon treatment which must be directed simultaneously to the causal infection and to the venous lesions to which it has given rise.

These remarks are applicable to the two patients under treatment in our wards, who are both entering on convalescence.

The first patient is a dressmaker, æt. 39, who has gone through two pregnancies to term without any complication. At the beginning of January, consequent upon overwork and possibly also on sexual excesses, she complained of a dull pain in the hypogastrium, rendering walking and standing difficult, accompanied by a copious, thick leucorrhœal discharge. In June she had copious metrorrhagia, for which she was admitted to Lariboisière, which she left a month later. In August, however, she was obliged to return to hospital in consequence of further hæmorrhage, this time into a surgical ward. She declined surgical treatment and went home, where she lingered on until November 15th, when she came to us.

She was diagnosed to be suffering from chronic parenchymatous metritis with slight ulceration of the cervix, copious leucorrhœa and readily-provoked bleeding. She was put on a treatment which I shall describe to you on a future occasion, but on December 15th she complained of lancinating pain and dull aching in the left lower limb, which became somewhat swollen, while the temperature ran up to 102·3° by January 1st. On this date she experienced acute pain in the calf and groin, and the entire limb became the seat of white, hard œdema.

The other patient is a married woman, æt. 22, who passed through a normal confinement on December 18th. She got up on December 30th to attend to her household duties, but on January 4th she noticed that she was passing very little urine, and that evening she was seized with acute lancinating pain in the left calf, this having been preceded by a sort of general numbness of the limb. The limb swelled up on the following day, and in 24 hours the œdema reached the hip. She was admitted on January 6th with a temperature of 103° F.

Both these patients were suffering from phlebitis of the left internal saphenous vein. A hard, tender venous cord could also be felt in the calf, and there was some effusion into the knee-joint. In view of the course in both cases it is highly probable that the phlebitis began in the calf veins, spreading thence to the internal saphenous.

From the point of view of treatment we recognise three stages in the evolution of an attack of phlebitis:—(1) An acute stage which corresponds to infection of the endovein, the formation of a clot and defensive retraction of the vein wall. (2) A period of convalescence or resolution, during which the venous lesions undergo sundry regressions, the clot becomes permeated with connective tissue and vascular granulations that absorb it in part and set up solid adhesions with the remainder. (3) A so-called residual stage at which all active retrogression is at an end and which is characterised by the existence of more or less obliterating lesions, and venous and trophic disturbances consequent thereupon.

During the first stage treatment is purely passive, and is limited to keeping the limb at rest, and measures directed to the causal infection. In the second stage treatment must be directed to bringing about absorption of the clot and repair of the venous wall lesions, with which object various physical and medicinal agents are brought to bear. In the third stage treatment must be active, since in its absence the residues may become permanent or will take a very long time to disappear, even in part.

Now, our two patients have been under observation quite from the onset, and as the infective origin of the lesions was undoubted we began by immobilising the damaged limb, at the same time treating the source of the infection as well as the infection itself.

Directly we are confronted by phlebitis, whether accompanied or not by fever, our first duty is to completely immobilise the affected limb. We made use of a metal gutter-splint, extending right up the thigh and fixed by a bandage. Before placing the limb in the splint it is covered with a thick layer of wadding, wide enough for the ends to be folded over each other in front, whereupon the apparatus is fixed by tightening the straps. I prefer straps to a bandage because it is easier to get at the limb to see how it is getting on. Before applying the wadding to the limb it should be dusted with a mixture of powdered talc and boracic acid.

Inasmuch as the patient cannot be expected to remain perfectly still, the limb should be placed in a sling or suspended in some way. Movement of the limb will thus be reduced to a minimum.

I see no advantage in the application of medicinal substances at this stage. Their application involves a certain unavoidable amount of movement and pressure which are not devoid of risk, and more than compensate for any advantage that might attend their use. If, however, there be much pain we may apply to the painful area a compress steeped in:—

Tinct. belladonnæ,
Extract opii. liq.,
Extract hyoscyami, āā 1 oz.

For the purpose of checking further infection, in the first case we ordered copious vaginal injections of boiled water at a temperature of 110° F., with tannin and laudanum, together with compresses to the abdomen steeped in the above lotion. I use tannin because I wished not only to sterilise the vagino-uterine secretions, but also to exert a curative influence on the ulceration of the cervix.

In the other patient, who still presented a fœtid lochial discharge, I ordered a slow intra-uterine injection of boiled water at 104° F. with chloride of zinc, followed by tannin injections twice daily, as in the former case.

When we wish to combat an infective condition nothing is better than hypodermic injections of metallic ferments (silver, platinum or palladium), to be made a couple of inches from the venous trunk that is involved. The effect in both these cases was remarkable, for the very next day, after subsidence of the slight rise of temperature which almost always follows these injections during the first few hours, the fever fell, permanently in the first case, but returning in 48 hours in the second, only to disappear for good after another injection.

There is no necessity to give antipyretics in presence of fever, since the injection of metallic ferments does all that is required. This may be repeated every other day in 10 cc. doses as long as there is any temperature. The best preparations to employ are the solutions that are neither stabilised nor isotoned, containing about three-hundredths of a milligramme (about 1/1700 of a grain) of the metal in each cubic centimetre. As far as my knowledge goes, no importance attaches to the choice of a particular metal.

The patients should be kept on milk diet or lacto-vegetarian diet so long as there is any temperature. When this has returned to normal they may be put on a mixed diet in accordance with their appetite and digestive powers, taking care to keep the bowels regular. The latter may be secured by means of enemata of tepid boiled water, or by giving after meals a warm infusion of senna leaves.

Immobility must be maintained on an average thirty days after the last rise of temperature. When, however, there has been no rise of temperature it may be reduced to twenty-five days or three weeks, never less. In any case, it is better to err on the right side for prolonged immobility entails no drawbacks at all comparable with the danger attending premature movement.

The surgical treatment of phlebitis has been recommended on the ground that it averts all danger of embolism, avoids the necessity for prolonged immobility, and is a safeguard against recurrence; but, in my opinion, surgical intervention entails far greater risk than the medical treatment, save in a few exceptional cases of varicose phlebitis with marked tendency to embolism and recurrence.

At the present time thirty days have elapsed since the last rise of temperature in our first patient, the second being in her twenty-fourth day. We have to decide on our attitude during the second stage which has now arrived, the stage of resolution and convalescence. When we have decided that immobility may be dispensed with we loosen the straps or bandages, open out the splint, leaving the limb therein for from twenty-four to forty-eight hours. On the third day we take off the splint and gently cleanse the limb, which is then wrapped in cotton wool, fixed by four strips of bandage. Matters are left thus for four days, unless there should be a rise of temperature or pain, in which event this stage is prolonged until things have returned to normal. After the four days take off the cotton wool and leave the limb free in bed. We may then proceed to a more thorough cleansing of the skin.

Now is the time for us to employ medicinal and physical agents. The most generally employed of the medicinal agents is hamamelis virginica, on account of its vaso-constrictive properties. Every morning the limb is gently rubbed with the following ointment:—

Ext. hamamelis liq., 3 parts
Benzoinated lard, 30 parts.

This drug should also be given internally in conjunction with viburnum prunifolium, which has the same properties. These are usually given in from 30 to 60-drop doses daily, but the effect is almost always to upset the stomach, so I prefer to give 10 drops daily of the following mixture:—

Ext. hamamelis liq.
Ext. viburni prunifol, āā 10 parts.

We get better effects from a small dose that is well borne and can be continued for a long time than from large doses that will soon have to be suspended on account of digestive disturbance.

Now comes the highly important question of movement and massage of the limb. We have recognised the error of the old teaching, according to which forty days' immobility was a minimum, since we learned from Cornil and Marie that after the sixth day of an attack of phlebitis there is already a sufficient reaction on the part of the venous wall to determine the formation of neo-capillaries that penetrate the clot, develop connective tissue, and soon convert clot and vein-wall into a cicatricial cord. We must not, however, go as far as Marchais, who asserts that this process is so rapid that phlebitis has ceased to be dangerous by the time the diagnosis is clear, and who attributes delayed embolism to subsequent inflammatory outbreaks in another part of the vein. Nor must we fall into the exaggeration of Delore and Poullet, who forbid active measures until several months have elapsed after convalescence. As a matter of fact, we may commence passive movements about six days after removal of the splint, taking the temperature regularly, and desisting should there be any rise.

Begin with movements of flexion, circumabduction and extension, first of the toes, then of the foot, without lifting the foot from the bed. A few days later we may tackle the knee, and, finally, practice abduction and adduction of the limb, which may also be slightly raised.

If these movements provoke no reaction, in ten days or so we may start on the veins, first by allowing the limb to hang out of bed for a few minutes at a time until it begins to get livid. Later on, the patient will be allowed to put the foot to the ground after stretching it on a plank which answers the purpose of an inclined plane.

At this stage I strongly forbid movements intended to combat the muscular atrophy by stimulating contraction, moving the joints, and, more particularly, manipulation of the veins themselves. If, however, by massage you merely mean manipulations that tend to stimulate innervation, circulation and nutrition without entailing any risk of displacing the clot or setting up some latent inflammatory process, then I am with you.

Therefore, only have recourse to the gentlest possible *effleurage* without any pressure and still without touching the phlebitic veins. Practised thus the *effleurage* may stimulate the skin and through it the peripheral circulation without inducing any change in the anatomical condition of the veins. In any case, this treatment, repeated daily for ten minutes or so, tends to get rid of the œdema and curtails the duration of convalescence.

To assist the action of the superficial *effleurage* the limb may be rubbed every evening with the following ointment:—

Ext. ergotæ liq., 3 parts.
Potassii iodid.,
Ext. nucis vom., āā 2 parts.
Vaseline, 30 parts.

The extract of ergot exerts a tonic action on the superficial veins, the iodide is a mild, but trustworthy resolvent, and the nux vomica stimulates cutaneous innervation.

I also recommend applying a mixture of two parts of iodine liniment and one of laudanum over the veins with a brush.

The duration of this period of convalescence, during which the patient remains in bed, varies from fifteen to thirty days. It may be regarded as at an end when pressure on the veins elicits no tenderness and all œdema has disappeared.

We now enter on the residual stage. The initial process has subsided, but the circulation in the limb is more or less defective, and it soon becomes cyanosed when allowed to hang down. All the muscles are wasted and their place is taken by fat, œdema is readily provoked, and the skin is thickened. There is a variable amount of functional impotence; lastly, the patient often complains of shooting pains in the limb, these pains being usually neuritic or neuralgic, to be distinguished from the early venous pain by the fact that pressure on the veins is no longer painful. This distinction is not without its importance, because should the pain be venous we must hold our hands or even retrace our steps awhile, whereas if merely nervous or neuritic it should disappear under treatment.

The treatment consists principally in baths and packs, *effleurage* and real massage, movements and medicinal agents.

A daily bran bath, at a suitable temperature, in which is dissolved a packet of salts resembling those of Bagnoles de l'Orne water, viz.:—

Sulphur monosulphide, 2 gr.
Sodii chlor., 4 dr.
Calcii biphosphat., 1 dr.
Calcii sulphat., 8 gr.
Ferri et manganese chlor., 2 gr.
Calcii bicarbonat., 25 gr.
Magnesia bicarbonat., 40 gr.
Lithine silicat., 10 gr.
Potassi silicat.,
Aluminis silicat., āā 40 gr.
Sodii arseniat., 2 gr.
Gelatin, 2½ dr.

For one packet

The active principles in this powder are the arseniate of soda and the silicates, which are intentionally prescribed in comparatively large doses.

The duration of the baths at first will be fifteen or twenty minutes, gradually increased to forty minutes. The patient is left in bed for an hour after each bath, after which ten minutes' *effleurage*, as described above. Then another ten minutes' rest, whereupon the patient may get up and take a few steps, to stop at once should the limb tend to become cyanosed or should there be any pain or aching in the limb.

Order twenty or thirty of these baths, then desist for a fortnight or so, then three times a week.

The *effleurage* must be as gentle as possible to begin with, then gradually strengthened, but still avoiding the damaged veins. After a time we may employ genuine massage, but under no circumstances must we manipulate or rub the region of large veins, *i.e.*, between the poplitei, in the popliteal space, Hunter's canal and Scarpa's triangle.

Active movements will be necessary to stimulate the nutrition of the atrophied muscles and to get rid of cutaneous thickening and superfluous fat. We must begin with flexion and circumduction of the thigh, aided by walking in short steps, stopping on the supervention of fatigue or heaviness.

The patient must not be allowed to remain erect, when standing he must walk in order to avoid venous stasis and to assist the return of the blood by muscular contraction. Advise them never to sit with crossed legs, these to be always extended in the horizontal position.

At this residual stage local moist applications are of great service. We may employ compresses steeped in lead lotion or in a solution of sal ammoniac (5 to 10 per cent.).

Medicinal agents, though less active, must not be neglected. Iodide of potassium and arseniate of soda are useful adjuvants. Order a tablespoonful of the following mixture to be taken just before lunch and dinner:—

Sodii arseniat., 1¾ gr.
Potassi iodid., 80 gr.
Aquæ destil. fl., 10 oz.

F.M.

To be taken for ten days, then discontinued for a like period, and so on until complete recovery.

I am not in favour of making the patient wear an elastic stocking at this period, for I prefer to leave muscular action unhampered, inasmuch as this favours the re-establishment of the collateral circulation. Merely apply a crêpe bandage lightly round the limb, and not until the patient resumes his ordinary occupation will you authorise his wearing an elastic stocking.

Recovery will be completed and confirmed by one or two courses of treatment at a thermal station. Bagnoles de l'Orne has acquired a special reputation in this connection, but it is by no means the only one. The thermal treatment accelerates the venous circulation, diminishes hæmostasis and disperses all traces of œdema. In arthritic subjects the internal administration of the water will be attended by benefit. Among other stations may be recommended Ussat, Brides-les-Bains, Aix-les-Bains, Plombières-les-Bains, and Bourbonne-les-Bains.

In presence of undue adiposis, muscular atrophy and hard œdema, the mud baths of St. Amand and Dax can be recommended.

I may appear to have dwelt unduly on details, but you will find in practice that none of these is unimportant, and the best results can only be obtained by careful attention to the minutest precautions.

NOTE.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by David Newman, M.D., F.F.P.S.G. Surgeon, Royal Infirmary, Glasgow. Subject: "The Value of Early Diagnosis in Surgical Diseases of the Kidney, with Special Reference to Physical Methods of Examination."***

ORIGINAL PAPERS.

ON ASCITES RELIEVED OR CURED BY PARACENTESIS. (a)

BY FRANCIS HAWKINS, M.D., M.R.C.P.LOND.,
Physician to the Royal Berkshire Hospital, Reading.

(Concluded from page 454.)

CASE V.—Paracentesis performed eight times in two years; no re-accumulation for three years; death.—A man, æt. 25, single, had formerly been in the army, and when in India suffered from enteric fever and malaria, and was invalided home two years ago, his papers stating that he had heart disease. In July, 1895, he noticed that his feet were slightly swollen. This disappeared, and on his applying to enter the police force, it was found he had a varicocele. For this he was operated upon, and some time afterwards—about two weeks, he thinks—he noticed that his abdomen was gradually getting larger, and he experienced difficulty in buttoning his trousers. On July 14th, 1896, he was admitted under my care. He had never been a heavy drinker, and had not suffered from syphilis. He was a tall, well-built, well-developed man. There was no swelling of the feet; the abdomen was much enlarged, especially in the flanks (the umbilicus was not everted), and evidently contained free fluid. The liver dulness extended from the fifth rib in the nipple line for 7½ in.; its lower border could be distinctly felt as very firm and smooth. He had never suffered from hæmatemesis or melæna. He complained of palpitation on any excitement, and the apex beat was very distinctly seen in the fifth interspace inside the nipple line; no murmur was heard. The lungs were normal. In 24 hours he passed 30 oz. of urine, sp. gr. 1020; no albumin; temperature, 98.4°. On February 3rd he passed blood by the bowel. On February 26th a distinct systolic murmur was heard at the apex. The abdomen slowly but gradually increased in size, and on March 13th paracentesis was performed, 3 pints, 16 oz. of clear fluid being withdrawn. The abdomen was then tightly bound. On March 28th 18 pints were withdrawn, and on April 24th 16 pints 10 oz. The urine now increased in quantity, but no albumin was present. On May 22nd 17 pints 10 oz. were withdrawn. He afterwards complained of a feeling of soreness over the whole abdomen, and the temperature rose to 100°. A few days later he was allowed to sit up, and the fluid not re-accumulating to any amount, he was discharged on July 4th, but was re-admitted on October 3rd, and on October 20th 20 pints of fluid were drawn off. On this occasion he fainted, and the temperature rose to 101°. He, however, soon recovered, and was discharged nine days later. He was again admitted on January 23rd, 1897, and six days later 36 pints 10 oz. of fluid were removed. The urine had now sp. gr. 1002, no albumin. He was discharged on February 9th, and paracentesis was not required until July, when 34 pints 10 oz. were removed. He was now so much better in health that he joined his brother in the business of a greengrocer, and I frequently saw him about the streets; but in March, 1898, he again came to the hospital. His skin was now somewhat yellow in colour, and a distinct double murmur was heard at the apex. On March 12th paracentesis was performed, and 27 pints of fluid of a brownish colour were taken away. This was followed by severe acute pain over the epigastric region. On this occasion the urine contained albumin for the first time. He was discharged on April 5th, and resumed his occupation. In June, 1898, he was again admitted to the hospital. The abdomen was somewhat distended, but there was no evidence of fluid. The liver was enlarged, and could be distinctly felt for a good four inches below the costal margin. Its lower border was firm, rounded and regular. There was some slight œdema of the legs; urine, sp. gr. 1010; albumin a trace; the murmurs at the apex were still present. Twenty days later he was suddenly seized with pain in the left leg; he had a rigor, and the temperature rose to 104°. The following day, when I saw him, the left leg was of a red colour, and much swollen, the whole leg being tender to touch. In six days the temperature became normal, the leg was less swollen, and there was no tenderness. He gradually improved, and was discharged in August. In November he was again admitted. He now complained of great breathlessness, a constant hacking cough, and much pain over the præcordium. Well-marked friction was heard all over the cardiac area; no murmur was now heard at the apex. There was no evidence of fluid within the abdominal cavity; urine sp. gr. 1010—trace of albumin. He was treated for pericarditis. The friction ultimately disappeared, his cough and breathlessness left him, and he was discharged on December 9th. I saw this man from time to time, and on no occasion did I detect fluid within the abdominal cavity. He was continuing at his work. I should, however, mention that he was becoming exceedingly emaciated. On January 19th, 1902, he was carried into the hospital, and the following note was made:—"Patient admitted almost comatose; cyanosis marked; all superficial veins, trunk and limbs distended and knotty; great dyspnœa; abdomen distended; fluid present. The following day the man died. In this case paracentesis was performed eight times in two years; no re-accumulation of fluid for nearly three years. I must now briefly describe the autopsy. The abdominal cavity contained five pints of pea-soup-like fluid. The omentum was shrivelled up, the mesentery thickened and shortened, and the intestines were greatly distended. The liver was covered with a thick greyish-white coating, resembling, as the house physician described it, "a bladder of lard." It was adherent to the diaphragm. The spleen was enlarged, and its capsule much thickened, somewhat resembling that of the liver. The heart weighed 23½ oz. The pericardium was universally adherent. The right auricle was calcified, as was the whole of the right ventricular wall, with the exception of a small part near its apex. Part of the left auricle and ventricle was also calcified. There was very little muscular substance left. The right pleural cavity contained some fluid. The pleura was thickened, and the lung was adherent all over the diaphragm. The left lung was universally adherent, and the pleura was in parts cartilaginous. The following is a report from the Clinical Research Association:—"The pleura consists of dense laminated fibroid tissue which is almost devoid of nuclei. The liver is similarly covered with a fibroid capsule, and, on section, the subjacent tissues are penetrated with strands of dense fibrous tissue. The hepatic substance shows much nutmeg congestion."

(a) A paper read before the Windsor and District Medical Society.

Ending my paper at this point, I should merely have shown that paracentesis had been performed in cases of ascites from the very earliest time, and have given particulars of cases where it had been a means of cure or relief. But I wish to proceed somewhat further and consider the pathological conditions present in these cases in order that we may the better understand in what class of case we may justly expect relief or cure after paracentesis. My last case affords us an opportunity of so doing, and it exemplifies a class of case which had not received much notice from a clinical point of view until Curschmann, in 1884, and Hale White, in 1888, directed attention to them. The former spoke of this condition under the name of "zuckergussleber," or "icing-liver," and pointed out its close resemblance to hepatic cirrhosis, and the latter under the name of "perihepatitis," while Rolleston describes it as a "universal chronic perihepatitis." These names are, I venture to think, unfortunate, because they seem rather to imply that the condition of the liver is the actual disease, whereas it is but partially so, and occurs only in association with other conditions. Hence, to my mind, the name given by Nicholls, of Montreal—viz., "multiple progressive hyaloserositis," or "chronic inflammation of the serous membranes," is better as expressing general rather than special local pathological changes. It is important to recognise that this universal perihepatitis is only a part of the disease, being secondary to and associated with changes in other serous membranes. In my case, seeing the advanced stage of change in the heart, it is reasonable to suppose that the disease commenced in that organ, but the changes were, as you will remember, multiple, and this was so in all recorded cases of which I have read. This disease is slowly progressive. The chief physical signs of the serous membrane within the abdominal cavity being affected is ascites. The effusion of fluid recurs in most cases again and again after paracentesis, and yet the exciting cause of this effusion of fluid may become latent for some time. In my case, after repeated tappings, no re-accumulation occurred for nearly three years. The most remarkable case of this disease, illustrating, as it does, the re-accumulation of the ascitic fluid and the value of paracentesis, is recorded by Rumpf. A female, æt. 33, when she first consulted him in 1869, died in 1885. During this time—that is, sixteen years—paracentesis was performed 301 times. This patient, however, could attend to her household duties up to the last year of her life. Rolleston refers to an interesting case of a woman under the care of Dr. Ewart, who was married after the twentieth tapping and died after the sixtieth. Osler refers to this condition in a child on whom paracentesis was performed 121 times. The duration of life in this disease varies, according to Nicholls, from two to sixteen years, the average duration being six years. My case, you may remember, lived about seven years from the first onset of the ascites. Here we have evidence of certain pathological changes within the abdominal cavity associated with ascites when paracentesis affords great relief

But, we must ask ourselves, are such changes present in the other cases recorded? I think not. These cases are cured; there has been no return of the ascites for many years. I think that in Case III. we may have some local, not universal, perihepatitis, because, although the notes of the case make no mention of the fact, on auscultation over the liver during the early part of the illness, friction was distinctly heard. I regard this case (3) as one where the ascites was associated with peritonitis with chronic renal disease, and I may here remind you that Fagge points out that when in a case of renal dropsy the abdomen is filled with fluid to a degree disproportionate to that of the serous effusion in other parts, this is probably due to perihepatitis.

Now, as regards Cases II. and IV., the ascites was, I think, associated with peritonitis and chronic renal disease. It is perfectly true that in both of these cases there may be some perihepatitis, but, as far as I know, there is no evidence to support it, and I think that all three of these cases differ from the class of case illustrated by Case V. True, the difference may be only one of degree, and not of kind, for Hale White regards chronic nephritis as a causative factor in cases of "formative inflammation." All such cases are liable to be mistaken for cirrhosis of the liver, and such cases as II. and III. are, I think, not common; at least, the study, both clinically and pathologically, of cases of chronic renal disease shows that the presence of ascites unaccompanied by serous effusion in one or both pleural cavities is an exception. I would, however, say, given a case of ascites, where the effusion of fluid within the abdominal cavity is out of all proportion to that in any other part, and where, in addition, you have albumin in the urine, paracentesis should be performed early, and should be repeated as often as is necessary. But for the scantiness and incompleteness of the notes, I might refer to another case of ascites which I believe to be due to chronic peritonitis. Here paracentesis was performed 36 times in one year, after which the man remained fairly well for one year, and then he died. This man had a large umbilical hernia. He died some miles away from

Reading, and I did not know of his death for some months afterwards, when I heard that, before his death, he had fæcal vomiting, and that the cause of his death had been given as strangulated umbilical hernia and cirrhosis of the liver. This leads me back once more to Case IV., where the liver was, in my judgment, in a state of early cirrhosis, and a more recent examination of the patient confirms this view. And you may naturally ask, was not the ascites due to the condition of the liver? I think not; for in studying the natural history of hepatic cirrhosis, one learns albumin is not of frequent occurrence in such cases—in other words, the kidneys are not often diseased in hepatic cirrhosis—and, further, when ascites occurs, it is usually a terminal sign, and although paracentesis may be deemed necessary and performed, yet the patient dies within six to eight months after its first being performed; and this applies, in my experience, to patients in the wasted, toxæmic condition, and also to the fat, non-toxæmic stage. Did time allow I would give illustrative cases, but practically the same view has been expressed by Frerichs, Murchison and others. But, in 1892, Bristowe, in a paper read before the Medical Society of London, recorded some cases which he diagnosed as cirrhosis of the liver, where the ascites was cured by paracentesis, and Cheadle in the same year also recorded similar cases; but more recent writings would tend to show that when the ascites is cured by paracentesis, it is not due to the cirrhotic condition of the liver. Hale White, for instance, found, on consulting the records of Guy's Hospital for five years, that not one single case of uncomplicated cirrhosis of the liver long survived after paracentesis had been performed. He concludes that, "The supervention of ascites in uncomplicated cirrhosis of the liver means that the end is near, and that if a case of cirrhosis of the liver lives long enough to require a second paracentesis, it is in the highest degree probable that either the diagnosis is incorrect, or, at any rate, some other cause than cirrhosis exists to explain the ascites." But I have wandered from my cases. And now as to the bearing of the first case. The ascites in this case I judge to be associated with tubercular peritonitis. I am well aware that the evidence from necropsies of cases of tuberculosis of the peritoneum would almost negative such a conclusion, but clinical experience will, I venture to think, support it.

THE SURGICAL TREATMENT OF THE IMPERFECTLY DESCENDED TESTICLE. (a)

By EDRED M. CORNER, M.C., F.R.C.S.,

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It is impossible to give hard-and-fast rules of treatment for cases of imperfectly descended testicle, because they vary so much in themselves, particularly in their imperfections of descent, and also in their concurrent deficiency, imperfect development. There are, therefore, two points of greater magnitude to bear in mind in treating these cases—the imperfect descent, and the imperfect development. To improve the imperfect descent by operation in reality does the patient very little good. Indeed, although much can be done by operation to cure the imperfect descent, unfortunately little can be done to improve the second factor, imperfect development. It is impossible for us to make a dwarf grow to a Sandow, or an imbecile become a Darwin. They have not the requisite capital. Similarly, we cannot make a testicle grow to full size and maturity if it is not so designed and capitalised. In consequence, operations which are merely aimed at curing the imperfect descent of an imperfectly descended testicle must fall into disrepute, because they do not improve the development of the gland, which is by far the more important factor. Thus, by neglecting the question of the future development of the gland, the results of operations of orchidopexy are unsatisfactory. But not only do the operations of orchidopexy not improve the development of the imperfectly descended testicle, but often they actually do harm, by causing venous congestion and inflammation in the gland. Tersely it may be stated, that orchidopexy is an operation which very often fails, both anatomically and physiologically. Anatomically, because the gland fixed in the scrotum seldom remains there; physiologically, because the testicle is largely converted by it into useless connective tissue instead of useful epithelium. Except in very carefully selected cases, it is commonly a murderous operation. But as it is the most popular operation for imperfect descent of the testicle, it is necessary, having condemned it heartily, to examine very carefully into the other lines of treatment left to us, which are three.

The first; to leave the case alone.—This line of treatment can be pursued safely until one or any of the following occur: (*a*) attacks of pain in the testicle; (*b*) attacks of inflammation in the testicle; (*c*) hardening of the testicle; (*d*) dilation of the inguinal canal, or the development of a hernia.

The second; orchidectomy or castration.—This is only justifiable when the spermatic cord is twisted, the testicle much sclerosed, or the patient twenty-three years of age or more.

The third; orchidocœlioplasty or the abdominal reposition.—This is the most useful operation from the patient's point of view, because it neglects the comparatively unimportant imperfect descent of the gland, and ministers to the all-important imperfect development of the gland. An imperfectly descended testicle can rarely if ever form spermatozoa—that is to say, become spermatogenetic. So that its whole value may be taken to lie in its internal secretion, which is fostered by the abdominal reposition of the gland, and not in its external secretion. The reposition can be done in two ways, an extra-peritoneal orchidocœlioplasty, and an intraperitoneal orchidocœlioplasty. The latter is preferable, the gland being placed under conditions similar to those of the ovary. Increased liability of the onset of malignant disease is not incurred after orchidocœlioplasty, because it is not the abdominal position of the organ, but the concurrent imperfect development, which gives it its additional proclivity to become malignant.

From what has been said, particularly the four factors which should terminate the period of treatment by waiting—namely, pain, inflammation, hardening, and dilation of the inguinal canal, it will be seen that very few cases of imperfectly descended testicle will escape operation, especially when it is remembered that quite 80 per cent. are associated with a hernia sac. And having explained my ideas on the scope and limitations of the various lines of treatment, it only remains to state the cases in which the operation of orchidopexy is useful. It is particularly indicated in cases of movable testicle, slight imperfections of descent, and in the younger subjects, say under seven years of age.

(a) Read before the Harveian Society, April 9th, 1908.

DYSPAREUNIA IN THE MALE

OCCASIONED BY A CONDITION IN THE FEMALE.

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It is not often that the advice of a gynæcologist is sought by the male for dyspareunia, but on two occasions it has fallen to my lot to be consulted for such a condition.

In the first case, Mr. B. came to me, complaining that since the birth of their last child, intercourse had become painful for him, though having no such effect upon his wife. He said he was quite sure something must be wrong with her and only subsequent to the birth of the last child, coitus having been perfectly natural up to this point. He described the pain from which he suffered as of a cutting nature, which, at one time, was severe enough to prevent the act, and on the last occasion that coitus was attempted, he bled quite freely. I saw his wife, and on inquiry, found that her last labour had been normal, except that the perinæum had been torn (this had also happened at the two first confinements, but was promptly repaired by suturing.

On examination, the vagina admitted two fingers easily, no obstruction could be felt; in fact, everything seemed to be perfectly normal, visual examination at first gave no indication of the cause of the trouble, the perinæum *looked* all right. The lady then volunteered the statement that her husband complained that he felt as if he were entering a blind pouch low down; it was then that I examined the perinæum more thoroughly, and found that, although the superficial parts were healed, the deeper structures had not united. What happened was that the skin of the perinæum, when the penis was introduced, stretched like a thin band, with a tense cord-like edge; this was easily demonstrated with a glass dilator; it was this sharp edge of skin which was the cause of so much pain to the husband. I split this band centrally, and did a perineorrhaphy. The result has been perfectly satisfactory in every way.

The second case was of a totally different nature. Mr. T. sought my advice because intercourse was painful to both him and his wife; he felt sure there must be something wrong with her, as during coitus he seemed always to come into contact with a hard bony substance, which was so painful to him that he had frequently to desist from intercourse, and the knowledge that it was always going to be painful prevented them from indulging, except at very long intervals. They were very desirous of having a family, and although they had been married seven years there had been no sign of pregnancy.

I saw the wife, an intensely nervous woman, and examined her with considerable difficulty; she was quite virginal, penetration having never been effected. At the very commencement of my examination I soon found the bony substance complained of by the husband; this was the os pubis; directly I attempted to examine the patient, she, by arching her back, completely altered the normal position of the introitus, so that the examining finger impinged upon the os pubis; this is what always happened to her husband whenever he approached her, and was caused by fear of pain. The hymen was exceedingly tough and inelastic, and would only admit the little finger; locally, nothing else of an abnormal nature could be detected. Sexual desire and feeling were non-existent in the female, but she ardently desired a family.

I resected the hymen, dilated the introitus, and made the patient wear a glass vaginal plug for a few hours every day for a week. The result was eminently satisfactory, coitus was easily and naturally performed, and sexual feeling was soon established. Within three months of the date of the operation the patient became pregnant.

The Honyman Gillespie trustees have appointed D. E. Anderson, Esq., M.D.Paris, M.B., B.A., B.Sc., London, F.R.S.E., etc, to the Honyman Gillespie Scholarship and Lectureship in Allopathic Medicine.

HENOCH'S PURPURA,

AND ITS ASSOCIATION WITH INTUSSUSCEPTION. (*a*)

By HUGH LETT, M.B., Ch.B., Vict., F.R.C.S.,

Assistant Surgeon to the London Hospital and the Belgrave Hospital for Children.

This paper is founded on a case of Henoch's purpura in which an intussusception developed. Briefly, the clinical features of the case were as follows:—The patient, a child, æt. 3, had always been perfectly well until September 27th. On that day he had frequent stools which were partly formed, and in the evening the left knee and elbow were painful and swollen. The next morning both legs were swollen and he had severe paroxysms of abdominal pain. In the afternoon two purpuric spots were noticed on the left leg. The following day, September 29th, he was admitted to hospital, a cæcal intussusception was operated upon and reduced. The abdominal symptoms were completely relieved, but the purpura became more severe, and the hands, arms, legs, and face were covered with the eruption. Three days after the operation he complained of abdominal pain, and blood was passed per rectum on several occasions. Four days later a second intussusception developed, but the boy's condition prevented any further operation, and he died three days later with an unreduced enteric intussusception.

Henoch, in 1874, brought forward a number of cases of purpura associated with intestinal colic, vomiting, intestinal hæmorrhage, and painful swelling of the joints, and since then the condition had been recognised as a clinical entity under the name of Henoch's purpura. The case was brought before the Society in order to discuss the differential diagnosis between Henoch's purpura and intussusception, and also the diagnosis of an intussusception occurring during an attack of Henoch's purpura. That the matter was one of considerable difficulty is proved by the reporting of cases of Henoch's purpura which were operated upon as cases of intussusception, and also of cases of intussusception which occurred during an attack of Henoch's purpura, but not recognised until the patient reached the post-mortem room.

An important point to bear in mind in this connection is that not infrequently the abdominal signs, viz., paroxysmal pain, vomiting, and intestinal hæmorrhage, and even tenesmus, appear before the cutaneous lesions. Osler and others have pointed out that visceral crises might occur independently of the skin lesions. The history of a similar previous attack, however, joint pains, hæmaturia, or the vomiting of blood, should remind one of the possibility of the case being one of Henoch's purpura. In the absence of all these signs it might also be remembered that the majority of cases of intussusception occur in babies, whereas Henoch's purpura is rarely met with at that early age. Barnard found that out of 187 cases of intussusception, 135, or 72 per cent., were under one year old, while McAdam Eccles obtained a very similar result from a smaller number, *i.e.*, out of 40 cases, 27, or 68 per cent., were under one year. The joint pains are, as a rule, temporary and precede the abdominal symptoms, but they are present in a very large proportion of cases. In both conditions the pain is extremely severe and paroxysmal, but between the paroxysms the patient is fairly comfortable, though in the later stages of intussusception the pain is more continuous. A rise of temperature might be present in both, but is more frequently met with in Henoch's purpura than in intussusception. If severe vomiting be present

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(*a*) Abstract of a paper read before the Society for the Study of Disease in Children, April 10th, 1908.

from the beginning, especially if the vomit contain blood, the probabilities are against the case being one of intussusception. Tenesmus is an early symptom in intussusception, and frequent tenesmus, with the passage of mucus and blood, is in favour of intussusception, though tenesmus does occur in Henoch's purpura. In the earlier stages of intussusception the abdomen is neither tender nor distended, and this is the rule in the majority of cases of Henoch's purpura, though a considerable number of cases of the latter disease have been described in which the abdomen was tender and distended.

Finally, Mr. Lett believed that the crucial test, and the one which should be relied upon above all others in making a positive diagnosis of intussusception, was the finding of an abdominal tumour. Statements varied as to the frequency with which a tumour could be felt. Rose and Carless considered that a tumour could be felt in about half the cases; McAdam Eccles found a tumour present in 80 per cent.; and Barnard said that an abdominal tumour would be found in 75 per cent. of the cases if an anæsthetic were given. Mr. Lett, however, thought that if a careful examination were made by the rectum and abdomen, a tumour would be found still more frequently. He had operated upon twenty-two cases of intussusception, and in every case he had been able to feel a tumour before operation, either by the rectum or through the abdominal wall. In a few cases it had been necessary to give a little chloroform before it could be found, and an examination under an anæsthetic should always be made in cases of suspected intussusception, if the tumour could not be felt. The shape of the tumour was characteristic, and during an attack of pain, or frequently as the result of manipulation, it became more definite. Hæmorrhage into the mesentery and a blood clot in the lumen of the bowel had been responsible for the diagnosis of intussusception, but these conditions were extremely rare, and the tumours thus formed had not the distinguishing features of an intussusception. Hæmorrhage into the intestinal wall rarely produced a tumour which could be palpated, and, even if it did, the consistency, outline, and size of the tumour contraindicated the diagnosis of intussusception. Intussusception did sometimes occur in the course of Henoch's purpura, and here again the diagnosis rested upon the presence of a tumour. Severe tenesmus, if present, was also a sign of considerable value. In the case he described there was a definite sausage-shaped tumour, and though the purpura was noticed, and the possibility of the hæmorrhage from the bowel being due to Henoch's purpura fully recognised, an intussusception was diagnosed from the presence of the tumour.

OUT-PATIENTS' ROOM.

GREAT NORTHERN HOSPITAL.

Congenital Œdema.

AMONGST Mr. Arthur Edmunds' out-patients was a girl, æt. 20, who applied for advice concerning a small ulcer on her right leg which had resulted from a slight injury a few weeks previously. She stated that as long as she could remember her right leg had been larger than the left, and on examination the enlargement was seen to be very marked indeed. The enlargement extended from the fold of the buttock and the groin to the toes; the external genitals were normal. The limb was not appreciably longer than that of the opposite side, but the calf measurement was about two and a-half inches more. There was a certain amount of pitting on pressure, and the patient herself had noticed a considerable diminution in the size of the leg when she rested in bed, but it never diminished to the size of the normal member. The foot was slightly tender, and about three inches above the ankle-joint there was a small ulcer with an œdematous sloughing base. The rest of the skin of the leg was perfectly normal, painless, and free from tenderness. The trunk was symmetrical, and there was no facial asymmetry, but the right arm was slightly larger than the left. This type of case, Mr. Edmunds said, is of considerable interest, although practically nothing is knows as to its ætiology. The term "trophœdema" has been devised by Henry Meige to describe a series of cases of hereditary œdema, the characteristics of which are that it is "dur, blanc et indolore." His cases were mainly congenital, and occurred in many generations of the same family; but sporadic cases exist, and in some instances the swelling only appears after an injury. Thus Etienne recalls a case where a similar œdema was produced in a young girl by breaking faggots across her knee. The present case presents, he considered, some points of dissimilarity to the typical trophœdemas, but it probably belongs to this group. Although the œdema was not absolutely hard, yet the amount of fluid which could be removed by pressure was comparatively small, and the residual solid œdema was considerable. Ulceration is not a common feature, but a limb in which there is such pronounced lymph stasis must of necessity be imperfectly nourished, and a slight injury can quite readily produce an ulcer. It is possible, also, that some of the tenderness was secondary to this ulceration. The distribution of the œdema is typical, the limitation at the gluteal fold and the absence of any enlargement of the genitals occurring in the majority of such cases; the absence also of bony enlargement is also characteristic, and distinguishes these cases from hemi-hypertrophy and from true elephantiasis. Treatment of these cases has hitherto been unsatisfactory, the diminution in size which can be obtained by massage or elevation of the limb being merely temporary, and no drugs have yet been discovered which have any effect on the swelling. The introduction by Handley of the operation of lymphangioplasty may prove of benefit in these cases, but so far the method has not been applied to them.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

OPERATION FOR COMPLICATIONS OF MASTOID DISEASE (continued from "Operating Theatres," January 8th, 1908, MEDICAL PRESS AND CIRCULAR, p. 42).—This was the case of a boy, æt. 14, who had been operated upon for suppurative middle ear disease, and had later on developed symptoms at first thought to be due to temporo-sphenoidal abscess, and later to cerebellar abscess. The cause of the symptoms was found after operation to be an excessive accumulation of fluid in the lateral ventricles. When the case was last described the boy had a discharge of foul-smelling pus from the cerebellar trephine opening. This discharge gradually ceased and the boy began to improve in strength and in general condition. In about a week's time he suddenly became comatose, with Cheyne-Stoke's breathing and considerable pallor of the skin. He was, of course, quite unable to take nourishment. It was noted that there was some dulness at the bases of both lungs; this was at the time supposed to be due to hypostatic congestion. The general condition was much too precarious to admit of any further operative procedures, as it was quite clear that it would be impossible to give him an anæsthetic. Three days later he died. At the post-mortem examination the dulness which had been observed at the bases of both lungs was found to be due to the presence of infarcts. On removing the brain it was evident that there was considerable flattening of the cerebral convolutions, but there was nothing to mark where the cerebral hemispheres had been freely explored with the finger in the temporo-sphenoidal region. The left cerebellum was normal, and everything pointed to the fact that the mastoid disease on the left side had been completely removed. The right cerebellum was in a state approaching liquefaction, there was really very little of it remaining; on exploring it some very thick greenish-yellow pus was found coming from the region of the temporal bone, and on investigating this bone a considerable quantity of the same kind of pus was found in contact with it. Mr. Beale said that during life there was nothing to indicate the presence of this pus until coma supervened; it would be remembered that many weeks previously there were symptoms of a right cerebellar abscess, and after trephining the right cerebellum a large amount of fluid was removed from the right lateral ventricle, and after this the symptoms entirely abated. Later on the boy had several attacks of severe headache, but there was not at any time any unusual rise or fall of temperature, nor were there any localising symptoms. The cerebellar wound was being drained up to the time of the boy's death. The wound which had been made to drain the right middle ear and mastoid region was also open. He could, therefore, but assume that the pus had been accumulating between those two wounds, probably close to the petrous portion of the temporal bone, but it produced absolutely no symptoms until the boy became comatose, when, as before stated, he could not possibly from his general state and from the condition of his lungs have taken an anæsthetic. Mr. Beale pointed out that the pus might have been present when the right cerebellum was trephined and that, although the cerebellum was fully explored and the lateral ventricle was tapped through the trephine opening, the pus was not detected. Though these procedures removed all the symptoms of cerebellar abscess, it did not follow that there was no abscess, for the relief of tension might account for the disappearance of the symptoms. At the same time, if the pus was present it was a very remarkable fact that it did not find its way out through the cerebellar wound. On the whole, he was inclined to believe that the abscess which caused the boy's death was of the nature of a residual abscess, due to imperfect or incomplete drainage.

ROYAL FREE HOSPITAL.

Fracture of Skull in Left Occipital Region.—Mr. T. P. Legg operated on a middle-aged man who had been brought to the hospital in a profoundly unconscious condition. He was said to have fallen from a cart, and when seen soon after admission the following signs were present:—There was an irregular wound in the left occipital region; the bone could not be felt by a probe; his breathing was slow and stertorous; the pulse was 48 per minute, full and regular; the right pupil was dilated, the left was small; both failed to react to a strong light; there was some drooping of the left angle of the mouth, and it seemed as if the left arm and leg were more flaccid than the right limbs; there was no hæmorrhage from either external ear, or in the mouth, or in the nose; there was some fulness in the sub-occipital region on the left side, and this suggested a deeply situated hæmatoma. The symptoms and signs were typical of cerebral compression due to hæmorrhage, which might be either extra-dural or sub-dural. Mr. Legg said it was noticeable that there was no history of a "lucid" interval after the accident, but no one saw the accident or knew how long it had happened before the man was found; probably it was only a short time. Operation was undertaken on the possibility of the hæmorrhage being extra-dural, though it was recognised that the chances of being able to save the patient's life were remote. The wound in the occipital region was excised, and a flap of all the extra-cranial tissues turned downwards. A fissured fracture was seen running upwards towards the vertex and downwards to the base of the skull. A trephine was applied to one side of the line of the fracture, and on removing the disc of bone no extra-dural hæmorrhage was found, but instead of the dura being white, it was bluish in colour, which meant that the hæmorrhage was effused on to the surface of the brain. Moreover, the latter did not pulsate at all. It was therefore decided to complete the operation by sewing together the margins of the flap. Mr. Legg remarked that this case raised several important points as regards diagnosis, and especially treatment. That the man was suffering from cerebral compression due to hæmorrhage was obvious; the main question was whether the hæmorrhage was intra- or extra-dural, or in both situations, as was so commonly the case. The absence of a "lucid" interval after the accident suggested that the hæmorrhage was intra-dural or intra- and extra-dural. It was often impossible to tell in which position it was situated without trephining, and therefore he thought that if there was present any localising signs or a wound, operation was the best procedure, provided also that the pulse and aspect of the patient did not suggest he was actually dying. If there was nothing to guide one where to operate, nothing should be done, and in all cases it must be recognised that the prognosis was very bad. The signs in this man suggested he had a hæmorrhage on the right side, but the wound should be always explored in the first instance, and then, if there was not sufficient to account for the symptoms in the region of the wound, trephining should be done at the place indicated by the signs. This man was found to have an intra-dural hæmorrhage in the occipital region, and as this was evidently only part of a large general intra-dural hæmorrhage, a second trephining in another place on the right was not indicated. When the hæmorrhage is intra-dural, Mr. Legg pointed out, it is seldom advisable to open the dura, because the blood is in the meshes of the pia; it cannot be removed, nor can the bleeding spots be usually found, for, as a rule, the hæmorrhage comes from the contused brain substance. Mr. Legg remarked that too much reliance must not be placed on the difference in the size of the pupils. From their inequality it may be inferred that there is greater compression on one side than the other, and perhaps the larger pupil is on the side of the greater amount of blood. But their condition does not help one to diagnose an intra- from an extra-dural hæmorrhage. He also pointed out that a fissured fracture in the occipital region generally extended into the base of the skull, and though this man had no external signs of such an injury, he had probably sustained this fracture. In these injuries, also, there was frequently laceration of the frontal lobes of the brain by *contre-coup*.

The man died soon after the operation had been completed. At the post-mortem a fracture of the base of the skull extending into the left middle fossa and skirting the foramen magnum was found. There was a large hæmorrhage over the convexity of the brain, and a laceration of the frontal lobe. There was no extra-dural hæmorrhage.

The sum of £111 has been subscribed by friends and supporters of the Hertford General Infirmary for a testimonial to Dr. J. T. Tasker-Evans in recognition of his valuable services to the institution for the long period of 29 years as honorary medical officer, a position he has now resigned.

TRANSACTIONS OF SOCIETIES.

HARVEIAN SOCIETY OF LONDON.

Meeting held April 9th, 1908.

The President, Mr. D'Arcy Power, in the Chair.

Mr. Louis B. Rawling read a paper entitled

THE SURGICAL TREATMENT OF THE INCOMPLETELY DESCENDED TESTIS,

based on an investigation of 120 cases admitted into St. Bartholomew's Hospital during the past five years. The conditions prior to and at operation were alluded to, and it was shown that the almost constant presence of a peritoneal process added to the necessity of operative treatment. In dealing with the question of the treatment of the affected testis, those cases were first discussed in which one organ was normally placed whilst the other was incompletely descended. Scrotal placement was attempted in 40 cases, in 29 of which the ultimate result was observed. In 25 of these the late result was unfavourable, the testis either retreating to the pubo-scrotal, pubic, or inguinal regions, and becoming small and atrophic. In 4 cases only was the result at all favourable. The remaining cases could not be traced, though in three the early result showed that only failure was to be expected. For these and other reasons it was obvious that scrotal placement, except in the most favourable cases, was doomed to failure from the very beginning. The three alternatives—to allow the testis to remain in the inguinal region, to replace it in the abdomen, and to remove it altogether—were then considered. All evidence pointed to the fact that the inguinal testis was a source of great discomfort to the patient, and that it was more than usually liable to infection, torsion, and malignant disease, whilst the uselessness of the replaced testis from a spermatogenetic point of view was generally acknowledged. In 50 cases the testis was removed, the patients being of all ages, and it was apparent that the removal of the one organ in no way interfered with the development, mental or physical, of the patient, and the procreative powers were in no wise impaired. The normally placed testis fulfilled all the desired functions, internal and external.

Granting, therefore, that due time was allowed for the further descent of the organ, and that exposure showed that scrotal placement was out of the question, it was advisable that the affected organ should be removed and the inguinal canal sewn up.

Attempts to place the testis in the scrotum offered the best chance of success when the operation was carried out after seven years of age and well before puberty.

With regard to double failure in descent, it appeared necessary that every effort should be made to place the testes in the scrotal region, for the examination of testicles removed showed that the spermatogenetic functions were more active when the organ was in that position than when abdominally replaced. All evidence showed that the abdominally replaced testes were functionless, from a procreative point of view, and double abdominal replacement was therefore most inadvisable. In case of failure in scrotal placement it was even preferable that the testes should be allowed to remain in the canal rather than that they should be abdominally replaced.

Mr. Edred M. Corner also contributed a short paper on the subject, which will be found in another column on page 474.

The President said that it was important to distinguish between a useless and a partly developed testis. In the former case removal was advisable; in the latter replacement should be effected. He spoke of the unsatisfactory results following the operation of scrotal placement with orchidopexy.

Mr. Eccles considered that it was most important to bear in mind the property of the testis in producing an internal secretion, even when its procreative function was lost. For this reason removal should not be carried out in cases where there were grounds for thinking that the organ might have some function from its internal secretion unless the other organ were well developed. In adults removal of the imperfectly descended organ was often advisable. He considered that the operation of orchidopexy and scrotal placement was generally unsuccessful, because retraction usually occurred. He suggested a method of relieving the tension on the cord by unlooping it round the epigastric artery; this procedure considerably diminished the retraction following scrotal orchidopexy. He did not consider that the occurrence of malignant disease in an undescended testis was so common as had been stated.

Mr. Laming Evans criticised the accuracy of the statistics as to the occurrence of imperfect descent of the testis.

Mr. Lawrence Jones insisted on the importance of early operation when scrotal placement was undertaken.

Mr. Ivor Back believed that when an operation was undertaken, removal of the undescended testis was the best course to adopt.

Mr. Campbell Williams believed that orchidopexy was very unsatisfactory as regards any further development of the fixed organ.

Mr. Crisp English said that in many cases where the testis was undescended the best course to adopt was to avoid operative interference. When the condition became complicated by hernia, or local disease, an operation became necessary.

Dr. Kenneth Lees and Dr. Claye Shaw discussed the advisability of the operation of removal of the organ from a psychical point of view.

Mr. Rawling replied.

Clinical cases were also shown at the meeting:—

(1) A case of ruptured aortic valve, by Dr. Kenneth Lees.

(2) A case of ataxy of acute onset in association with tabes dorsalis, by Dr. Carmalt Jones.

(3) A case of arterio-sclerosis with retinal changes following parenchymatous nephritis in a boy, æt. 9, by Dr. W. H. Willcox.

(4) A case of scrotal tumour, by Mr. Crisp English.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, April 10th, 1908.

Dr. E. Hobhouse in the Chair.

Mr. Hugh Lett read a paper on a case of "Henoch's Purpura associated with Intussusception." The patient, a child of 3, was quite well until two days before his admission to hospital. He then had pain and swelling of the left knee and elbow. The next day both legs were swollen, and he had severe paroxysms of abdominal pain. The same afternoon two purpuric spots were seen on the left leg. He was admitted the following morning, and a cæcal intussusception operated upon and reduced. The purpura steadily became worse, and he finally died from a second intussusception of the enteric variety nine days after the first operation. Mr. Lett drew attention to the difficulty often met with in diagnosing between intussusception and Henoch's purpura when the abdominal symptoms appeared before the onset of any cutaneous lesions, and also to the difficulty in many cases of undoubted Henoch's purpura of deciding whether an intussusception were present or not. After a survey of the literature, he indicated the main points in the differential diagnosis between the two conditions, and laid stress on the importance of determining the presence of a tumour before making a diagnosis of intussusception. (An abstract of this paper will be found on page 475.)

Dr. G. A. Sutherland thought there was a special form of gastro-intestinal hæmorrhage associated with Henoch's purpura. All the signs of intussusception might be present, with the exception, perhaps, of a palpable tumour. Further, he, like the reader of the paper, had had experience of the occurrence of intussusception in Henoch's purpura. He thought that the diagnosis of spontaneous reduction, made sometimes after the abdomen had been opened, might be reserved for those cases in which no evidence of hæmorrhage was present. For if hæmorrhage were present he should regard it as a sufficient explanation of the symptoms.

Mr. Duncan Fitzwilliams said that the presence of a tumour settled the diagnosis in practically every case. He thought that it was possible to recognise the presence of a tumour in 85 to 90 per cent. of cases in infants, if careful examination were made under an anæsthetic.

Dr. J. Porter Parkinson read a paper on a case of "Tetanus Neonatorum." The patient, an infant of two weeks, had been ill for four days. The mother had had several other children, and one had died when six days old from "lockjaw"; he was unable to take the breast, and was said to have had similar symptoms. On admission to hospital there were general rigidity and opisthotonos, also a well-marked risus sardonicus. The umbilicus looked unhealthy, and discharged a thin, sticky fluid. The child improved, but died suddenly from asphyxia 17 days after admission. It was discovered that the mother had treated the umbilical wound with Fuller's earth, and it was suggested that this might have been the cause of infection both in this child and also in the previous child who had died from tetanus. Dr. Parkinson drew attention to the prevalence of this practice, and to the fact that this possible source of tetanus was well recognised by coroners. He thought that the knowledge of this should be more widespread.

Dr. Cautley and Dr. Carpenter discussed the paper.

A Member said that he had a large practice among the poorer classes, and Fuller's earth was used by probably 95 per cent. of mothers. To attribute the disease to that was, he thought, casting an undeserved reflection on the preparation.

Dr. Leonard Guthrie showed a case illustrating Eustace Smith's bruit. The patient was a boy, æt. 7. The superficial veins were enlarged over the front of the chest. On auscultation an undulating musical venous bruit could be heard at the base of the heart, occupying the whole of the cardiac cycle. The bruit was intensified and the venous engorgement became more pronounced when the head was retracted. The condition was probably due to pressure of enlarged mediastinal glands on the innominate vein, or superior vena cava.

Dr. Langmead showed a case with Eustace Smith's bruit. The patient, a girl, æt. 5½, had whooping-cough in April, 1907. Since then she had had frequent coughs, which were neither laryngeal nor paroxysmal. There was some impairment of note in the interscapular region on the right side. To the right of the manubrium sterni, a definite to and fro rushing murmur was heard when the head was retracted, but it was lost when the head was flexed.

Dr. Guthrie, in reply to discussion, said he thought he could diagnose the condition by other physical signs—namely, diminution of resonance to the right of the sternum in the second and third spaces, and by the character of the breath sounds. The breath sounds were almost tracheal in character, and were heard behind as well as in front. Spasmodic cough was a very prominent symptom, and was frequently regarded as whooping-cough.

A case of "Aortic Regurgitation" in a boy, æt. 4, was shown by Dr. Porter Parkinson. He was brought to the hospital for fainting fits. There was no history of rheumatism or other acute specific fever. The cardiac impulse was in the fifth space just outside the nipple line. There was a well-marked diastolic murmur at the base of the heart, best heard on the left side, and conducted down the sternum. The pulse was regular and collapsing. Capillary pulsation was well marked.

A case of "Recovery from Encephalitis" in a girl of 1 year and 8 months was shown by Dr. George Carpenter. Three weeks before the onset of the attack she had had measles. When admitted to hospital she had screaming fits, double optic neuritis and squint; the temperature was sub-normal. Lumbar puncture was followed by an abundant flow of fluid, which was sterile, and contained no cellular elements. She ultimately recovered completely, except that she was perhaps not so bright as she had been before the illness. The optic neuritis disappeared.

The Chairman said that lumbar puncture was of interest in such cases. It was frequently performed for suspected meningitis, and the symptoms disappeared. In one case in which there was marked retraction of the head the condition cleared up. It followed pneumonia, and pneumococci were found in the fluid.

A case of "Hypospadias" was shown by Mr. Hamilton Burt.

The heart of a child, æt. 7, with "Infective Endocarditis of the Pulmonary Valves," probably supervening on congenital disease, was shown by the Chairman. As the result of ulceration there was a communication with the aorta. In life there had been a very loud, harsh, and almost continuous bruit.

The stomach of a child, æt. 3½, who had died from tetany was also shown by the Chairman. The stomach was very small, and there was no dilatation of the colon.

Specimens from a case of "Bilateral Renal Apoplexy" were shown by Dr. Edmund Cautley. The patient, a boy of 3 months, died after an illness of two days' duration, characterised by convulsive movements and unconsciousness. There was no apparent cause for the condition.

A specimen from a case of "Congenital Morbus Cordis" was shown by Dr. George Carpenter.

A specimen and skiagram from a case of "Traumatic Separation of the Lower Epiphysis of the Femur" in a lad, æt. 14, were shown by Mr. John Poland. The diaphysis was displaced outwards and backwards without injury to the popliteal vessels. The specimen showed the appearances at the end of 38 days after the injury. The new bone deposited between the displaced epiphysis and stripped-up periosteum in front of the diaphysis was particularly to be noted.

LIVERPOOL MEDICAL INSTITUTION.

Meeting held April 9th, 1908.

Cases.

Dr. F. S. Heaney reported a case of "Malunited Fracture of Leg Bones" on which he had operated twice. The fracture of the tibia was spiral and comminuted, and, in spite of careful treatment, some 14 weeks after the injury the lower fragment of this bone was found united with the upper fragment of the fibula. The fracture was identical with one shown by Mr. Lane in his recent work on fractures, and the same peculiar vice of union had supervened in both cases, as well as in others that had come under observation. In the present case union had been brought about by screwing and wiring. Dr. Heaney advocated operation in all such cases in the first instance.

Mr. Newbolt was of the opinion that all cases of compound fracture of the tibia and fibula should be operated on as soon as possible.

Mr. R. C. Dun reported a case of "Acute General Peritonitis" in a child, æt. 4, the result of perforation of a typhoid ulcer in the lower ileum. The sudden appearance of acute peritonitis was the first indication of illness. The diagnosis of acute appendicitis with peritonitis was made. At the operation no cause for the peritonitis was found. The child lived 12 hours after the operation, and at the post-mortem definite changes, characteristic of typhoid in Peyer's patches, were found. A small perforation through an ulcer was present 4 ft. from the ileo-cæcal valve. Mr. Dun commented on the rarity of typhoid at that age, and especially perforation, the fact that there were no symptoms of illness until the perforation took place, and the difficulty of making an accurate diagnosis in such a case.

Dr. P. Marsh thought it quite possible for a child to have an attack of ambulatory typhoid as met with in adults. He agreed that typhoid is very rare in children so young, and especially perforation.

Mr. Paul gave his experience of Butlin's operation for cancer of the tongue and mouth during the three years since Mr. Butlin's lecture had been published.

The total number of cases was 35. Lip, 3; cheek, 3; palate, 1; tongue, 28. Of these 11 were favourable in size and situation, 15 were advanced cases, and 9 involved the bone. Of the favourable cases 9 were free from recurrence, 1 died from operation, and in 1 no report was obtained (a slight case). Of the advanced cases 8 were free from recurrence, 1 has recurrence, 5 died from the disease, 1 no report. Of the bone cases, none are known to be free, 4 have recurrence, 1 died from operation, 2 from disease, and 2 no report. Altogether, 17 free, 5 recurrence, 7 dead of disease, 2 of operation, 4 no report. Those free have been operated on in years and months, respectively—3.4, 3.0, 2.11, 2.11, 2.10, 2.5, 2.2, 1.10, 1.9, 1.7, 1.3, 1.2, 1.1, 0.5, 0.4, 0.4, = 17.

Mr. Paul strongly advocated a definitely planned attack on the glands in all suitable cases of cancer. He previously thought, and he believed most surgeons thought, that they had fully recognised the importance of this for several years. But it was one thing to accept a general principle and another to adopt a definite plan of attack, and since he had carried out thoroughly the details of Butlin's operation on the neck his results in tongue cases had been infinitely better than they ever were before.

BRACHYDACTYLIA—A STUDY IN HEREDITY.

Dr. H. **DRINKWATER** read a paper on the above subject, giving an account of a brachydactylous family. The chief defect in these people consists of an abortive condition of the middle phalanx in all the digits, both of hands and feet. Sometimes in the middle and ring finger this middle phalanx is reduced to a small cubical bone, but in most instances it has become ankylosed to the ungual phalanx. In no instance is it seen as a separate bone in the first or fourth finger or toe. The first phalanx of the thumb is greatly shortened, and in young children shows no sign of an epiphysis. In this respect it has undergone precisely similar changes to the middle phalanx of the fingers. The epiphysis of the so-called metacarpal bone of the thumb is at its base, whereas that of the other metacarpals is at the distal end. This shows that the metacarpal bone of the thumb is in reality the first phalanx, and that the first phalanx is homologous with the second phalanx of any other digit. The same holds good for the big toes. The metacarpals are all short and undulated at the distal ends. There are 25 people living belonging to one family who show these defects. The stature and the finger measurements of the abnormals of these families are always less than the "normals." The hands and feet are always symmetrically affected. They are prolific with from 8 to 17 children in a family; one woman has had 99 descendants (three generations). The fecundity of the woman exceeds that of the men. There is not a single abnormal individual over 23 years of age who has remained single, whilst among the normal relatives more than a dozen have remained single. The defect has been traced through seven generations, comprising 174 individuals. Among the children of abnormal parents the defect is found in over 50 per cent., thus agreeing with Mendel's law of inheritance. The children of normals are in every instance normal. The deformity prevents the abnormals from learning trades requiring manual dexterity. They are all English.

Dr. T. **BRADSHAW** said that the great point of interest in the paper, from the view of the physician, was the possibility of the inheritance of the disease taking place on Mendelian lines, so that we could in many cases assure our patients that unaffected individuals need have no fear of transmitting a family disease to their posterity. Unfortunately, there were many diseases which were clearly transmitted by unaffected people, as was shown by Dr. Gossage in the current number of the *Quarterly Journal of Medicine.*

Dr. R. J. M. **BUCHANAN** thought that the study of heredity in disease was important in that it might throw light on the ætiology of diseases about which we still remain more or less ignorant. He had found a tendency to hereditary transmission in pernicious anæmia, and quoted an instance he had met with of a mother and two sons having died from this disease; there seemed to be an hereditary tendency in the splenic anæmia of adults.

Dr. **HUBERT ARMSTRONG** recalled a family of which some years ago he had been able to show before the Institution several members in three generations. The deformity in these was microdactylia, and their hereditary history was very similar to that of Dr. Drinkwater's series, and the deformity was also symmetrical.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD FRIDAY, APRIL 10TH, 1908.

The President, Dr. A. J. **WALLACE** (Liverpool) in the Chair.

DR. **ALEXANDER STOOKES** (Liverpool) exhibited two specimens—(1) Fibromyoma uteri, (2) adeno-carcinoma corporis uteri, which presented similar physical signs. The former occurred in a patient, ii.-para., æt. 43, who had suffered for two years from menorrhagia, and for the last four months had continuous bleeding. A nodular tumour could be felt in the lower abdomen, and per vaginam a polypoid mass occupied the cervical canal. The growth proved to be multiple fibromata. The second specimen occurred in a single woman, æt. 51, who had enjoyed good health until 18 months ago, when she began to have severe pains in the left side and menorrhagia. These symptoms persisted. An irregular hard tumour was felt in the lower abdomen, which on abdominal section proved to be the uterus enlarged by adeno-carcinoma, involving the entire thickness of the uterine wall. The right ovary was also the seat of adeno-carcinoma. Recurrence with a fatal result occurred four months after the operation.

Dr. **BRIGGS** communicated a case of pelvic kidney with congenital absence of both Mullerian ducts occurring in a patient, æt. 33, one year married, who complained of occasional, never periodic, pain in the lower abdomen, and slightly increased frequency of micturition. She had never menstruated. On physical examination she was a healthy, intelligent woman. The breasts were rather small and the pelvis somewhat undersized. No abdominal tumour could be found. The vagina, 1¼ in. in length, ended in a loose cul-de-sac, beyond which the lower pole of a pelvic tumour could be felt. Per rectum the tumour felt to be partly in front and partly to the left of the rectum, but the fingers could not reach to the upper limit of the tumour.

On abdominal section, the left kidney was visible, lying totally within the pelvis against the bladder, to which a 1-in. ureter passed. It was one-third larger than normal. The hilum was directed upwards and to the right, so as to face the direction of the renal vessels. A superficial vein 3 inches longer passed to the vena cava, and covered the renal artery, which was apparently derived from the bifurcation of the aorta, and corresponded in site of origin to a very large middle sacral artery. There was no kidney in the loin of the same side. The right kidney was two-thirds of the normal size. The total absence of uterus, Fallopian tubes, or ovaries, or any representation of them, was manifest. The disposition of the peritoneum was traced—

(*a*) From the bladder in front to the rectum behind, as a smooth pouch, with the deepest portion barely reaching the vaginal cul-de-sac.

(*b*) The kidney was fixed in the pelvis, and curved in front by the peritoneum.

(*c*) The rest of the pelvis was lined by a smooth peritoneum devoid of folds.

The operation was barely exploratory.

Dr. **ARNOLD W. W. LEA** (Manchester) narrated a case of "Dermoid Cyst" of the mesentery, and showed the specimen and sections. The patient was an unmarried woman of 39, who complained of colicky abdominal and hypogastric pain and vomiting. Menstruation was regular. There was frequent micturition. Per vaginam, a tumour the size of a fœtal head could be made out, which on abdominal section proved to be a cyst of the mesentery. Removal by enucleation was carried out. The cyst was lined by large multinucleated cells, but did not show any specialised epithelial elements.

Sir **William Sinclair** (Manchester) read a paper on

ANALGESIA VERSUS ANÆSTHESIA IN OBSTETRICAL AND GYNÆCOLOGICAL PRACTICE.

He reviewed the various means adopted to mitigate pain in the Middle Ages, including the use of wine and concentrated alcohol for operations in time of war. In the practice of midwifery there did not appear to be any method employed to relieve pain at that time. The difficulty of obtaining an anæsthetic that did not interfere with the progress of labour was recognised. There were well-known drawbacks to the administration of ether and chloroform. Reference was made to spinal anæsthesia produced by cocaine and its derivatives, and to the inadvisability of such procedure in obstetrics.

A few years ago great successes were reported from the Lying-in hospitals of Germany from small doses of scopolamine, but this was not without real danger to both mother and child. The speaker went on to advocate the use of a combination of morphia, alcohol, and cocaine as an analgesic in minor gynæcological operations, and in such manipulations as the removal of retained placenta following abortion, etc. He gave 2 oz. of alcohol, masked by the liquid extract of liquorice, about two hours before operation, followed by a hypodermic injection of ¼ or ⅓ gr. of morphia, 20 minutes before the operation. The vagina was then swabbed with a 10 per cent. solution of cocaine. By this method any minor operative procedure was possible. The amount of morphia required modification according to the type of patient. In some cases where a general anæsthetic was necessary, the amount required was exceedingly small, if morphia and alcohol were previously administered.

Dr. **Knyvett Gordon** (Monsall) had used this method of producing analgesia in a large number of cases in which, on account of the serious condition of the patient, a general anæsthetic was contra-indicated—*e.g.*, in vaginal operations in advanced puerperal sepsis.

Dr. **Arnold W. W. Lea** (Manchester) also spoke in favour of this method. He had employed it in painful obstetric manipulations—as, *e.g.*, the removal of a macerated fœtus from a patient with advanced cardiac disease. He attached importance to the influence of suggestion in producing analgesia.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Clinical Evening held April 3rd, 1908.

The President, **Richard Lake**, F.R.C.S., in the Chair.

The following cases were shown:—

Dr. Chas. W. Chapman: A case of aneurysm of the arch of the aorta, with dilated veins over the chest and abdomen.

Dr. Arthur Saunders: A case of congenital syphilis.

Dr. F. G. Crookshank: A stained film of cerebro-spinal fluid from a case of cerebro-spinal meningitis.

Mr. Duncan C. L. Fitzwilliams: (*a*) A case of congenital absence of fibula and outer two toes. (*b*) A radiograph showing congenital absence of radius and thumb. (*c*) A case of mal-development of the fingers of the right hand. (*d*) A case of scoliosis due to accessory (?) vertebra. (*e*) A case of congenital asymmetry of face, dermoid (?)

Mr. Percy Dunn: A case of unusual ocular paralysis.

Mr. John Pardoe: A case of Charcot's disease of the knee-joint.

Mr. Donald Armour: A case of tumour of testicle in a man, probably malignant.

Mr. Aslett Baldwin: (*a*) A case of malignant tumour of submaxillary gland in a man, æt. 65. (*b*) A case of enchondromata of bones of hand in a boy. (*c*) A case of congenital syphilis in a girl. (*d*) A case was described of successful operation for removal of malignant growth of tonsil and surrounding parts. The case could not be shown as the patient (a woman) had been readmitted to the hospital for a perforated and gangrenous appendix, and had undergone a second operation for intestinal obstruction, but was progressing favourably.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD

FRANCE.

Paris, April 26th, 1908.

Criminal Abortion in France.

It is well-known that the natality in France is exceedingly low—much lower than any other European nation; and this fact led the Germans to say that "France loses a battle every year."

The reasons of this abnormal condition are complex, but, for practical purposes, might be reduced to two main factors—the practice of Malthusianism and criminal abortion.

The limitation of families is general, especially in the large towns, where the complications of living are great and form the exciting cause. Purely selfish motives, however, are not foreign to this culpable practice. Criminal abortion is not infrequently due to the same causes, but it is more particularly practised to hide a fault.

Prof. Boissard, of the Tenon Hospital, has uttered recently a cry of alarm as to the increasing number of criminal abortions in France. The percentage of abortions treated in the Paris hospitals had risen from 6 to 18 per cent. between the years 1898 and 1904, and is still increasing. M. Boissard said that he was convinced that two-thirds of the total number of abortions were due to criminal practices.

Prof. Lacassagne, of Lyons, writing on the same subject, said that abortions were more numerous than births. There are 150 midwives practising in Lyons. One related that she had attended at least three miscarriages a week, or about 150 a year. If, to take the average, 100 midwives attended 100 abortions each in the year, the total would be 10,000. As the natality of the second city of France is from 8,000 to 9,000 per annum, it follows that the number of abortions exceeds that of births. Thanks to antisepsy and the cleverness of the women who practise this criminal industry, abortion can be provoked on a large scale and without much risk.

Exophthalmic Goitre.

The treatment by sulphate of quinine of exophthalmic goître is recommended by Prof. Lancereaux. The fundamental trouble in this disease being the vaso-dilatation of the blood-vessels of the neck and head, M. Lancereaux estimated that quinine, by reason of its vaso-constrictive properties, should have a favourable effect. It was thus that he treated over 20 patients by 10-grain doses of quinine sulphate, given twice a day for several months, with intervals of rest. Under its influence the vaso-dilatation phenomena ceased, as well as the nightmares, tachycardia, exophthalmia, and even the goître considerably diminished.

Pigmentary Nævi.

Several cases of pigmentary nævi, treated and cured by the action of radium, were presented by M. Mazotti before the Medical Society. The cicatrices were soft and smooth; both the hairs and colouration had disappeared. These results are the more remarkable, as these kind of nævi had hitherto been rebellious to all treatment.

Atrophic Cirrhosis of the Liver.

The patient should be kept in the recumbent position the greater part of the day, and placed on milk diet.

As medical treatment, iodide of potassium should be prescribed for weeks:—

Iodide of potassium, 1 dr.
Sulph. of strychnine, ⅛ gr.
Water, 10 oz.

A tablespoonful twice a day.

As a stimulant to the biliary secretion, salicylate of soda might be given, but many patients ill support this drug. In such cases it may be replaced by benzoate of soda associated with jaborandi:—

Benzoate of soda, 5 gr.
Phosphate of soda, 10 gr.
Powdered jaborandi, 2 gr.

For one wafer; two daily in an infusion of boldo.

Each evening an aloes pill should be taken.

In certain patients oliguria is frequent, and in such cases theobromine associated with phosphate of soda, which increases its activity, succeeds frequently:—

Theobromine, }
Phosphate of soda, } āā 10 gr.

For one wafer. One every hour until three have been taken. In case of non-success, the following pills:—

Powdered squill, 1 gr.
Powdered digitalis, 1 gr.
Powdered scammony, 1 gr.
Two to four pills in the 24 hours.

Hæmorrhage is the gravest complication of cirrhosis of the liver. It is best treated by rest, repeated injections of serum, and the administration of chloride of calcium.

GERMANY.

Berlin, April 26th, 1908.

The Ætiology and Pathogenesis of Epityphlitis.

This subject was discussed at the Verein für Innere Medizin, on the introduction of Hr. v. Hansemann, who read a paper on the subject.

He began with some general observations. One could not contemplate the important ætiological discoveries in regard to a large number of diseases during the past thirty years without a certain feeling of unpleasantness. Causes for diseases of all kinds had been discovered, but it was soon seen that these causes did not apply to all cases, or that they were met with in other diseases, and even in people who were healthy. Disputes took place on the subject amongst medical men, which were often decided by a majority of votes, until at last the idea gained ground that all was not lasting. These phenomena rested on an imperfect mode of thinking. We always looked for the causes of diseases, when we ought to determine the conditions under which they made their appearance. He would follow this mental process in regard to the theme to be discussed.

What were the conditions necessary for the occurrence of epityphlitis? Parasites and foreign bodies were named in the front rank as causes. But against this was to be objected that parasites scarcely came into consideration as primary causes. In only one case in the human subject had he seen the oxyuris vermicularis in the vermiform appendix, and once in an ape he had found the head of a tapeworm, and in both cases in a healthy intestine. It was the same in regard to foreign bodies; it was only exceedingly rarely that they were present in the vermiform appendix, and when they were present they were not the exciters of inflammation. Naturally foreign bodies were found now and then, but they could even penetrate through the walls of the intestine without setting up peritonitis, without setting up any inflammatory symptoms at all. (Here a fish-bone was shown that had penetrated the wall of the intestine, found accidentally at the autopsy.) These two factors could therefore be excluded as exciters of epityphlitis. It was the same with coprolites, which were not causes of inflammation, but were more likely developed by the inflammation.

An important condition for the development of epityphlitis was the presence of pathogenic bacteria—a condition that was always antecedent. *Per se*, however, they were not to be considered as a direct cause. We must distinguish two groups of bacteria—(1) the ubiquitous, which were always to be found in the intestines—they acted as exciters of inflammation only under special circumstances; (2) such bacteria as were only exceptionally present, such as the bacilli of tubercle and influenza, and others. In certain cases they might be the primary exciters of inflammation. In times of influenza epidemics, epidemics of epityphlitis had been known to have been caused by influenza bacilli. With regard to other bacteria, however, such as the bacteria of suppuration, further conditions must be present for the onset of inflammation.

An important *rôle* favourable to inflammation had been attributed to the lymphatic apparatus of the vermiform appendix. The bacteria were said to be captured in the follicles, and to have then worked their mischief. At the present day, however, considering the structure of the vermiform appendix as the result of retrogressive development in the human subject, the lacunæ were not so much looked upon as capturers of bacteria, and if these did get in they also got out again.

For the ubiquitous bacteria mentioned above to act as exciters of inflammation, other conditions were necessary, and, above all, stasis, as we could observe also in other organs. The inflammations associated with stenosis of the pylorus, with gall-stones, and those associated with diminished power of emptying the bladder might be recalled to memory. Even in closed cavities we observed the same conditions—for example, the peritoneum, in which bacteria were otherwise rendered harmless by absorption. A similar condition was present only occasionally in the vermiform appendix. It was interesting to compare the conditions in infants, children and adults. In the former the vermiform appendix had a funnel-shaped opening into the cæcum; this became narrower later on; it sometimes persisted, however. With such a wide opening, perityphlitis did not occur, with the exception of those cases in which tubercle bacilli were present. The significance, also, of the valve of Gerlach was not properly recognised. The appendix was very movable, and the valve would be open or closed according to its position. It might happen that bacteria might enter through an open valve and find themselves in a closed sac from a change of position of the appendix, and they might then develop their pathogenic properties. Inflammation of the cæcum, the typhlitis of earlier authors—the existence of which had been denied, but unjustly, as it undoubtedly occurred, set up by fæcal accumulations and other causes—played an important *rôle*, as the opening of the vermiform appendix was closed by swelling of the mucous membrane; it might then be converted into a closed sac. Tuberculous changes in the cæcum might also shut off the opening through swelling of the mucous membrane.

From all this it was explainable why inflammation of the vermiform appendix was so rare in children. It also explained the rarity of the occurrence in old people, who would have had the disease earlier in life if they had had a predisposition to it. It also explained how somatic conditions might have an influence on the origination of an epityphlitis, such as pressure in straining, gymnastics, etc. By causing a change of position of the vermiform appendix, closure of it might be brought about. Remains of recoveries from inflammation of the organ were frequently found accidentally at autopsies. They might favour a disposition to recurrence of the disease.

Practically, the most important point was the prognosis, to know whether the appendix must be removed or whether the attack should be allowed to run its course. Undoubtedly, extirpation was done too frequently, as not infrequently little, or even no disease at all, was found on the extirpated organ. In the latter case the disease had been seated in the cæcum. This might be successfully treated after removal of the vermiform appendix. In general we must concede that we did not know what would happen in any given case. A vermiform appendix might also become obliterated without inflammation by so-called senile involution. The obliteration caused by inflammation and that set up by senile involution were to be distinguished; in the former case the obliteration began at the opening; in the latter at the apex.

AUSTRIA.

Vienna, April 26th, 1908.

Antagonism of Poisons.

These may either be chemical or physiological. Meyer declared at the Gesellschaft the former produces an innocent compound, while the latter is more complex in its action, and not so reliable, owing to the indefinite action of the poison and antidote. The chemical treatment is easy, as all can understand the result of an alkali and acid when brought together, but with an organic poison and its antidote the neutralising action is not on each other, but on the effects of each other, such as atropine on pilocarpine, the former paralysing the action of unstriated muscle and the heart, while the latter stimulates. In the greatest number of cases the inhibitory action of the drug is first observed, although the stimulating property is not infrequently observed. When the central system is involved, the difficulty is increased; for instance, morphia and hydrocyanic acid, which are paralysers, will be difficult to arouse with atropine, which is a stimulant in this case. Again, chloral-hydrate and alcohol produce paralysis, while caffein, or a mixture of morphia and picrotoxin would be the antidote. The rise and fall of temperature is another difficult action to control. Where two motor fields are awakened, the one to liberate, the other to restrain the impulse, the resulting action is very difficult to determine.

We have yet another complication to consider in the vegetative nerve system or the involuntary, as vessels, glands, and many muscles are controlled by this group of nerve centres, which is comprehensive. These nerve fibres come from the middle and posterior part of the brain, through the oculo-motor, facial, glosso-pharyngeal and vagus. There is another portion of the fibres coming from the spinal cord which can be traced as far as the fourth lumbar; while a third part has been traced to the sacral part of the cord and conveyed in the pelvic nerve to modify the colon, bladder and genitals. This system of nerves is really antagonistic to the cerebral and reflex, as proved by the application of different drugs. The cranial and sacral involuntary nerves have their terminal ends stimulated by pilocarpine and paralysed by atropine, while the sympathetic system is not affected by either of these. On the other hand, adrenalin and cocaine act violently on the sympathetic system as stimulants, and codeia as a paralyser. We have another difficulty in prescribing for a particular organ when it is supplied with nerves from two systems, such as the vegetative and sympathetic—ex. gratia, the blood vessels, which we have seen are contracted by pilocarpine and distended by cocaine and adrenalin. The antagonism that exists in other secretions of an abstruse character can only be conjectured in the pancreas and suprarenal bodies, the thyroid and ovaries, or the glycogenic function of liver, which so alter and modify metabolism that disappointment is often the result of many of our efforts.

Specialisation.

At the Congress for Internal Medicine, Prof. Müller dilated largely on the abuses of this partial education in medicine. This is one of the great blemishes in the profession which called louder for a fundamental clinician. If the specialist is only a specialist he is of little worth in internal medicine. A good practitioner can always make a good specialist, but a specialist, no matter his merit, will never make a good clinician. Pathology is the handmaid to medicine, and has always been, the fundamental principle in Austrian medicine, just as physiology has been the dominant factor in German medicine. More recently chemicals and physic have been added as scientific tests in confirming many of the hypotheses abstracted from the other two fundamental principles.

Laryngo-Rhinology.

The International Congress opened this week with a history of the subject by the President. The first history he had of carrying light into any of the orifices of the body, particularly the throat, was in 1854, when Manuel Garcia, a famous music master in London, constructed a mirror for examining the vocal cords. In 1858 Ludwig Turck commenced to use a similar instrument in the examination of morbid conditions of the throat. Czermak, of Budapest, commenced shortly afterwards with artificial light, though Turck remained firm in the belief of sunlight, by means of which all his classic work has been done. Bruns, in 1862, was the first to remove a polypus, while Schrötter, in 1874, introduced the cocaine anæsthetic. Since then Störk and Schnitzler have developed this special subject into what it has now become.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Late Miss Spencer, Edinburgh Royal Infirmary.—The death is announced of Miss Spencer, who last year resigned the post of Lady Superintendent in the Infirmary. Miss Spencer was of Irish birth, and, after being trained at St. Thomas's Hospital, came to Edinburgh in 1877 as Assistant Superintendent, and ten years later succeeded to the post of Superintendent. The managers of the Infirmary recognised her thirty years of arduous service by presenting her with a service of plate, and adopted a minute expressing their appreciation of the "unwearied, devoted, and whole-hearted attention" she gave to her duties. Miss Spencer's character was one that commanded respect as well as regard; she was reticent and dignified under all circumstances, and was greatly esteemed by those who, through their intimate knowledge of her, were best able to form a judgment.

Leith Hospital.—The directors of Leith Hospital have unanimously appointed Mr. Henry Wade, F.R.C.S.E., to the post of Assistant-Surgeon to the institution rendered vacant by the resignation of Mr. Charles Heron Watson, F.R.C.S.E.

Belvedere Fever Hospital.—At a meeting of the Glasgow Council, a series of questions involving serious allegations against this hospital were put by one of the Town Councillors. He asked whether it was the case that a nurse died of enteric, after having been kept on duty for a week or ten days, during which she was complaining of feeling ill, and whether, as a protest, the other nurses refused to attend the funeral; whether there had been overcrowding to the extent of 50 patients being in a ward adapted for 15; whether there had been understaffing, and whether the Medical Superintendent had been refused more nurses. The Convener of the Public Health Committee asked that the answers might be delayed. Belvedere Hospital is under the same general management as Ruchill, in which the recent inquiry showed that overcrowding and understaffing to a scandalous extent had existed during the past year.

Medical Officer of Health for Edinburgh.—It has been agreed, subject to the approval of the Town Council, to disjoin the offices of Medical Officer of Health and Police Surgeon. The Medical Officer of Health, who will give his whole time to the work, is to receive a salary of not less than £800 per annum. As regards the Police Surgeonship, it is proposed to appoint a casualty surgeon and several divisional police surgeons at about £75 per annum.

Larbert Asylum Superintendentship.—A short list of three has been made from the eleven applicants for the post at present held by Dr. Robertson, who goes to take up duty at Morningside in June. The election will take place on May 7th, when one of the following three gentlemen will be appointed:—Dr. Campbell, Inverness District Asylum; Dr. Rutherford, Edinburgh Royal Asylum; and Dr. Sturrock, Midlothian and Peebles District Asylum.

Isolation of Phthisis at Bangour Asylum.—Dr. Keay, the Superintendent, having reported to the Parish Council that it is desirable to provide specially for the phthisical insane under his care, the Edinburgh District Lunacy Board have decided to obtain plans with the view of erecting a small sanatorium and isolation block for 20 patients in the Bangour Village Asylum.

Edinburgh Medical Officership.—The duties of the casualty surgeon, one of the offices which results from the partition of the work hitherto carried on by the Medical Officer of Health single-handed, has been defined by the Public Health and Lord Provost's Committees. It is recommended that the post be held at a salary of £100 a year by the occupant of the Chair of

Medical Jurisprudence in the University. The duties of the casualty surgeon will be to examine candidates for admission to the police and fire brigade, to pass medical certificates granted in cases of proposed retirement under the superannuation scheme, and to give his services in connection with claims made against the Corporation in respect of injuries received.

LETTERS TO THE EDITOR.

THE REFERENDUM OF THE COUNCIL OF THE BRITISH MEDICAL ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am afraid that your correspondent's zeal for his cause outruns his discretion, and that he shows his hand too plainly to be a good diplomatist. "Festina Lente" alleges that I have confused the Referendum with the Draft Charter, implying that I do not know the difference between the two, and then he proceeds to castigate me for "this absurd misunderstanding." I regret to disagree with him. I maintain that the Referendum, although a hostile document promulgated by the Council, is yet a most valuable *précis* of the Draft Charter: it places before the members the vital points at issue; it reminds the members of what the framers of the Draft Charter have done in the effort to introduce reforms; and it illustrates forcibly the opposition with which the majority of the Council have met the new proposals. Again, I maintain that its rejection has "marked a new era in the history of the Association," for had it been approved by the branches the Draft Charter would have been condemned in its most vital clauses, which would have implied a vote of non-confidence in the framers. Your correspondent affirms that, in his opinion, "the voting has not been on the merits of the Charter at all, but a trial of strength between two parties, the smaller of which has been defeated." I conceive that in speaking of a trial of strength, it would merely have been just to have made some reference to the strong minority on the Council who disapproved of the Referendum. It is quite possible that the report of this minority, issued with the Referendum, had a great deal to do with the result of the voting. Had the Council been unanimous upon the Referendum question, their appeal to the branches might have terminated differently, but being opposed by a strong minority among themselves, the inference is obvious that some members even of the Council concede the necessity for the reforms upon which the Referendum so conveniently sought the suffrages of the Association. Your correspondent, however, is too timorous, too imaginative, too much wedded to the past to be able to discuss this question with an open mind. He sees "danger," "imminent danger" in these schemes of reform; and, as he tells us, "every instinct of prudence and caution rises up against the proposal to turn the Association into a medical trades union and a political faction." But I fail to grasp the reasons for this fear, this misgiving, respecting the future of the Association, should these objects be ultimately attained. No one has ever seen the Falls of Niagara without regretting the display of so much natural force unconverted into a profitable use. And the same regret may be applied to the Association. The British Medical Association, in membership, is the most powerful medical body in the world, and yet its political power in the present day is absolutely *nil*. It needs but little reflection, therefore, to understand, under those circumstances, how much is lost, in a political sense, to the medical profession in Great Britain and the Colonies. The object of the Draft Charter is to amend this anomalous state of things, and thus the time should come when the Association is in a position to return a member of its body to the House of Commons, with a mandate ensuring the proper representation of the interests of the medical profession in that Legislative Assembly. Practically, every important Trades Union, and every body representing a community of interests in this country has its advocate, or advocates, in the House of Commons. On the other hand, the medical profession is the only one which has no political status. The policy, therefore, of trying to amend this anomaly is sound, is conceived in the best interests of the profession, and will do more than anything else to convince the members of the Association that much is to be gained by striving for political recognition and importance.

I am, Sir, yours truly,

NIL DESPERANDUM.

RESEARCH DEFENCE SOCIETY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A Society has been formed, with the name of the Research Defence Society, to make known the facts as to experiments on animals in this country; the immense importance to the welfare of mankind of such experiments; and the great saving of human life and health directly attributable to them.

The great advance that has been made during the last quarter of a century in our knowledge of the functions of the body, and of the causes of disease, would have been impossible without a combination of experiment and observation.

The use of antiseptics, and the modern treatment of wounds, is the direct outcome of the experiments of Pasteur and Lister. Pasteur's discovery of the microbial cause of puerperal fever has in itself enormously reduced the deaths of women in child-birth.

The nature of tuberculosis is now known, and its incidence has materially diminished.

We owe the invention of diphtheria anti-toxin entirely to experiments on animals.

The causes of plague, cholera, typhoid, Mediterranean fever, and sleeping sickness have been discovered solely by the experimental method.

Not only have a large number of drugs been placed at our disposal, but accurate knowledge has replaced the empirical use of many of those previously known.

The evidence before the Royal Commission has shown that these experiments are conducted with proper care; the small amount of pain or discomfort inflicted is insignificant compared with the great gain to knowledge and the direct advantage to humanity.

While acknowledging in general the utility of the experimental method, efforts have been made by a section of the public to throw discredit on all experiments involving the use of animals. The Research Defence Society will therefore endeavour to make it clear that medical and other scientific men who employ these methods are not less humane than the rest of their countrymen, who daily, though perhaps unconsciously, profit by them.

The Society proposes to give information to all inquirers, to publish *précis*, articles, and leaflets, to make arrangements for lectures, to send speakers, if required, to debates, and to assist all who desire to examine the arguments on behalf of experiments on animals. It hopes to establish branches in our chief cities, and thus to be in touch with all parts of the kingdom, and to be at the service of municipal bodies, hospitals and other public institutions

The Society was formed on January 27th of the present year, and already numbers more than 800 members. It is not an association of men of science or of medical men alone; its membership has been drawn from all departments of public life, and includes representatives of every class of educated Englishmen and Englishwomen, including many who have taken an active part in the prevention of cruelty to animals. This fact is in itself a remarkable protest against the attacks which have been made on the researches that the Society has been formed to defend.

The annual subscription is five shillings to cover working expenses, but larger subscriptions or donations will be gladly received. The acting Hon. Treasurer, *pro tem.*, is Mr. J. Luard Pattisson, C.B. (of the Lister Institute), and an account in the Society's name has been opened with Messrs. Coutts and Co., 440, Strand. The Hon. Secretary is Mr. Stephen Paget, 70, Harley Street, W., to whom all communications should be addressed.

I am, Sir, yours truly,

CROMER

(President).

SANITARY ADMINISTRATION.

To the Editor of The Medical Press and Circular.

Sir,—One of the periodical articles on Local Government Board reports which the *Times* systematically publishes appears in its issue of April 18th. The present article deals with the report by Dr. Reginald Farrar on the sanitary administration of a large number of small urban districts in the West Riding of Yorkshire, and another report by Dr. R. Deane Sweeting on a recent epidemic of scarlatina in the urban district of Burnham-on-Crouch (Essex). These reports tell the usual story. The members of the councils of the districts of this class "lack the public spirit and experience necessary for dealing with health problems, and are apt to be unduly biassed by local and personal considerations." In other words, the majority of members of the councils are mean, vulgar or ignorant men, unable to understand the importance of sanitary laws, or influenced by sordid personal motives, and holding their positions with the set purpose of obstructing or preventing effective administration. In such districts it is found that sanitary laws are almost entirely disregarded, or, at the best, administered in a perfunctory fashion to satisfy the bare letter of the statutes. Out of 36 urban districts in the valleys near Huddersfield, the salary paid to the Medical Officer of Health is, in 28, less than £30 per annum, and in six of these is less than £10. In none does the salary reach £50. The poverty, and not the will, of these unfortunate officials it is that compels them for such paltry hire to make themselves the servants of their ignorant masters, and to stifle their conscience in presence of the injury to the people and to the State to which, as they must see, the neglect of elementary sanitary laws gives rise. The Sanitary Inspector in these districts is often a person of very inferior education and position, sometimes a foreman road-mender or a rate-collector, paid to devote only a small part of his time to his duties, and, being devoid of the requisite technical knowledge, incompetent to make the necessary representations to his council. That this state of things should be allowed to continue is, of course, the fault of the public. They can, if they choose, turn out inferior members of local authorities and replace them by men not capable of sacrificing the welfare of the poor—it is upon the poor that the misery mostly falls—through ignorance or in pursuit of selfish aims. Unless the spirit of the people can be roused, democratic institutions will bring the nation to ruin. These institutions cannot be properly administered unless the bulk of intelligent citizens will take part, either by accepting office or helping to choose and elect representative men. In the meantime, what is our profession doing to improve its status in the service of the State? Would combination aimed at raising the salaries of medical officers and placing them in a position to carry out their duties without fear of their ignorant employers, be stigmatised as trades unionism? Is there no means of organising the profession and giving it some of the political power it ought to command? Can nothing be done to improve the present deplorable position of medical public servants, as once more disclosed in the reports to which I have referred.

I am, Sir, yours truly,

M. O. H.

April 21st, 1908.

THE IRISH UNIVERSITY BILL—PROMISES AND PERFORMANCE.

To the Editor of The Medical Press and Circular.

Sir,—Mr. Birrell, when introducing the Irish University Bill in Parliament, on March 31st, said, referring to the professorial staff of the Queen's Colleges of Cork and Galway, which it is proposed shall be constituent Colleges of the New University in Dublin:—

"The existing Professors in the Colleges of Cork and Galway will, *of course*, go on and be Professors of the new University, but upon the old terms. When they die or retire the Senate will appoint their successors."

Thus the promise. As to the performance, by the provisions of the Bill as printed after his speech, the entire staff, Presidents, Professors, and office-bearers, are summarily dismissed.

Mr. Birrell further stated that only the first appointment of Professors to the new College in Dublin was to be made by a Commission consisting of three members nominated by the Crown and four appointed by the temporary Senate of the new University.

By the Bill, however, the Commissioners are to appoint all officers of the constituted Colleges, including Presidents and Professors of Cork and Galway; they are directed to offer the dismissed Presidents and Professors of those Colleges, so far as "practical and *expedient*," analogous offices in Cork and Galway respectively; and they are to give to those whom they may not deem it expedient to appoint, such compensation as they may think fit.

As the compensation is to be paid out of the revenues of the Colleges, the prospect for the unemployed does not seem brilliant, especially in Galway, which is only to receive a beggarly £1,400 a year more than its present inadequate income.

The existing Presidents and Professors hold their offices under the Royal Sign Manual during His Majesty's pleasure. I do not think that servants of the Crown have ever before been treated in so arbitrary a manner and with such a total disregard of any compensation for the loss of their positions, or adequate compensation being secured for loss of employment.

The profession is specially interested in the question, so many of the Professors being medical men. There does not seem to be any justification for the breach of the promises made to Parliament, and I for one protest against the treatment meted out to men who have faithfully and efficiently discharged the duties entrusted to them.

I am, Sir. yours truly,

M.D.

THE ORAL USE OF SERUMS.

To the Editor of The Medical Press and Circular.

Sir,—Your editorial remarks in your issue of April 15th are calculated to leave an impression that, you will allow me to say, is not justified by facts.

That impression amounts to this—that, whilst recognising that my work on the "Rôle of Normal Serum in Disease" is not based on Paton's work, you consider that I have been anticipated by him in that work.

Will you allow me, in order to avoid any possibility of misconception, to point out, without the smallest desire to detract from the value of Paton's work:—

1. That most of his observations are based on the oral administration of *immune* serum.
2. That though he has in many cases administered the plasma of various animals in a similar manner, he has never, apparently, used normal serum as such.
3. That my work, so far published, deals with the local and internal administration of *fresh normal serum*. This work is based on the undoubted power that fresh serum has, *inter alia*, of inhibiting destruction of tissue.
4. That whatever Paton's plasma is, it certainly is not fresh normal serum.

I am, Sir, yours truly,

E. C. Hort.

[We are very pleased to insert Dr. Hort's note. There was not the least intention of imputing to him any but the most honourable motives. At the same time, it certainly appeared to us that Mr. Paton was first in the field with the oral administration of normal serum in the treatment of various diseases. Doubtless Mr. Paton will come forward himself, and the matter of priority can be thrashed out between him and Dr. Hort.—Ed. Med. P. and C.]

OBITUARY.

DR. UNDERHILL, PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS, EDINBURGH.

It is with feelings of the deepest regret that we have to chronicle the death of Dr. C. E. Underhill, the eminent and esteemed President of the Royal College of Physicians. Dr. Underhill's health had for the past year given grave cause for anxiety, and his death, deeply as it is lamented, was not altogether unexpected. He was of English birth, and was educated at Shrewsbury, Cambridge, and Edinburgh. In 1870 he graduated, and shortly thereafter began to practise in Edinburgh. In his early days he was associated with the late Dr. Matthews Duncan, and this no doubt determined the direction of his work. Among other offices held, he was a Physician to the Royal Hospital for Sick Children, and to the Royal Maternity Hospital. Two years ago he became President of the Royal College of Physicians, and under ordinary circumstances would have occupied the chair until the ensuing winter. Dr. Underhill held a very high position in the medical profession of the city of his adoption. He succeeded early to a large and very responsible practice on the removal of Dr. Matthews Duncan to London, and this practice he held up to almost the day of his death. It was characteristic of him that he shirked neither the cares of practice nor the onerous duties of his Presidentship, though the state of his health would have more than justified his doing so, and delegating part of his work. Dr. Underhill, however, was well fitted to be the head of the medical profession in Edinburgh by character as well as by professional eminence. He was a high-minded gentleman whose opinion was constantly being sought and treasured on many points of ethics and conduct. His advice was always freely given, and in such a form that the most sensitive could not take offence. He was impartial, sincere, and upright. Little wonder, then, that his death makes a gap for which it will be hard to find an occupant.

EDITH PECHEY PHIPSON, M.D.BERN, L.R.C.P.I.

WE regret to announce the death of Dr. Edith Pechey Phipson, one of the ablest of medical women. Mary Edith Pechey was the daughter of a Baptist minister, and was born at Langham, near Colchester, in 1846. After completing her school education, she devoted herself to teaching for a few years, but when the question of medical study for women was raised, she joined those who applied to the University of Edinburgh in 1869, and was one of the first five to matriculate in October of that year. In 1877 Miss Pechey took a diploma from the Irish College of Physicians, which led the way to the admission of women to the medical profession, and also obtained the M.D. of the University of Bern, as no English University would at that time give a degree to women. For a few years she practised medicine in Leeds, but on the foundation of the Kama Hospital for Women in Bombay in 1882 she was appointed Senior Physician to it, and did splendid service in organising its very extensive work, and to a great extent revolutionising the whole standard of hospital nursing in India.

PROFESSOR LEOPOLD VON SCHROTTER.

PROFESSOR LEOPOLD SCHRÖTTER VON KRISTELLI, of the Vienna medical faculty, died suddenly on Tuesday night, April 21st, in the 71st year of his age. As President of the Congress of Laryngologists he recently delivered an inaugural address. The delegates to the Congress were painfully surprised by the news of his sudden death, although, at the request of his family, the Congress did not adjourn. He was best known to the public as the leader of the movement for the prevention of tuberculosis and as the founder of the Alland Sanatorium near Vienna. His influence also aided the development of Abbazia and the Austrian Riviera as a health resort.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for review since the publication of our last monthly list:—

SIDNEY APPLETON (London).

Diseases of the Nervous System. Edited by A. Church, M.D., and Julius L. Salinger, M.D. Illustrated. Pp. 1905.

Anatomy of the Brain and Spinal Cord. By Harris E. Santee, M.D., Ph.D. Fourth Edition. Revised and Enlarged. Illustrated. Pp. 453. Price 12s. 6d. net.

Medical Gynæcology. By Howard A. Kelly, A.B., M.D., LL.D., F.R.C.S. Illustrated. Pp. 662. Price 25s. net.

EDWARD ARNOLD (London).

Movable Kidney; Its Pathology, Symptoms and Treatment. By Harold W. Wilson, M.B., B.S.Lond., F.R.C.S.Eng., and C. M. Hinds Howell, M.A., M.B., B.Ch.Oxon., M.R.C.P. Lond. Illustrated. Pp. 104. Price 4s. 6d. net.

The Influence of Alcohol and Other Drugs on Fatigue. By W. H. R. Rivers, M.D., F.R.C.P. Pp. 136. Price 6s. net.

BAILLIERE, TINDALL AND COX (London).

A Text-Book of Pathology. By Francis Delafield, M.D., LL.D., and T. Mitchell Prudden, M.D., LL.D. Eighth Edition. Illustrated. Pp. 650. Price 25s. net

Meat and Food Inspection. By William Robertson, M.D.Glas., D.P.H. Illustrated. Pp. 372. Price 10s. 6d. net.

The Diagnosis and Treatment of Pulmonary Tuberculosis. By Francis M. Pottenger, A.M., M.D., Illustrated. Pp. 377.

Clinical Lectures on the Surgical Diseases of the Urinary Organs. By P. J. Freyer, M.A., M.D., M.Ch. Illustrated. Pp. 425. Price 12s. 6d. net.

Aids to Ophthalmology. By N. Bishop Harman, M.A., M.B., F.R.C.S. Fourth Edition. Illustrated. Pp. 165. Price, cloth 2s. 6d. net, paper 2s. net.

The Pocket Osteology. By Philip Turner, B.Sc., M.B., M.S., F.R.C.S. Pp. 187. Price 3s. net.

ADAM AND CHARLES BLACK (London).

Cancer: Relief of Pain and Possible Cure. By Skene Keith, M.B., F.R.C.S.Ed., and George E. Keith, M.B., C.M. Pp. 155.

Home Nursing and Hygiene. By Florence Hufton-Windust. Pp. 122. Price 1s. net.

CASSELL AND CO., LTD. (London).

The Romance of Medicine. By Ronald Campbell Macfie, M.A.Aberd., M.B., C.M. Illustrated. Pp. 312. Price 6s.

CHURCHILL J. AND A. (London).

Hernia: Its Cause and Treatment. By R. W. Murray, F.R.C.S. Pp. 99. Price 4s. 6d. net.

EDWARD EVERARD (Bristol).

A Chronology of Medical History. By James Young, M.D.

HENRY FROWDE (London).

The Quarterly Journal of Medicine. Edited by William Osler, etc., etc. Vol. I., No. 3. April, 1908. Price 8s. 6d. net.

HENRY FROWDE AND HODDER AND STOUGHTON (London).

Diets in Tuberculosis: Principles and Economics. By Noel Dean Bardswell, M.D., M.R.C.P., F.R.S.Edin. and John Ellis Chapman, M.R.C.S., L.R.C.P. Pp. 184. Price 6s. net.

CHARLES GRIFFIN AND CO., LTD. (London).

Infancy and Infant-Rearing: An Introductory Manual. By J. B. Hellier, M.D.Lond., M.R.C.S.Eng. Illustrated. Second Edition. Revised. Pp. 164. Price 3s. 6d.

Tropical Medicine, Hygiene and Parasitology: A Handbook for Practitioners and Students. By Gilbert E. Brooke, M.A. Cantab., L.R.C.P.Ed., D.P.H. Illustrated. Pp. 498.

JOHN HOGG (London).

Knaves or Fools? By Charles E. Wheeler, M.D., B.S., B.Sc.

H. K. LEWIS (London).

An Essay upon Disease: Its Cause and Prevention. By G. E. Richmond, M.D.Lond. Pp. 96. Price 2s. net.

J. B. LIPPINCOTT AND CO. (London).

Treatment of Internal Diseases: For Physicians and Students. By Dr. Norbert Ortner. Edited by N. B. Potter, M.D. Translated by F. H. Bartlett, M.D. Pp. 658. Price 21s. net.

Text-Book of Ophthalmology. By Dr. Ernst Fuchs, of Vienna. Translated by Alexander Duane, M.D., of New York. Third Edition. Price 25s. net. 1908.

LONGMANS, GREEN AND CO. (London).

Proceedings of the Royal Society of Medicine. Vol. I., Nos. 4 and 5. February and March, 1908. Price 7s. 6d. net each.

A Mind that Found Itself. By Clifford Whittingham Beers. Pp. 363. Price 7s. 6d. net.

MACMILLAN AND CO., LTD. (London).

A Treatise on Chemistry. By H. E. Roscoe, F.R.S., and C. Schorlemmer, F.R.S. Vol. II. The Metals. New Edition. Pp. 1436. Price 30s. net.

METHUEN AND CO. (London).

Diseases of Occupation from the Legislative, Social and Medical Points of View. By Thomas Oliver, M.D., F.R.C.P. Pp. 427. Price 10s. 6d. net.

NEW SYDENHAM SOCIETY (London).

Atlas of Clinical Medicine, Surgery and Pathology. Fasciculus XXV. Diseases of Fallopian Tube, Ovary, Uterus, etc

NISBET, JAMES AND CO., LTD. (London).

Injuries of Nerves and Their Treatment. By James Sherren, F.R.C.S.Eng. Pp. 310. Price 5s. net.

OAK PRINTING COMPANY (Chicago).

The Correction of Featural Imperfections. By Charles C. Miller, M.D. Second Edition. Enlarged. Pp. 136.

HENRY RENSHAW (London).

A Manual of the Practice and Theory of Medicine. By Sir Wm. Whitla, M.A., M.D., LL.D. 2 vols. Pp. 1900.

W. B. SAUNDERS CO. (Philadelphia).

Nothnagel's Practice of Medicine: Diseases of the Heart. Edited, with additions, by George Dock, M.D. Illustrated. Pp. 1,000. Price 21s. net.

Surgery: Its Principles and Practice. Vol. III. Edited by W. W. Keen, M.D., LL.D. Illustrated. Pp. 950. Price 30s.

Atlas and Text-Book of Human Anatomy. Vol. III. By J. Sobotta, M.D. Edited by J. Playfair McMurrich, A.M., Ph.D. Illustrated. Pp. 250. Price 25s. net.

A Text-Book of Surgical Anatomy. By W. F. Campbell, M.D. Illustrated. Pp. 500. Price 21s. net.

SMITH, ELDER AND CO. (London).

Saint Bartholomew's Hospital Reports, Edited by H. Morley Fletcher, M.D., and W. McAdam Eccles, M.S., F.R.C.S.

JOHN WRIGHT AND CO. (Bristol).

The Medical Annual: A Year-Book of Treatment and Practitioners' Index. 1908. 26th year. Pp. 883. Price 8s. 6d. net.

Supplementary First Aid to Miners. By William B. Arthur, L.R.C.P., L.R.C.S.Ed. Pp. 27. Price 6d. net.

On the Best Method of Sewage Disposal for all Communities. By F. Wallis Stoddart. Third Edition. 1908. Illustrated.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Interstitial Keratitis after the Use of Calmette's Ophthalmo-Reaction.—Dr. Arnold Knapp (*Arch. of Ophthalmology*, March 1908), comments on the absence of unfavourable symptoms arising during the application of the above test. Kalt, at the Paris Ophthalmological Society, in October and November, 1907, recorded a case in which severe symptoms set in after the use of a 1 per cent. tuberculin solution, and lasted one month, with reduction of vision. He considered the presence of tuberculous internal eye trouble a contraindication to the use of the test. Knapp records a case of typical tuberculous interstitial keratitis which followed the instillation of tuberculin. The principal points about the case were the following:—A healthy girl, æt. 9, came to hospital on account of a scrofulous superficial keratitis of the right eye of two months' duration. The right cornea presented a central, broken-down, superficial infiltration. Marked photophobia. But little progress followed the usual treatment in hospital. An ulcer which formed on lid margin also proved very resistant to treatment. On December 14th one drop of a 1 per cent. tuberculin solution was put into the left eye, which was quite healthy. In six hours the lids were very red and swollen and there was great pain. For two days the condition remained about the same, viz., the lids could be separated with difficulty, thin muco-fibrinous, microbe free discharge. Temperature rose to 100.4° F. In ten days infiltrations appeared round the temporal margin of the cornea. They were in the superficial layers of the true cornea and the overlying epithelium was elevated. On January 28th the infiltrations had coalesced, forming three yellowish-grey patches, 2 to 3 m.m. in diameter, with deep-seated corneal vessels running to them. This unfortunate case demonstrates that the ophthalmo-raction cannot be regarded as harmless. M.

Varicose Ulcers of the Leg.—E. Adams, in a paper (*Post Graduate*, March, 1908) on this common affection, discusses various forms of treatment, and in particular the operations of Trendelenberg and Schede. The former, which consists in removing a portion of the internal saphenous vein, should, in the author's opinion, only be done when the valves of the saphenous vein have been demonstrated to be insufficient. This can be done in the following way:—The patient is put lying down, the leg raised and emptied of blood; after several minutes compress the internal saphenous vein about the lower third of the thigh, by means of a bandage, then lower the leg and let the patient stand up; if the blood flows into the saphenous vein from above and distends that portion of the vessel above the bandage, the valves are incompetent, and the operation should be performed. Schede's operation consists of a circular incision at the upper and middle third of the leg, encircling the limb, and the removal of all the veins to the deep fascia. Adams draws the following conclusions:—1. Varicose ulcers are very stubborn to treatment; the best results have been obtained by the use of sponge grafts, combined with Unna's bandage. 2. Radical operations on varicose veins are necessary to ensure a permanent cure. 3. Trendelenburg's operation in combination with Schede's gives the best results. G.

Retention of Urine in Adolescents.—V. Blum (*Wien. Rundschau*, October, 1907) reports the case of a boy, æt. 13, who at the age of 7 had fractured his frontal bone and had severe concussion. At 11½ hæmaturia appeared, and subsequently both nocturnal and diurnal incontinence of urine. The boy's genital organs were small and poorly developed, the prostate being rudimentary; the bladder was distended, reaching above the umbilicus. The urine was clear and free from albumin; the knee-jerks were greatly exaggerated. The urine was slowly drawn off by catheter, but temperature rose to 104°, and the patient became rapidly worse, dying the following day. A post-mortem examination showed an acute hæmorrhagic pyelonephritis in both kidneys, with dilated ureters; it also demonstrated the fact that there was no stricture, valve or any abnormality in the urethra which could possibly have caused a mechanical obstruction to the outflow of urine. In the absence of obstruction to the passage of urine, the retention was primarily attributed to the poliomyelitis, which was found in the cord at the level at which the centre for micturition is generally supposed to be. This case seems to prove beyond doubt the existence of a vesical centre in the spinal cord. G.

Tumours of the Urinary Bladder.—Von Frisch reports (*Wien. Klin. Woch.*, No. 40) shortly on 300 cases of bladder tumour. Most of the patients were elderly; 256 were men, the remaining 44 were women. About two-thirds of all the cases proved on microscopic examination to be malignant. In all the cases the growths were explored, and, if possible, removed, by a supra-pubic incision; in one case only was a tumour removed by the vesico-vaginal route; 42 of the patients died from the operation, or an average mortality of 14 per cent. The average time in healing after operation was 25 days. In 164 of the cases it was possible to trace the after-histories for periods varying from one to seventeen years. Of these there were 53 apparently benign papillomata, with 21 recurrences; 49 epitheliomas, with 29 recurrences; and 62 carcinomatous tumours, all of which had recurred. The operative prognosis of carcinoma seems almost hopeless as regards cure, but in many cases life was prolonged and in others suffering much alleviated. G.

Tertiary Syphilis.—L. Bonnet (*Lyon Médical*, November, 1907) describes the case of a man, æt. 79, with two ulcers on his right forearm. He contracted syphilis at the age of 24, and was treated with mercury for one month. He was entirely free from any symptoms of syphilis for 54 years, until the two sores appeared on his arm. These were typical gummata, and healed up in 12 days on the administration of K.I. in large doses. The frequency with which tertiary lesions occur seems, to a great extent to depend on the insufficiency of the early administration of mercury, and the mildness of the secondary symptoms; but it is very rare indeed for such a long period as 54 years to elapse between the primary and tertiary manifestations. Out of 4,400 cases recorded by Fournier, in only three cases did the history extend over 50 years. G.

Dangers of Lumbar Puncture.—Prof. Wolff (*Berlin. Klin. Woch.*, November) attempted to perform an operation on the knee of a man, æt. 36, under spinal anæsthesia. The needle was inserted without any trouble between the third and fourth lumbar vertebræ. No cerebro-spinal fluid came away after the canal had been entered, but there was a free escape of pure blood. The needle was at once withdrawn without attempting to make a spinal injection, and the operation was carried out under a general anæsthetic. A few hours later severe pain came on in the patient's back. The pain was spasmodic in character, and extended to the front of the chest and the shoulders. The next day there was severe pain in the neck, and later on in the head itself, these pains lasting for about a week. Five days after the operation the sixth nerve on the right side suddenly became paralysed; this only passed off after three weeks. The hæmorrhage on the introduction of the needle was evidently due to the puncture of an intra-dural vessel. G.

Remarks on the Treatment of Fractures of the Patella of Long Standing.—Lord Lister (*Brit. Med. Journ.*, April 11th, 1908) describes a method he used when there was considerable separation of the fragments of the patella, instead of employing free division of quadriceps extensor muscle to approximate the fragments. The operation is done in two stages. In the first stage an incision is made over each fragment. A wire is passed through the upper fragment, and the long ends of this wire are pulled through under the skin to the lower incision, where the one end is passed through the lower fragment. The upper fragment is then pulled down as much as possible by a very strong sharp hook, the point of which is inserted in the tendon of the quadriceps at its attachment. The wire is secured in the usual way, and then is cut short. The limb is put up in an elevated position with the knee extended to relax the quadriceps. The limb is gradually lowered in the course of a few days. When the wounds are healed, the treatment can be completed. The patella is cut down on, the broken edges of the patella freshened, and the quadriceps will be found sufficiently extended to allow the fragments to be wired in apposition with one another, with resulting good bony union. S.

Remarks on Treatment of Four Hundred Cases of Epithelioma.—Bulkley and Janeway (*Med. Record*, March 21st, 1908) point out that routine treatment of every lesion diagnosed as epithelioma, whether it be by excision, caustics, X-rays, or other means, is to be deplored, as each case should be a special study from the beginning until a perfect cicatrix results. They emphasise the following facts:—Epithelioma runs a relatively benign course. It occurs chiefly about the face, in places where radical operative measures are apt to produce serious deformities, which very materially add to the patient's discomfort. Their experiences of 35 years demonstrate that, while many cases can be permanently cured by caustic pastes, these are at times disappointing, and may lead to an aggravation of the trouble. The curette cannot be depended on alone, but requires additional destructive agents to the base left after operation. By the proper use of X-rays we have a safe and—in cases that have not been grossly neglected or maltreated—a sure method of cure, with the least amount of deformity. In cases where knowledge and experience show that these measures are not likely to avail in checking the course of the disease, complete surgical removal should be undertaken, as this has been shown to be permanently successful in a reasonable proportion of cases. S.

Arthrodesis and Tendon Transplantation.—Jones (*Brit. Med. Journ.*, March 28th, 1908) in discussing arthrodesis (of the ankle especially), is strongly of opinion that it should not be performed on children under 8 years of age, nor until the surgeon is satisfied that the muscles are paralysed beyond hope of recovery. The preliminary preparation of the foot by wrenching and the tenotome must correct all deformities. The operation should be so planned that at its completion the bones lie in apposition to the foot, which should be placed in an over-corrected position. This is effected by the ex-section of skin flaps, by the shortening of lengthened tendons, and by the removal of graduated wedges of bone. The wedge should never be taken from the tibia, lest the tibial epiphysis be injured. Splints should be applied and retained until union is pronounced to be complete, and appliances should be worn until the surgeon has evidence that the ankle can bear body weight without fear of yielding. In the author's opinion the indications for tendon transplantation are:—(*a*) To fortify a weakened group of muscles; (*b*) to supplant a completely paralysed muscle or group of muscles; (*c*) to obstruct an over-acting spastic group; (*d*) to deviate tendon action when perverted, as in transference of the tendo-Achillis to the outer side of the os calcis in congenital club-foot to prevent inversion of the ankle; (*e*) as a help in partial arthrodesis. It is important to remember that a muscle, if stretched for a sufficiently long period, will cease to act; also that an over-stretched muscle will regain its power if relieved from strain. The causes of failure in tendon transplantation may be thus summarised:—(*a*) Inadequate tension of the reinforced muscle; (*b*) inadequate preliminary correction of deformity; (*c*) early adhesions of transplanted tendons; (*d*) insufficient freeing of the tendon; (*e*) over-deflection of the transplanted tendon; (*f*) over-strain upon the transplanted tendon. In tendon transplantation the author insists on:—(1) The over-correction of deformity as a preliminary act; (2) the removal of skin flaps to secure the uninterrupted continuity of the over-correction; (3) the direct and not angular deflection of the tendon, with free tunnelling in one plane through the soft tissues; (4) the firm suturing into periosteum or bony groove; (5) the careful choice, tension, and nursing of the transplanted tendon; (6) the maintenance of a hyper-corrected position until voluntary power is assured to the tendon; (7) the deflection of the body weight during walking from the reinforced tendon. It is also often well to shorten all the paralysed tendons, and prevent the over-action of their opponents by tenotomy. In all the author's cases of arthrodesis and tendon transplantation, he employs the tourniquet, and insists upon scrupulous asepsis. All hospital cases are treated as out-patients and return to their homes on the day of operation. No difficulty arises from this arrangement. S.

MEDICAL NEWS IN BRIEF

Meeting and Exhibition of the Electro-Therapeutic Section of the Royal Society of Medicine.

The first monthly meeting of the section held in Scotland will be in the rooms of the Royal Philosophical Society, Bath Street, Glasgow, on Friday, 22nd May, at 8.30 p.m. Mr. Wm. Deane Butcher, M.R.C.S., President of the Section, will occupy the chair, when the following papers will be read:—Dr. H. Lewis Jones, Medical Officer in charge of the Electrical Department, St. Bartholomew's Hospital, London, "Interrupted Currents for Electrical Testing and Treatment"; Dr. Dawson Turner, Medical Officer in charge of the Electrical Department, Royal Infirmary, Edinburgh, "Some Reflections Based upon the Work done in the Electrical Department of the Royal Infirmary, Edinburgh"; Dr. Samuel Sloan, a Vice-President of the Section and Chairman of the Scottish Committee, "Ionic Medication in the Treatment of Some Obstinate Cases of Pelvic Disease in Women." An exhibition of electrical apparatus will be held in the same place, from 3 p.m. till 10.30 p.m. of the same day. Light refreshments will be provided free of cost to visitors. The meeting and exhibition will be open to all duly qualified medical practitioners. As the attendance in the evening will probably be considerable, it is requested that those who may find it convenient to visit the Exhibition in the afternoon will do so.

The Tsetse Fly.—Dr. Koch's Proposals Opposed.

The Berlin Association for the Preservation of Game in Africa recently protested against the proposal of Professor Koch to shoot down all big game in the African Colonies in order to exterminate the tsetse fly. Professor Matschie, of the Royal Zoological Museum, said that, according to Professor Koch, the tsetse fly was formerly prevalent over the whole of South Africa, but had disappeared in districts where gregarious game, such as the buffalo and the antelope, had ceased to exist. This claim, he added, could be only conditionally admitted. In the first place, it had not been proved that the tsetse fly was once distributed over the whole of South Africa, and in the second place there were many districts where big game had been exterminated and where the tsetse fly was still found in large numbers. Professor Koch, he continued, might be right as regards the Transvaal and the Limpopo districts, for the tsetse fly, which was once prevalent there, had now disappeared, but it seemed equally probable that this disappearance might be due to the clearance of the bush and undergrowth. Dr. Sander, of the Army Medical Corps, also pointed out that the tsetse fly needed much shade and preferred low dense undergrowth, and he contended that the pig, the donkey, the zebra, the wild cat, the dog, and other small animals were equally with big game intermediaries for the spread of the tsetse fly. The opinions expressed at the meeting are to be forwarded to the Colonial Office. —*Morning Post.*

Infants' Health Exhibition.

The Incorporated Institute of Hygiene, of Devonshire Street, W., is promoting an infants' health exhibition, which will be opened on June 15th, and will show the latest improvements connected with foods, clothing, the nursery, the bedroom, recreation, physical exercise, school life and education. The exhibition will appeal strongly to mothers, heads of families, members of the medical profession, matrons, nurses, and school teachers.

Army Medical Service.

An examination of candidates for not fewer than thirty commissions in the Royal Army Medical Corps will be held on July 29th and following days. Applications to compete should be made to the Secretary, War Office, London, S.W., not later than July 20th, on which date the list will be closed.

The Army Council has decided that medical officers shall practice in peace time military requirements based on definite instructions so as to ensure smooth working of the Medical Services in war time.

Hospital for Sick Children.

An earnest appeal to the public for support of the specially deserving charity the Hospital for Sick Children, Great Ormond Street, is being made through the London Press. It is pointed out that Her Majesty the Queen, who has for many years taken great interest in the hospital, has graciously consented to open in June the new out-patient department which has recently been built by Mr. W. W. Astor as a memorial to his late daughter. The hospital was founded on a small scale by that immortal friend of children, Charles Dickens, Dr. Charles West, and a few others, fifty-six years ago, and was the first hospital ever established in this country for children. It has been well called "the mother of children's hospitals," and has been the model for all other similar institutions. It is not, however, merely the oldest, but it is also now the largest children's hospital in the British Empire. It treats children from all parts of the country, and students from every quarter of the world frequent its wards to study children's diseases. Unfortunately the hospital is burdened with a debt of £15,000, and the assured annual income falls short of the necessary annual expenditure by £5,000, while the new out-patient department, by adding immensely to the efficiency of the hospital, will increase this deficit by £1,000 a year. Contributions should be sent to the Secretary, Mr. Stewart Johnson, at the Hospital, Great Ormond Street, London.

Medical Sickness and Accident Society.

At the usual monthly meeting of the Executive Committee of this society, held on the 15th inst., Dr. de Havilland-Hall in the chair, it was reported that the amount of sickness pay disbursed by the society in the first three months of this year had been somewhat augmented by the epidemic of influenza, but the number of claims from this source now being received is not great, and the illnesses are for the most part of short duration. The number of new members obtained this year is larger than in any previous similar period and has so far beaten the record figures of last year. The annual report, to be presented to the members on May 21st, will show that during the year 1907 the society has largely grown, both in members and in financial strength.

PASS LISTS.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on the 16th inst., with the following results:—

First Examination, Four Years' Course.—Mr. Thomas Gray.

First Examination, Five Years' Course.—Of 33 candidates entered the following 16 passed:—Stanley D. Large, Ibrahim Ladhabhai Asrani, William F. Gibb, James Remers, William C. Davis, Percy W. Laidler, John M. Milne, Donald S. Graham, Bhaskar Mahadev Tembe, Devarayadoorg Venkata Giri, Arthur Butterfield (with distinction in Chemistry), William W. W. Watt, Edgar Annequin (with distinction in Chemistry), John N. Clark (with distinction in Chemistry), Clement M. Bradley, and Matthew McL. Bainbridge; and 1 passed in Physics, 4 in Biology, and 5 in Chemistry.

Second Examination, Five Years' Course.—Of 20 candidates entered the following 9 passed: Morris Greene (with distinction), Charles L. Ievers, Robert E. N. Martyn-Clark, Patrick Walsh, Richard A. Mirzan, Gordon Beveridge, Leon Galdemar, Archibald C. Tait, and Henry G. Lamberty; and 2 passed in Physiology.

Third Examination, Five Years' Course.—Of 26 candidates entered the following 13 passed:—Sydney G. Tibbles, Robert W. A. Brown, Thomas Walsh, Walter Crosse, Daniel Murphy, Stanley W. Hogg, Ruttonbai Cooverji Nazir, Abhayabala Singha, Ethel A. Mordaunt, Isabel P. Ashley, William C. L. Malone, Richard F. Lunn, and Devarayadoorg Venkata Giri; and 1 passed in Pathology and 2 in Materia Medica.

Final Examination.—Of 47 candidates entered the following 22 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—James H. Johnston (with honours), Alexander D. Falkner, Gajanan Jinabhai Mahimtura, David L. Luckhoo, Millicent V. Webb, Mahlon W. Locke, Thomas B. Eames, Dwarkabai Wassantrao Kamalakar, Ruttonbai Cooverjee Nazir, Charles A. Paterson, Robert W. Pickup, Vincent S. Delany, Michael J. Hayes, Harry Stokes, Edward Lewis, Leo Patchett, Krishnarao Ganpatrao Dhairyawan, Aiknath Viswanth Bam, Arthur M. Davie, Jacobus du Toit Malan, Adeline M. Watts, and John B. Cooke; and 3 passed in Medicine, 6 in Midwifery, and 4 in Medical Jurisprudence.

The Royal University of Ireland.

The following candidates passed the Second Examination in Medicine:—

Upper Pass.—Henry L. Barneville, William K. Calwell, Frederick Crooks, Samuel R. Foster, Robert J. McConnell, Laurence P. Mulligan, William Wilson.

All the above may present themselves for the further examination for Honours.

Pass.—Michael J. Black, John L. Brown, David Calwell, Patrick E. Carroll, Peter A. Clearkin, Pierce Cotter, John F. Craig, Alexander J. Dempsey, Laurence Doyle, Francis H. Duke, David J. Foley, Henry A. Gillespie, Thomas D. Graham, Harry P. Hannigan, Robert Harrington, Joseph Horan, Michael J. Horgan, B.A., Norman L. Joynt, Ignatius P. Kelly, John L. Kilbride, Jane L. Law, Homer H. C. Lynch, Patrick McCartan, Daniel J. MacClancy, Hugh J. S. McClintock, Louis J. E. McHugh, Daniel McSparron, William M. Millar, Edgar Morison, Mary A. Murphy, Daniel O'Brien, William O'Brien, Patrick J. O'Grady, Joseph Patrick, Joseph H. Porter, Adiel E. H. Reid, Thomas G. Rothwell, James J. Ryan, Samuel J. Turkington, Patrick W. White, Samuel J. Yeates.

Exempt from Further Examination in Anatomy and Physiology.—Eileen M. O'Keeffe.

Society of Apothecaries of Ireland.

At the Primary Examination, held during the present month, the following candidates passed:—Part I.—Biology.—R. B. F. Frazer, R. H. Pettersson, S. J. S. Reid. Chemistry.—R. B. F. Frazer. S. J. S. Reid. Materia Medica and Pharmacy.—E. Carter, H. R. Coombes, F. C. Eberhardt, J. McManus.

Part II.—Anatomy.—G. S. Bate, J. A. A. Boddy, C. S. Foster, E. A. S. Hoare, A. J. V. Mathews, J. G. Reidy. Physiology.—G. S. Bate, J. A. A. Boddy, J. Brearley, P. Hirschbein, E. A. S. Hoare, J. B. Holmes, J. G. Reidy, W. G. Tickell, C. B. Welsby.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

Original Articles or Letters intended for publication should be written on one side of the paper only and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

Reprints.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

Mancas.—It is very difficult for us to award praise or blame in these cases. The difficulties of hospital administration are too well known to us. The admission of emergency cases must depend on the discretion of the house-officer, and he has to be guided by the number of beds available. There should always be beds available for accidents, of course, but at busy times it is not possible to manufacture them at a moment's notice.

Bis dat qui Cito dat.—A trip to the Canary Islands would probably meet the requirements of the case.

Aero-cult.—There is an apparatus of the same description invented by M. Bernheim, of Paris, who passes the air in buildings through several layers of amianth heated to 180 deg. Cent., and thus effects sterilisation.

THE POST OF CORONER.

The professional status of a coroner in this country has always been a matter of debate. Whether it is best that he should belong to the legal or the medical profession is still a question which has absolutely to be determined. Apparently in America the qualifications for the post of coroner are not so stringently insisted upon, as the following funny incident will show:—An inquest was being held upon a man who had been run down and killed by a motor-car. "Where was he struck?" asked the coroner of the medical witness. "At the junction of the dorsal and cervical vertebræ," was the reply. Whereupon the coroner said, "Will you please point that out on the map?" indicating with his finger a large map that hung on the wall.

Dr. B. B. F.—We cannot advise without knowing more of the circumstances of the case. So far, however, as we can judge, the matter must rest entirely upon the interpretation of the bond.

Mr. S. S. J.—The date for sending in applications has now passed, but there will be another examination held in the autumn, of which due notice will appear in our columns.

Dr. W. D. L. is thanked for his communication, which is greatly appreciated

Dr. J. Purcell.—Of the foreign health resorts, we should say, from personal knowledge, that Aix-les-Bains would be the most suitable for your patient, and June the best month.

Meetings of the Societies, Lectures, &c

Thursday, April 30th,

Royal Institution of Great Britain (Albemarle Street, Piccadilly, W.).—3 p.m.: Mr. W. Bateson: Mendelian Heredity. (Lecture I.) (Tyndall Lectures.)

Friday, May 1st.

West London Medico-Chirurgical Society (West London Hospital, Hammersmith Road, W.).—8.30 p.m.: Prof. H. Spencer: The Advantage of Abdominal and Pelvic Examination in Pregnancy. Dr. S. Taylor: Some Neglected Remedies.

Royal Institution of Great Britain (Albemarle Street, Piccadilly, W.).—5 p.m.: Annual Meeting. 9 p.m.: Prof. J. Larmor: The Scientific Work of Lord Kelvin.

Appointments.

Askins, J., M.B., B.Ch., B.A.O.Dub., Medical Inspector of School Children by the Merthyr Tydvil (Glamorganshire) Education Committee.

Barry, J. P., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Inistioge District of the county of Kilkenny.

Casey, Charles, L.R.C.S.Irel., L.A.H.Dub., Medical Officer and Medical Officer of Health to No. 2 District of the North Dublin Union.

Dunn, Arthur Gibson, M.B., B.S.Durh., M.R.C.S., L.R.C.P. Lond., Resident Medical Officer at the Newcastle-upon-Tyne Dispensary.

Edwards, H. J., M.D.Durh., D.P.H., Certifying Surgeon under the Factory and Workshop Act for the Lynton District of the county of Devon.

Fothergill, W. E., M.D., C.M.Edin., Honorary Assistant Gynæcological Surgeon to the Manchester Royal Infirmary.

Howe, C. W., M.B., B.S.Edin., D.P.H., Certifying Surgeon under the Factory and Workshop Act for the Haddenham District of the county of Cambridge.

Kelly, M. W., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Killanne District of the county of Wexford.

Pirie, W. R., M.B., M.S.Aberd., Assistant Physician to the Aberdeen Royal Infirmary.

Roderick, Stanley James, M.B., C.M.Edin., Medical Inspector of School Children by the Llanelly (Carmarthenshire) Education Committee.

Smith, Frederick, M.B., B.S.Aberd., Assistant Anæsthetist to the Aberdeen Royal Infirmary.

Thomas, Frank Leslie, M.B., B.S.Lond., L.R.C.P.Lond., M.R.C.S., Honorary Medical Officer to the North Devon Infirmary, Barnstaple.

Wilshaw, R. H., M.B., Ch.B.Vict., D.P.H., Medical Officer of Health for the Combined Sanitary Districts of Worthing Borough and East Preston.

Vacancies.

Staffordshire County Asylum at Stafford.—Second Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance. Applications to the Medical Superintendent.

King Edward VII. Sanatorium, Midhurst, Sussex.—Senior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19, Devonshire Street, Portland Place, London, W.

Lambeth Workhouse.—Assistant Medical Officer. Salary, £125 per annum, with board, apartments, and washing at Renfrew Road Workhouse. Applications to James L. Goldspink, Clerk, Guardians' Board Room and Offices, Brook Street, Kennington.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, apartments, attendance, and washing. Applications to the Medical Superintendent.

Lincoln General Dispensary.—Resident Male Junior House Surgeon. Salary, £175 per annum, with furnished apartments, fire, and gas. Applications to the Secretary, 2, Bank Street, Lincoln.

London County Asylum, Horton, Epsom, Surrey.—Assistant Medical Officer. Salary, £150 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London, S.W.

Fermanagh County Asylum.—House Surgeon. Salary, £62 per annum. Applications to C. Wilson, Secretary. (See Advt.)

The Children's Hospital.—House Surgeon. Salary at the rate of 50 guineas per annum, with board, &c. Applications to Hon. Secretary, Medical Board. (See Advt.)

Births.

Brownlie.—On April 24th, at Drayton House, Redcar, wife of A. Brownlie, M.D., of a son.

Hubert.—On April 23rd,, at Rosehill, Billingshurst, Sussex, the wife of W. A. Hubert, M.R.C.S. Eng., L.R.C.P., Lond., of a son.

Marriages.

Forsyth—Livermore.—On April 22nd, at the Parish Church, Neston, Cheshire, Charles Forsyth, F.R.C.S. Ed., and J.P. of Hong-Kong, second son of Charles Forsyth, Esq., of Berwick-on-Tweed, to Dorothy Mary, daughter of Mr. and Mrs. Martin Livermore, of Turzum, Neston.

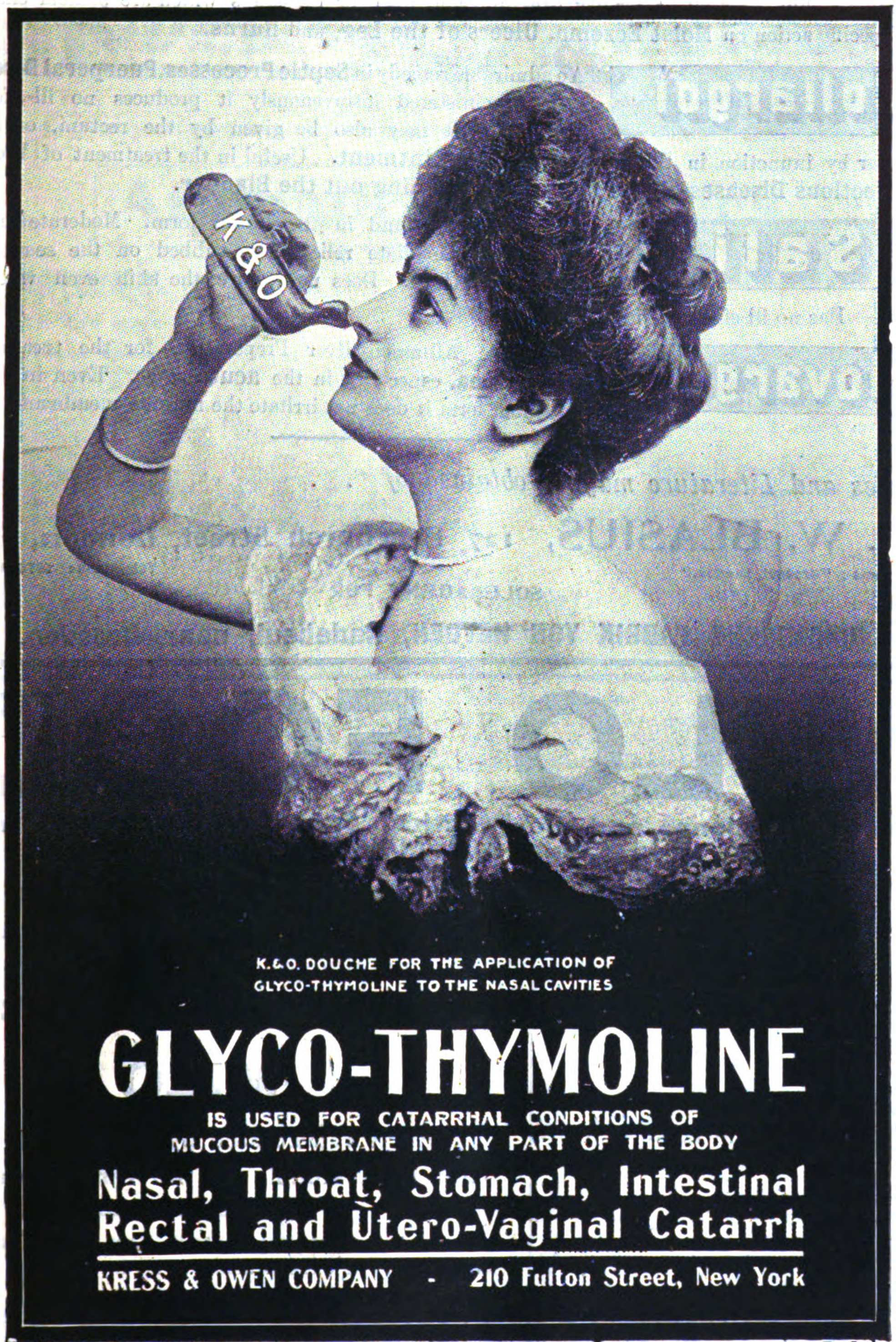
Gibson—Palmer.—On April 23rd, at Holy Trinity Church, Redhill, Robert Esplin Gibson, eldest son of David Gibson, of Demerara and Redhill, to Gwendoline, fourth daughter of the late Montague Palmer, Esq., M.R.C.S., L.R.C.P.Lond., F.S.A.

Deaths.

Carden-Noad.—On April 22nd, at 16, Waldemar Avenue, Ealing, the only son of the late Henry Minchan Carden-Noad, Ph.D., F.R.S., Henry Carden-Noad, L.R.C.P. Lond., M.R.C.S.Eng., in his 67th year.

Marvin.—On April 24th, suddenly, of pneumonia, Harry Forbes Churton, M.R.C.S., L.R.C.P., elder son of Lt.-Colonel W. Marvin, late Army Pay Department.

Prangley.—On April 24th, at Tudor House, Anerley, Henry John Prangley, M.R.C.S., L.R.C.P., aged 50.



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Oil of Gaultheria	9-32 „
Fluid Extract of Wild Indigo	1 1-4 minims
Boric Acid	10 15-16 grains
Menthol	5 64 grain
Thymol	15-32 „

DOSE—One fluid drachm.

Therapy.

A non-poisonous, non-irritant antiseptic, possessing a wide range of usefulness in medicine, surgery, and obstetrics, as well as in toilet and domestic hygiene.

Valuable in genito-urinary diseases; as a soothing application to stings, burns, and ulcers; as a gargle in throat affections; and as a general, mild, innocuous disinfectant.

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Each fluid ounce contains:—

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Thymol	1-2 grain
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Euformol is largely used for disinfecting faeces, as in typhoid fever, etc. Mixed with an equal volume of water and sprayed about the sick-room, it is a refreshing deodorant, and prevents the spread of infection.

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'BYNIN' AMARA is an analogue of Easton's Syrup, in which the sugar is replaced by an active Malt Extract. This affords a far better vehicle than syrup, as it is actively digestive and nutritious, and there is not the likelihood of the sugar crystallizing out, and carrying down in the crystal the alkaloid principle.

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'Bynin, Liquid Malt	1 ounce.

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"And Influenza."
"Builds up the System."

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which causes no by or after-effects, and forms the preliminary for a short, healthy, dreamless sleep, from which the patient awakes fresh and invigorated.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MAY 6, 1908. No. 19.

NOTES AND COMMENTS.

Inebriate Committee. IN accordance with his promise, the Home Secretary has now appointed a Departmental Committee to inquire into the law relating to inebriates, the detention of the latter in reformatories, and to recommend what alterations in the law or its administration are required. Reform in this direction has been long and urgently needed, and we are most thankful to see that an effort is being made to bring it about. At the risk of seeming ungrateful, however, we cannot but express disappointment that a reference to a Departmental Committee has been deemed sufficient. In our opinion this is not a departmental matter at all, but a national one of far and wide-reaching importance, involving the liberty of the subject at many points. A Royal Commission is the only body capable of handling such a question in the manner it deserves, and we fear that the report of the Departmental Committee will not be deemed of sufficient weight to authorise those large changes in the law which alone can render the position of the inebriate one of less disadvantage to society and of greater protection to himself. Admittedly the timid measure introduced by the late Lord Ritchie has failed entirely, as it was predestined to fail, but if it had only shown how comprehensive any legislative enactment must be to have any chance of success, it would not have been without value.

Needed Powers. IT is plain to medical men and others who have experience of drunkenness in the various classes of society, that inebriates, once established in their habits, are a well-nigh hopeless class to deal with, except under wide and strong powers. The object of society should be not to translate a few Jane Cakebreads from the prison to the reformatory when they are in a degenerate and parlous condition, but to attempt to give properly-constituted authorities a commission to prevent those who give way to drink from squandering their health and their property, from abusing the rights of citizenship and the duties of the family, and from committing crimes and outrages, through indulgence in stimulants. The only way to treat these questions efficiently is to give the State power over the drunkard such as it possesses over the lunatic. The medical profession know, as no one else knows, the impotence of themselves and everybody concerned in preventing drunkards from obtaining stimulants and carrying on their disastrous careers. Every member of the profession must hundreds of times have wrung his hands hopelessly while men have dissipated their businesses and women ruined their homes through indulgence in alcohol, and, together with the relations of their patients, have bemoaned their inability to take any step to prevent the evil that they see. Only by certificate and guardianship, either in an asylum or at home, can any adequate restraint be exercised.

Drug Habits. BUT, pressing as is the need for such drastic treatment of inebriates, hardly less so is that of narcomaniacs and drug-takers. Although exact figures are impossible to obtain, medical men generally are agreed that the increase in self-drugging with sedatives has been enormous, and that what drink is to men, drugs are to women. The best pharmacists are often unable, or unwilling, to refuse to supply drugs which they know are taken in excess, and the institution of co-operative chemical stores and the putting-up of powerful drugs into tablet form, have given an enormous impetus to the habit by granting increased facilities and removing any check the medical attendant can exercise. We feel that the communal treatment of inebriety which does not embrace in its province the restraint of the drug-taker, is likely merely to divert the morbid impulse into another and almost more hopeless channel. We trust the Departmental Committee will ask that its powers may be extended in this direction before it settles to its work. As constituted, with the exception of one or two untried persons, the Committee is an excellent one, and we especially welcome the name of Dr. Mercier, whose experience and acumen are so well recognised in the profession, and whose non-official position will enable him to pursue the original line that he pursues so successfully in matters of morbid psychology.

Motor Taxation. IN the new Budget confident rumour says that additional taxation is to be put on motor-cars. In the general way no objection could be taken to such an impost, for motor-cars are the luxury of the rich and entail a heavy burden on those who are poor by the damage done to roads, and by the decreased pleasure in walking and bicycling which cars travelling at a high rate of speed entail. But, in justice to the medical profession, we hope that the Chancellor of the Exchequer will see his way to exempt them from such a tax. The advent of the motor has already somewhat altered the conditions of practice, and it will do so still more in the future. By increasing the range of a single man's activity, it has made competition keener, and many medical men are finding that without a motor their chances of keeping up their practice are more and more difficult. Many such can ill afford the capital outlay and the extra annual expenditure, but in self-defence they feel bound to incur it, and any fresh burden will press very hardly. No man who owns a car can honestly say that it is used solely for the purposes of his profession; naturally the owner employs it as occasion offers for himself and his family, but the proportion of medical men who would buy a car unless forced to do so for professional purposes must be very small. A medical man's car should be treated as part of his professional expenses, and a tax which presses on trade or professional means of communication is notoriously bad.

Women Referees.

A QUESTION was asked in Parliament last week as to the number of women who come under the provisions of the Workmen's Compensation Act, and whether the Home Secretary was placing any women-doctors on the list of medical referees or medical assessors, so that women claiming under the Act might have the benefit of their services if necessary. We do not know what influences were at work to get the question put, but it is one involving a principle that cannot too strongly be deprecated. The advent of women into the medical profession may or may not be a good thing; the decision of that point, either in the affirmative or the negative, is entirely beside the question. But, unhesitatingly, it is a bad thing if it raises the further question as to there being any undesirability or impropriety in men attending female patients. In other words, a medical man, when he advises a woman who seeks his services, should be above suspicion, and it is a fact that any transgression against this rule is visited with the severest penalties by the disciplinary machinery of the profession. In our opinion it is more than unfortunate that any suggestion to the contrary should enter the public mind, and we believe women doctors in the aggregate would join us in reprobating it. To the particular question in point Mr. Gladstone replied that, although there were three million women affected by the Act, only two references to referees took place last year in which women were affected, and that the practical difficulties of making appointments were too great to be overcome, but that he would always consider an *ad hoc* reference to a woman practitioner. Which seems a very sensible conclusion to come to.

Non-Alcoholic Claret.

A MILD shock was lately administered to teetotallers by the returns of the Government Analyst, which showed that ginger-beer and other harmless, necessary drinks contained proportions of alcohol running to 3 per cent. and more. Except to those who hold the very name of alcohol in horror, this *exposé* need cause no surprise or regret, for the quantity of liquid that would have to be consumed before the drinker got any "forrader" would be so enormous that the subject would be certain to desist from mere distension long before his higher centres showed evidence of unnatural stimulation. We would trust Mr. Stiggins himself in a cellar of ginger-beer—provided there were no pine-apple rum there as well. But the sapping of principle which indulgence in ginger-beer denotes has led the way to another beverage being admitted into the category of teetotal delights. This beverage is no other than claret. At Boston, last week, a publican was charged with serving alcohol to a man on the black-list, and he put forward as his plea that he only supplied the delinquent with that non-intoxicating drink, claret. A local teetotaller supported the "trade" by testifying to his habit of drinking claret on occasions, and a chorister, who was always an abstainer during Lent, also said that he and his teetotal friends all took claret during that close season. If these be modern views, we can only imagine what the indignation of our early Georgian ancestors would have been had they heard claret described as non-intoxicating; and for our own part, we confess, that the pledge would press but little hardly on us while we were permitted to indulge without stint in that very prince of wines.

LEADING ARTICLES.

WHY IS NOT TUBERCULOSIS PREVENTED?

THE problem of tuberculosis and its extinction has been forced upon the attention of the community in so many ways and over so great a period of time that there is some danger of a reaction unless satisfactory results are forthcoming. It is of no little significance that the discussion of the subject is now mainly carried on in the lay, as apart from the medical journals. The progress of our scientific knowledge with regard to tuberculosis has been rapid within the last quarter of a century, and the public has firmly grasped the principle that the malady must be ranked among the preventible diseases. As a matter of fact, the response of the nation to philanthropic appeal has been prompt and not ungenerous. Huge and often costly sanatoria for the treatment of consumptives have been erected in various parts of the kingdom, and municipal and Poor-law institutions have been also founded for the same purpose. In spite of these efforts, however, it must be acknowledged as a fact beyond dispute that the national means for the adequate treatment of tubercular patients are absolutely incomplete, inadequate, and unsatisfactory. Of the total number of sufferers only a small proportion can be accommodated; many are in an advanced stage in which sanatorium treatment is of little or no use; while of those who find relief it is in many instances impossible to keep them long enough to ensure a complete cure, or, when a cure has been effected, they are often perforce sent back to the inevitable environment in which the disease was originally contracted. At the same time it is clear that an immense amount of good and useful work is performed by special sanatoria. Indirectly, they isolate a considerable sum-total of infection, and they further discharge a valuable function in the education of the public. For it is in these and similar preventive directions, rather than in curative measures, that the future elimination of tuberculosis lies. It is therefore desirable to ask ourselves whether, as a nation, we are reasonably acting up to the teachings of modern science in dealing with this great physical scourge. Take the two great principles of sanitary administration that sprang into existence directly the identity of human and bovine tuberculosis was definitely established, namely, the necessity of a rigid exclusion of tuberculous milk and meat from the national food supply. So far as milk is concerned, it may at once be stated that the system has yet to be devised which shall ensure that milk shall not be obtained from cows suffering from tuberculosis. In other words, the first, obvious, and elementary step in the reduction of the mortality and suffering from human tuberculosis has not yet been taken. Philanthropists and economists who bewail the excessive infantile mortality that is a standing reproach to our science might with advantage devote themselves to the practical task of ensuring the purity of the milk supply, at any rate, so far as the germs of tubercle are concerned. As to the flesh of animals intended for human consumption, precisely similar arguments, *mutatis mutandis*, may be applied. It is certain that infected meat can convey the virus in an active condition. It is equally certain that the specific micro-organisms may retain their vitality after running the gauntlet of cooking operations. It is obvious that the machinery of meat inspection is, under present conditions, crude and unscientific in method, and defective in application. The situation, indeed, may be summed up in the general statement that the nation is not at present effectually guarded against the infection of tubercular disease by means of a specifically infected food supply. The question naturally arises: How are these things to be remedied? The answer is somewhat complex. In the first place, it will be necessary to educate the public to the proper pitch, and to show them the practical benefit likely to accrue from preventive measures. The Local Government Board can do much, but it is likely that in the long run it will be necessary to strengthen the administrative arm by fresh legislation. Existing Acts regarding dairies, purity of food, and public health generally, will probably require amending in various directions. It is to be hoped that before long the legislature will turn its attention to the great questions involved in the final campaign against what has been aptly termed the "white scourge." The work has been well begun, but for the moment is almost looks as if British sanitarians were relaxing their grip of the practical side of things. The vastness and complexity of the problem, to say nothing of the vast expenditure that is involved, may account to some extent for this apparent pause. We have every confidence, however, that the sturdy pertinacity of our race, which has proved of supreme value in the conquest of many no less deadly scourges, will ultimately prevail against one of which the ultimate secrets have been disclosed by the labours of modern medical science.

CURRENT TOPICS.

Cancer Research and the Middlesex Hospital.

AN appeal is being made through the press by Lord Cheylesmore for funds of sufficient magnitude to endow the Cancer Department of the Middlesex Hospital, and make it independent of fluctuating subscriptions. The profession will cordially support the request, especially those members of it who have watched the excellent and unostentatious work which has been carried out there for the last eight years. The only objection conceivable is, that the work of the Middlesex might overlap or adversely compete with that of the Cancer Research Fund. We do not think this is, or is likely to be, the case. In the first place, the Middlesex Hospital has the advantage over the Fund of having clinical opportunities of testing accredited remedies, as well as the more academic facilities. The Hospital has done much good work in this direction already, principally, alas! of a negative character, but it enjoys unusual facilities of putting any promising plan to the final and decisive test; and it is by no means improbable that to the Middlesex may belong the "crowning mercy" of establishing a method of curing the disease. As to competing scientifically with the Fund, such rivalry is of an entirely healthy character, and the two agencies are far more likely to stimulate each other than to waste time and material in going over the same ground. In research work there is an inevitable tendency to disheartenment when avenue after avenue has been followed up and found to be blind. The best correction to such disappointment is to know that there are others working along other lines which may be more successful, unless every effort is put forward to keep abreast. But in any case, by the enthusiasm shown at the Middlesex, by the good work put in by many past and present workers, and by the prudent management of its affairs, the appeal stands on the strongest ground, and we feel sure that the wealthy, especially such as have seen their relatives suffer from cancer, can find no better outlet for their benevolence to humanity than by subscribing handsomely to the Department.

Human Freaks and the Public.

THE exhibition of so-called human "freaks" has been brought to the level of a fine art by the wiles of the American showman. One of his favourite captures is the "ostrich man," who swallows all kinds of solid articles, from tin-tacks to glass tumblers and open clasp knives. Sooner or later this unhappy juggler is unable to disburthen his stomach of its unnatural load, and he dies a miserable death, for a surgical operation is almost invariably unsuccessful. It is a question of public morality whether persons who assist as spectators at these unnatural performances do not become accessories to the fatal issue. At any rate, it is certain that, were there no fees from the audience, there would be a speedy end to this particularly deadly exhibition. In these days when there is so much cheap philanthropy abroad it is difficult to understand why the dangerous performance has reached a pitch of popularity that it has probably never before attained. Another curious fact is that the State, which is exerting itself to protect life and limb in almost every conceivable condition of social environment, has left the dangerous performer to risk his neck in a score of ghastly ways for the sake of earning his sorry livelihood. Of course, some of the "freaks" are merely harmless specimens of diseased processes, such as the giant, the dwarf, the "blue man" (coloured by nitrate of silver), and the fat woman. One of the most pitiable of all these pathological curiosities is the subject of advanced progressive muscular atrophy who is exhibited under the not altogether inappropriate title of the "living skeleton." As a rule he is one of the greatest attractions possible in this particular class of exhibits, and his salary—while it lasts—is equal to that of many a first-class barrister or fashionable physician.

A Sleeping Sickness Prevention Ordinance.

THE Governor of Uganda has promulgated an Ordinance for the prevention of sleeping sickness. He has thereby placed a vast part of territory under the conditions of a declared infected area. Stringent rules are laid down for the whole of the mainland of the Uganda Protectorate within a distance of two miles of the Victoria Nyanza and all the islands in the Victoria Nyanza. Fishing is prohibited within two miles of the shore, and the purchase of fish caught within that area is a punishable offence. No person is permitted to ply on the Victoria Nyanza. Traffic is permitted between the islands and the mainland only under certain strictly-defined conditions, including the use of special landing-places. The importance of strict preventive rules of this kind in the heart of Africa marks a new departure in the relation of the British Government to her native dependencies. If we recognise our moral responsibility in stamping out sleeping sickness in Uganda it is not easy to see logically why we are not compelled to bring an equal amount of energy to bear upon, let us say, cholera in India. On the whole, it is probably as easy, or easier, to banish cholera than to exterminate sleeping sickness. To have discovered the cause of the last-mentioned malady is a fact of which modern medicine may well be proud, and to rid the world of its presence will constitute a still nobler indication of the practical value of science to mankind.

A Proposed Official Register for Nurses.

A proposal is contained in the Bill recently introduced into the House of Lords by Lord Balfour of Burleigh, to "provide for the establishment of an Official Directory of Nurses." In the absence of sound evidence to the contrary, most medical men would probably regard the step therein indicated as a work of supererogation. The present system works fairly well, and it would be nearly as reasonable to demand a State registration of chefs, or lawyers' clerks, or watchmakers, or for members of any other class of skilled workers. Indeed, the claim has been seriously and repeatedly advanced in the case of the plumbers and the spectacle-makers. Were the principle of registration once generally accepted the world of industry would run a risk of becoming converted into a mass of isolated monopolies, each one struggling to wring the uttermost farthing from the pockets of the consuming public. From the economic point of view we imagine it would be an evil day for the community should nursing be made a monopoly. If there is to be a State registration of nurses—which we regard as an absolutely uncalled-for departure— there can be no logical objection to the establishment of an official Directory. The one appears to be dependent on the other. The State could hardly issue an official *Register* without having fixed upon its standards of education and of examination, and without the creation or the co-option of its educational examining bodies. If Lord Balfour proposes merely to issue a list of nurses who can produce satisfactory certificates of training and of moral character short of a State diploma, he is seeking to do what would probably be accomplished just as well, or better, by private enterprise. The whole movement appears to be a natural extension of the worst features of the Midwives Act, whereby a particular branch of nursing, useful and honourable in itself, has been translated into a false position of a semi-demi State-qualified medical description.

Diphtheria from Cats.

The times seem favourable for a critical review of the relations between mankind and domestic animals with regard to infection. The future control of tuberculosis in a great measure depends on the way in which the comparative disease is handled by the local and national health authorities. The list of diseases which are mainly or altogether due to the agency of the lower animals is extensive. Such maladies as influenza, glanders, plague, actinomycosis, anthrax, trichiniasis, and most kinds of tapeworm, will occur at once to the medical reader. It is not unlikely that many of the specific infectious diseases may be communicated to man either mediately or immediately by the agency of domestic animals. Many cases have been reported, though on scant authority, in which scarlet fever, small-pox, and other fevers have been attributed to infected horses, cats, or dogs. In Swindon recently two children died from diphtheria, the infection in each case having been traced to the household cat. The chain of evidence was rendered complete by the identification of the disease in the cats by the Medical Officer of Health for the district, Dr. F. E. Streeten. The fact that cats may not only contract the disease, but spread it broadcast cannot be too widely known. There is no more insidious bacterial foe than that which appertains to diphtheria. At the same time, there is a silver lining to the cloud in the fact that it is absolutely preventible, and one day will assuredly be prevented.

Medicine in the Royal Academy.

As a not unimportant factor in social life the world of medicine comes in for a fair share of attention at the hands of the painters at the Royal Academy. This year one of the chief pictures illustrates an incident of professional life. It is from the brush of the Hon. John Collier and displays his air of absolute realism and fine sense of drawing and colour. Apart from the title, however, it would be impossible to say from merely looking at the picture what particular tale it is intended to convey. A business-like, intellectual-looking consultant is giving advice to a young man who is obviously not in good health. Beyond that it would be unsafe to attempt to draw any inference of any value, although it is clear enough that a wide field of conjecture is thrown open to any of those who care to exercise their imagination. On the whole, the proposition most likely to suggest itself to the mind of the medical man would be that the patient is suffering from tuberculous disease. To that speculative diagnosis, however, there would be many equally possible alternatives, if it be allowable to apply that much-abused term to more than one possibility. For instance, the youth might be convalescent from some acute infectious fever or severe accident; he might be the victim of melancholia or some spinal cord lesion, or may have turned the midnight oil too freely. As a matter of fact, the precise position of affairs is indicated by the catalogue title, "The Death Sentence," whereby the artist indicates that the physician is communicating the fact that his patient is afflicted with a fatal malady. The situation is dramatic and full of the sudden pathos and tragedy that often flits across the path of a busy medical man.

Royal College of Surgeons in Ireland and the University Bill.

Mr. T. W. Russell has informed Sir William Collins in the House of Commons during the past week that it is not intended to make the Royal College of Surgeons in Ireland a constituent

College of the new University in Dublin. In reply to a further question, he stated that Mr. Birrell would be prepared to sonsider any further representations which might be made by the College of Surgeons. We understand that it is probable that the Royal College of Physicians will join with its sister College, and certainly this is the wise and obvious course to be taken. The College of Surgeons naturally fears lest its School should be overshadowed by the School of the new University supported by large Government grants. Even if that did not occur, another danger would lie in its path, namely, the difficulty of overcoming the probable prejudice of local bodies through Ireland to men who are not trained at the new University. For that reason, we think that the Colleges should together try to obtain an undertaking from Government to adopt without delay the Report of the Poor-law (Ireland) Commission, and to institute a Poor-law Medical Service, entry into which should be by competitive examination, instead of by the present demoralising methods. The Colleges must fight strenuously if they are to maintain their position, and if, in their effort to do so, they succeed in getting this report adopted, they would incidentally confer a benefit on the whole country.

A Dublin Surgeon of Elizabeth's Time.

It is interesting to learn of the high position occupied by members of our profession in Ireland at a time when in some other countries surgery was still a more or less despised craft. In a recent lecture, Dr. George Sigerson has recounted the life of a surgeon who took an honourable and conspicuous part in the civic life of Dublin in the time of Elizabeth. This was John Morphe, who seems to have been a pupil of that Denis Collier, "phisician and surgeon," who so "adventured his life in this contagious time of plague" in 1575, that he was admitted to all the liberties and appointed medical officer of the city. Morphe, who was a native of the County Dublin, and was allied with many of the gentle families of the Pale-Gaelic, Norse, and Norman periods, prospered so in Dublin practice that he became, for those times, a very rich man. He was an alderman and a sheriff of the city. His interest in public affairs was further shown by his bequests for the purpose of building bridges over the Dodder and Tolka. He left much money in charity and to various churches in which he was interested. One bequest of special interest is that to the Company of Chirurgeons of "one of my Silverton cupps and the heavy chist that is in the little chamber in the forestrete to kepe thyr wrythings in memory of me that wyssh to them encrease of vertuous knowledge." In the increase of virtuous knowledge which has come to the Dublin surgeons the memory of John Morphe should not be forgotten.

PERSONAL.

The King has been pleased to give directions for the appointment of Joseph E. Godfrey, M.B., Surgeon-General, and Chairman of the Local Government Board of British Guiana, to be a member of the Executive Council of that Colony.

His Majesty the King of Italy has been pleased to confer upon Dr. Thomas Reid, of Glasgow, the order of the "Commendatore of the Crown of Italy." This distinction is designed as a recognition of Dr. Reid's merit as an ophthalmic surgeon and also of his many services to the Clinique of Ophthalmology in the University of Turin, where his intimate friend Professor Reymond is chief.

Dr. Henry Gervis has been appointed a magistrate for the Borough of Brighton.

The German Emperor has conferred the Order of the Crown, Second Class, on Sir Felix Semon, K.C.V.O.

There is considerable improvement in the condition of Dr. Rainy, M.P.

We regret to hear that Dr. Spinks, of Bournemouth, was injured in the head and arm by the terrible tram accident last week.

At the London Hospital, Mr. G. P. Mudge will lecture on "Mendelian Inheritance" on May 6th and May 13th, at 4.30 p.m.

Professor Osler will deliver the Linacre Lecture at Cambridge on May 6th, taking as his subject "Thomas Linacre—His Life and Works."

Surgeon-General G. D. Bourke, C.B., Principal Medical Officer in Ireland, has been appointed to be a Governor of the Westmoreland Lock Hospital.

Dr. Octavia Lewin's goods, which were seized for non-payment of a fine of £10 for refusing to pay tax on armorial bearings, were sold by public auction on May 4th.

The new Glasgow Maternity and Women's Hospital was opened on April 24th, the ceremony being performed by the Duchess of Montrose, who was accompanied by her daughter, Lady Helen Graham.

An Association of Tropical Medicine has been formed in the Far East, and Dr. Paul C. Freer, Director of the Bureau of Science in the Philippine Islands, has been elected the first President.

A presentation has been made to Professor J. G. McKendrick, of Glasgow, on his retirement. It took the form of his portrait, to be hung in the University Buildings, a silver tray, and a sum of £450 to equip a laboratory of experimental psychology.

Mr. John Morley, on his elevation to the peerage, will probably assume the title of Viscount Morley of Blackburn. His father, Mr. Jonathan Morley, practised as a medical man in Blackburn, and Lord Morley was born there 70 years ago. He entered Parliament for Newcastle-on-Tyne in 1883.

A Hospital for Women and Children has been given to the city of Madras by Deman Bahadur N. Subrahmanyam. The donor stated that he proposed to hand over the hospital to the Wesleyan Society, which had sent out Miss Wilson, a graduate of Aberdeen University, as lady superintendent.

The fund being collected as a memorial to the late Dr. J. Everett Dutton, who died a year or two ago when on an expedition for the Liverpool School of Tropical Medicine, is nearing completion. More than two-thirds of the sum required has now been given or promised, the activity of Sir Rubert Boyce being largely responsible for this happy result.

The Annual Dinner of the Association of Scottish Medical Diplomates will be held at the Hotel Waldorf, Aldwych, London, W.C., on Tuesday, May 26th, the President, Dr. David Walsh, in the chair. Tickets, 10s. 6d. each (exclusive of wine) may be obtained from Dr. Arthur Harries, 11 Chandos Street, Cavendish Square, London, W. Ladies are invited, and any holder of a Scottish qualification will be welcomed.

Dr. Thomas Lambert Hinton, of St. Leonards, has just celebrated his one hundredth birthday. He and Sir Henry Pitman are the oldest members of the Royal College of Surgeons. Dr. Hinton has a distinct recollection of hearing the result of the Battle of Waterloo. From 1829 to 1846 he served in the 1st Bengal Fusiliers. On his way home from India he was wrecked oft Cape Finisterre. While in the water a child was flung to him, and he swam with it for a long time before being rescued.

A CLINICAL LECTURE
ON
EARLY DIAGNOSIS IN SURGICAL DISEASES OF THE KIDNEY, WITH SPECIAL REFERENCE TO PHYSICAL METHODS OF EXAMINATION.

By DAVID NEWMAN, M.D., F.F.P.S.G.,

Surgeon, Royal Infirmary, Glasgow.

FEW diseases occurring in surgical practice more clearly illustrate the value of early diagnosis than do the commoner surgical maladies which attack the urinary organs. These include tuberculosis, septic infection, and calculus, all of which, while they. as a rule, start in the kidney, rapidly lead to serious secondary changes in the lower portion of the tract.

A belief, unfortunately, prevails that infective diseases such as tuberculosis and septic lesions usually begin in the bladder or genital organs, and spread upwards to the kidneys, whereas it is now well-known that exactly the opposite mode of invasion is the rule. The natural conclusion to be drawn from this circumstance is that it is the duty of the medical adviser to discover not only the nature of the morbid process, but to fix as early as possible its exact locality.

By inference from symptoms alone this is almost impossible except in typical cases; but in actual practice how many such cases do we meet with? The subjective phenomena are too often misleading—pain being the least reliable of all. Often renal calculus, for example, causes no suffering in the region of the affected kidney, the only complaint being pain at the point of the penis or in the bladder.

Symptoms simply point the direction in which information may be obtained—nothing more. For example, pain and bleeding may originate in any portion of the urinary tract, but, while in many instances the character of the hæmorrhage and the situation of the pain correctly indicate the nature and site of the lesion, in others they seriously mislead, unless resort is had to physical proofs to guide and correct the inferences deduced from the subjective symptoms.

The objective methods which are most valuable in aiding an early and exact diagnosis are:—

(1) Bacteriological examination of the urine, inoculation experiments and ophthalmo-tuberculin reaction.
(2) Segregation of the urine.
(3) Sounding.
(4) Cystoscopy.
(5) Methylene blue test.
(6) Radioscopy.

To a consideration of these attention will be limited, taking it for granted that they are employed only as aids to the ordinary methods of clinical inquiry as to the general symptomatology, and in conjunction with the facts revealed by inspection, percussion, palpation, surface, abdominal ballottement, rectal and vaginal, auscultation, rectal insufflation, and a careful examination to ascertain the condition of the urine as regards pus, blood, or other abnormal constituents.

1.—BACTERIOLOGICAL EXAMINATION OF THE URINE.

The first difficulty which presents itself in a bacteriological examination is to obtain the urine free from external contamination. To make a reliable observation, the urine must be conveyed from the bladder to a sterilised vessel, all risk of contamination being obviated. How, then, are we to proceed? The appliances—namely, Melchior's catheter, tubing, and collecting vessels—must be sterilised by boiling in an alkaline solution, and afterwards washed in sterilised water; the glans penis and the prepuce, but especially the meatus, must be thoroughly washed with soap and water containing a little ammonia; this is followed by washing with spirits of wine, and afterwards with carbolic acid solution, 1 in 40 in water. The meatus should also be douched with sterilised water; afterwards the mucous membrane should be carefully everted and again thoroughly cleansed. All the parts of the patient having been thoroughly disinfected, the surgeon again cleanses his hands and lubricates the catheter with glycerine containing carbolic acid 1 part in 40, and passes it into the bladder. The urine is allowed to flow direct into the previously sterilised tubes of the centrifugal separator, and after a few minutes in the machine any deposit of microbes is thrown down, and can be at once examined microscopically, or by culture observations. The advantages of this rapid method are obvious.

The organisms which invade the urinary tract may be divided into two classes—those which induce decomposition of the organic constituents of the urine, and those which cause little or no chemical change in these substances. This distinction is a very important one. When organisms which do not possess the power of decomposing the organic constituents of the urine are introduced into the healthy urinary tract, they fail to produce any serious effect. For example, a pure culture of the bacillus coli, or of the tubercle bacillus, may fail to induce cystitis when injected into the uninjured bladder, but if separately, or along with them, urea-decomposing organisms are introduced, acute cystitis is sure to follow. When the infection is "mixed," the progress of the disease is usually very rapid. The principal organisms which induce decomposition are the staphylococcus pyogenes aureus and albus, some staff bacilli, and diplococci.

The *bacillus coli communis*, first recognised in 1886 by Escherich, is normally found in the intestine, but in diseases affecting the alimentary tract the number is enormously increased, and in certain well-known conditions the virulence of the organism is intensified.

In the urinary passages, as elsewhere, the virulence of the bacillus coli varies according to circumstances. In some cases its presence causes little or no disturbance, while in others its virulence is great, and death may take place even before suppuration is established, as in acute septic interstitial nephritis. The bacillus coli is by some observers supposed to be the most frequent cause of inflammation of the urinary tract, being in most instances absorbed into the circulation through lesions in the intestine and deposited in the kidney. This occurs most commonly when the intestinal tract is obviously diseased. It is found, as a matter of experience, that pyelitis or septic nephritis comes on very commonly in the course of convalescence from enteric fever, dysentery or acute diarrhœa. The bacillus coli or its products probably also plays an important part in the ætiology of certain nervous lesions associated with chronic inflammatory diseases of the urinary tract.

In the intestine it is clearly non-pathogenic, but when it migrates to other parts it is strongly pathogenic. The soluble products of the growth of the bacillus seem to be the same in their action whatever may be the medium employed, but the source from which the organisms are derived has a very important influence on their action. As an illustration of this, the organisms taken as a pure culture from a peritonitis arising from a perforation of the intestine are found to be more virulent than when taken from a healthy intestine; or again, if the intestine be obstructed artificially, the activity of the bacillus is increased. Also, in different cases of pyelitis and cystitis, degrees of virulence may be observed; but while the organisms derived from one case on cultivation and inoculation into animals may produce very mild effects, those taken from another case which appears to be exactly similar, may induce very grave results. The bacillus coli seems also to have the power of increasing the activity of other bacilli, or of rendering their products more harmful.

The discovery of the *tubercle bacillus* in the urine in diseases of the urinary tract has very much the same import in diagnosis as the detection of it in the sputum in pulmonary troubles. Its presence points to the cause, not to the gravity and extent of the lesion. In renal tuberculosis, as in phthisis pulmonalis, the organism may be present for a time and disappear, but, notwithstanding this possibility, its presence must be looked upon as an important danger signal. The presence of tubercle bacilli in the urine does not necessarily indicate disease in the urinary tract, as it is now recognised that the bacillus may be eliminated by the kidney without infecting the tissues through which it passes.

When examining the urinary *débris* for tubercle bacilli, it is necessary in most cases to prepare at least half-a-dozen specimens. Should bacilli be present, they will be recognised by a magnifying power of 750 diameters as minute rod-shaped bodies, coloured according to the nature of the staining fluid employed. They are from 3 to 7 micro-millimetres long; they may be straight, but they are more frequently curved or bent upon themselves at an obtuse angle; they are frequently beaded, and they occur in bundles or singly.

From the urine the micro-organisms are not easily cultivated, as putrefactive bacteria contaminate the culture and destroy the specific bacilli. Koch, however, states that he has succeeded in cultivating tubercle bacilli from cases of tuberculous pyelitis. In some instances the bacilli in the urine are so few in number that it is difficult, or almost impossible, to discover them simply by the microscope. In such instances inoculation experiments help greatly to clear up the diagnosis.

When tuberculous urine is injected subcutaneously into guinea-pigs or into rabbits, it produces a typical tuberculosis within 30 to 40 days. The local swelling may break down, caseate, and ulcerate, while the lymphatic glands related to the part become enlarged and firm, and after a time they may also caseate, and the disease passes on to another group. When injected into the peritoneal cavity, tuberculous urine produces an extensive tuberculous infiltration of the omentum and acute tuberculous peritonitis.

In cases suspected to be tuberculous the Calmette ophthalmo-tuberculin reaction may be employed, and it is valuable in certain cases. The method consists in dropping on the conjunctiva an attenuated tuberculin, and examining the eye at regular intervals thereafter, attention being particularly directed to the caruncle, and to the bulbar reflection of the conjunctiva at its inner margin. If the patient is tuberculous, usually from eighteen to thirty hours after the instillation distinct hyperæmia appears in the caruncle, and in forty-eight hours conjunctivitis results, but disappears within a short time. It is not by any means an absolute test, but it has its value in confirming the results derived from other methods.

In all cases of transient and slight albuminuria, hæmaturia, and pyuria, associated with acid reaction in the urine, occurring in young persons, a careful inquiry should at once be made to clearly demonstrate the cause of these symptoms. To allow time to pass in the hope that the warning may be neglected is folly. These are the distinct danger-signals of renal tuberculosis; wait not till the home signals are in full view; they may appear sooner than you expect; then it may be too late to avoid disaster.

The *streptococcus pyogenes* not infrequently gives rise to septic infection of the urinary tract, and brings about diffuse inflammation and suppuration. When present in pure cultures it does not decompose urea, but it is frequently associated with the presence of other organisms possessing that power; consequently it is generally found in alkaline urine. In character it closely resembles the streptococcus of erysipelas, and by most observers the two are regarded as identical.

Pneumococcus infection of the kidney may cause very acute and grave symptoms, and sometimes involve the life of the patient. It is a condition which has not been sufficiently recognised, being liable to be mistaken for acute nephritis, but the appearances of the orifices of the ureters are very striking and characteristic, and not uncommonly the disease is limited to one kidney. (*a*)

The writer has met with a number of cases within the last five years where the disease has been unilateral, and in a few marked improvement has been obtained by incision of the fibrous capsule to relieve tension of the swollen parenchyma.

We may now consider the micro-organisms which cause decomposition of urea, and are, therefore, found in alkaline urine only.

The *staphylococcus pyogenes aureus* is one of the most virulent septic organisms, and is very widely distributed, occurring in almost all suppurations, in normal saliva, in water, in dust, in the air, and especially on the surface of the skin. When it gains access to the urinary passages it rapidly propagates, causes decomposition of urea, and the alkaline urine, by acting upon the mucous membrane, reduces its resisting power and facilitates the entrance of the organism into the tissue.

Staphylococcus pyogenes albus is less malignant than the yellow form, but closely resembles it, and by some bacteriologists is regarded as a variety of the organism described above. It seems, however, impossible to transform the one organism into the other.

Besides those above-mentioned, there are many other varieties of organisms found in the urine in inflammatory diseases of the urinary tract, but these are the most important.

2.—Segregation.

Having determined the presence of micro-organisms in the urine, the next inquiry is to determine their source. This may be done by catheterising the ureters or by employing urine segregators, the objects being to obtain not only information as to the kidney which is diseased, but also an estimate of the functional activity of its neighbour.

As the first to employ this method of examination in this country, the writer may be permitted, after considerable experience, to express his opinion as to their value. When cystoscopy was less practised, and experience was still required to interpret the appearances revealed to the eye, the employment of segregation and ureter catheters was justified. They have not fulfilled expectations, and are clumsy and unreliable methods of trying to attain ends many of which can now be practically reached by the cultured use of the cystoscope.

No segregator has yet been devised which fulfils the claims made upon it and placed to its credit by some of its advocates. To believe that we can construct a water-tight partition in the living bladder requires considerable credulity, and an unusual adaptability of natural conditions to our contrivances.

The objects in view in catheterising the ureters are:—

(1) To determine by examination of the urine from each kidney whether the disease is unilateral or bilateral.

(2) The disease being limited to one side, to ascertain the character of the secretion from the opposite kidney.

(3) To ascertain the presence of a second kidney before performing nephrectomy.

(4) To test the patency of a ureter, to discover the presence and situation of a stricture or kink, and to localise a stone.

(5) To guide the operator in tracing the course of the ureter in certain operations on the pelvic organs, and in repairing ureteral fistulæ.

Ureter catheters are more reliable, but objections have been raised against the use of the catheters on account of the alleged danger of introducing septic matter into the ureter, either from the bladder or by instruments which have not been properly sterilised.

In many cases the ureter is already septic before

(*a*) See *British Medical Journal*, March 31st, 1906.

catheterisation is thought of. On the other hand, in cases of cystitis, where the kidney is supposed to be aseptic, unless in exceptional circumstances, the catheters should not be employed, as, even although they are carefully sterilised, and the bladder is as thoroughly cleansed as possible, there is danger of introducing septic matter into the ureter. Any injury of the ureter by the use of the catheter must add to this danger

While frequent employment of the catheter is to be condemned, as it exposes the patient to certain risks, and in many conditions the information obtained is unreliable, it has its value for diagnostic purposes. For example, in discovering the presence and situation of a stricture, or in locating a stone in the ureter, or in acting as a guide to aid the operator in tracing the couse of the ureters.

It is in the detection of albumin, tube-casts, and micro-organisms in the urine from one kidney alone, that the ureter catheters are most valuable, and it is just at this point that the cystoscope fails us. But all information that the use of the cystoscope can give us should be procured before the catheters are employed.

While fully recognising the high value of catheterism of the ureters as an aid in diagnosis, it should not be resorted to unless other methods of inquiry have failed to elicit the required information. The cases in which the operation is justified are not very numerous.

For examinations of the ureters by catheters and sounds, the simple cystoscope of Grünfeld is the most useful in the female. It has been modified, and the method of employing it has been improved by Kelly, by Pawlik, and by the writer, and, as now used, it is undoubtedly the most convenient instrument. But for general observation of the bladder in both sexes, and for sounding or catheterism of the ureters in the male, the writer prefers the ureter cystoscope of Casper.

3.—SOUNDING THE URETERS.

In cases of stone impacted at the lower end of the ureter, the ureteral catheter may fail to pass, but on introducing a metal instrument, and which may be called a ureteral resonator, the sound of the metal coming in contact with the stone can be detected by the ear as well as by the hand of the observer. The instrument devised by the writer consists of a probe which is fixed in a small flat handle and prolonged into a hollow brass globe or resonator. (*a*) One end of an indiarubber tube is fixed to the proximal end of the resonator; to the other end is fixed a wooden ear tube made to fit the external auditory meatus of the observer. The probe is introduced into the ureter, and when an obstruction is met with, the ear tube is fixed in position and the instrument rotated slightly. If a calculus is present, the sound produced by the probe grating upon it is easily heard.

(To be concluded in our next.)

NOTE.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by David Newman, M.D., F.F.P.S.G., Surgeon, Royal Infirmary, Glasgow. Subject: "On Early Diagnosis in Surgical Diseases of the Kidney, with Special Reference to Physical Methods of Examination."*** **(*Conclusion.*)**

ORIGINAL PAPERS.

FIVE CASES ILLUSTRATING DISEASES OF THE GALL-BLADDER,

FROM THE CASE-BOOK OF A GENERAL PRACTITIONER. (*b*)

BY G. REINHARDT-ANDERSON, F.R.C.S.,
Hon. Medical Officer, Southport Infirmary.

IT is a dictum of Dean Swift that "no man ever made an ill figure who understood his own talents, nor a good one who mistook them."

This excellent aphorism has stood me in good stead in submitting the notes of the following cases.

Difficulties of all kinds beset one in attempting to unravel the problems of obscure abdominal conditions. I do not refer now to fulminating peritonism, which obviously calls for active interference; but rather to those chronic conditions producing almost constant pain and perpetual ill-health.

These are the cases, perhaps, more often seen by those of us who are engaged in general practice.

They do not call aloud for operative interference; yet I would submit that the following cases illustrate the grave conditions which may underlie seemingly inconsequent symptoms, and the necessity that there is for careful examination of every abdominal case, also the propriety of early exploration if other means obviously fail.

CASE 1.—On July 5th, 1906, I was consulted by a hale-looking man, æt. 53, for irregular pain after food, at times slight, at others excruciating in agony.

He described his sensations as those of difficulty in passing wind under the right costal margin, and it was always relieved if he got a good evacuation of the bowels. The first severe attack of pain occurred two and a-half years ago, after eating a hearty meal of fish. The medical man who saw him during this attack ascribed it to fish-poisoning.

Other seizures occurred at long intervals, but it was not till January of the present year that they became more frequent and at the same time more severe.

He has never been jaundiced. Losing flesh rapidly: one stone since Christmas. His tongue was thickly coated, and bowels confined. I carefully examined his abdomen, but beyond a little tenderness in the epigastrium I could detect nothing.

By July 14th he reported himself as no better, so I sent him into the infirmary for observation. I may say he is a man of fine physique, being constantly in the open, as a gamekeeper, and of simple, abstemious habits.

On admission to the infirmary we found he had a temperature of 100° to 100.4° nearly every night. After a hearty meal on July 16th, a most severe attack of pain came on, which I was fortunate enough to witness.

No doubt the man was in the direst agony—screaming with pain, which he described as radiating all over his abdomen from the epigastrium. He was given full doses of morphia, and at my next visit all evidence of the severe storm of the day before had vanished. His tongue was clean, his abdomen was soft, with no sign of tenderness. The bowels had been well moved by an enema, and to this he ascribed his recovery. Careful dieting, rest in bed, and salol by the mouth, seemed to work wonders for him. The temperature fell to normal in about a fortnight. He then began to take ordinary food, and gradually regained a certain amount of health and strength.

At this stage of the case my opinion wavered between early carcinoma of the pylorus inducing severe spasm, or an impacked gall-stone in the cystic duct. However, in face of the absence of direct evidence and his marked improvement, operation was deferred, and therein I was wrong.

He went home on August 10th, but on the 13th he was readmitted very much worse.

The house surgeon notes:—"Patient readmitted, suffering from same symptoms as before—severe pain over a point lying between pylorus and gall-bladder, flatulence, vomiting with obstructive symptoms, no jaundice. High fever. Rigors on August 25th and 26th. Feels shivery at times."

I returned from my holidays September 1st, and found him looking ill, and with constant hectic fever, but unaltered physical signs. I urged operation, and this was done on September 5th, 1906. The abdomen was opened by an incision along the outer side of right rectus, continuing upwards to the middle line about 1 in. below costal margin. Exploration soon revealed the cause of all his trouble—the gall-bladder deeply hidden by adhesions, almost gangrenous and full of muco-pus, but no stones. It was a matter of no slight difficulty to effectually fix the gall-bladder

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(*a*) Made by Messrs. Gardner and Son, Edinburgh.

(*b*) Paper read before the Liverpool Medico-Chirurgical Society.

for drainage, but we were happily able to do so, and my patient has made a most excellent recovery. No longer troubled by pain or fever, with a clean tongue and good digestion. He still has a mucous fistula, and no doubt the correct treatment would have been to remove the gall-bladder. As he is in such good health he declines further treatment.

CASE 2.—On September 6th, 1906, a well-nourished young woman consulted me for constant pain after food, with occasional vomiting. The history she gave pointed to long-continued gastric ulceration. In fact, three years ago Mr. T. Thomas had seen her, in consultation with her own doctor, for suspected perforation. She had a fresh attack last year, and was fed rectally.

She has never vomited blood, but gets a feeling of stretching and pain in holding herself erect; pain not directly after food, often two hours later.

Has never been jaundiced. Bowels confined, and has not menstruated for five months. On examination I noticed much tenderness in mid-epigastric region and rigidity of muscles. M'Kenzie's sign was well marked. I diagnosed gastric ulcer (?), with old perforation and adhesions. She was admitted to the infirmary for gastro-enterostomy. Operation performed on September 15th, 1906.

To my surprise the stomach itself was perfectly normal. No sign on either posterior or anterior surface of present or past ulceration; but I found marked adhesions between pylorus and gall-bladder, and, after separating these, the gall-bladder was exposed, packed full of stones and much pus. These I removed, and she made an uninterrupted recovery. The gall sinus healed up in less than five weeks, and she remains in perfect health, with a good digestion and free from pain.

CASE 3.—In September, 1904, I was asked by Dr. Dall to see a young man whom he suspected of suffering from pyloric obstruction.

This is the history I obtained.

E. R., æt. 25, bootmaker.

About six weeks before, whilst at work, felt very sick, with acute pain across the shoulders. He commenced to vomit, and this sickness continued for a week, with much epigastric pain, more to the right than left side. With this incessant sickness there was marked constipation, relieved with difficulty by various aperients. His temperature was irregular and the pulse rapid.

I saw him with Dr. Dall on September 13th, 1904, and the opinion I formed at that visit, after careful examination, was that he might be passing through an aberrant form of enteric. However, the pain and sickness continued, and he was admitted to the infirmary on September 21st.

Condition on Admission.—Patient very sallow and thin. Tongue covered with brownish fur and dry. Temperature, 99.8°. Pulse, 120. He complains of severe pain in right hypochondrium, where there is great tenderness, but no tumour, only a slight resistance felt. There is some dulness over the epigastrium.

For three days he continued much in the same condition, complaining of much epigastric pain and occasionally vomiting. Temperature never rose to 100° F.; in fact, on the morning of the 24th, it sunk to 97°, and his pulse, which had been always 120 or over, was only 100.

But on the evening of September 24th he had a most severe attack of pain in upper abdomen, and became very collapsed.

I had to go to Scotland on that day, and did not see him till mid-day of Sunday, September 25th. There was now a very marked change in his condition. He was considerably blanched, and looked as if he were dying. A large tumour, extending almost to the level of the umbilicus, had suddenly developed, exquisitely tender, and with loud peritonitic friction to be heard over it. I felt totally at a loss to explain this development of the case. Diagnostic incision alone remained to clear up the case or to offer him the slightest hope. Accordingly I operated at 7 p.m. the same day.

On opening the abdomen by a long median incision above the umbilicus, the most extraordinary sight was revealed—a large bluey dark tumour filled the whole upper abdomen, obviously a blood tumour. Incision into the thin capsule was followed by an alarming gush of blood. I soon found that this was an enormous hæmatoma beneath the capsule of the liver, and it is no exaggeration to say that we scooped out in clots quite a quart of blood. When this was removed to the best of our ability, a large irregular cavity was left, from which free oozing took place. Hot saline douching arrested the flow, and finally a tube was inserted surrounded by a plentiful supply of gauze.

It is not necessary to say his condition seemed desperate in the extreme, and I entertained little or no hope of his ultimate recovery. But in abdominal surgery it is often the unexpected that happens. He continued to have a free bilious purulent discharge, with swinging temperature, and pulse always over 100, until November 9th, when discharge began to diminish. On this date it is noted that there was dulness posteriorly over right lung, with slight decrease of vocal resonance. An exploring needle was introduced twice, with a negative result.

However, he continued to improve, and began to get up. On November 30th the temperature was again swinging, with increased pulse rate and a troublesome cough. This continued till December 9th, when, during the night, he coughed up a large quantity of foul-smelling pus. From this date his recovery was uninterrupted. He left the infirmary December 31st, 1904, quite well, and remains in perfect health to the present time.

The explanation, I think, is not far to seek, because there is no evidence to prove that this was a pure hepatic abscess. My own idea is that we had to deal with a subphrenic abscess from the lesser sac burrowing into the liver, producing that remarkable hæmatoma.

CASE 4.—M. E., nurse, æt. 35. Consulted me April 6th, 1906. Always good health till 12 months ago, *i.e.* (April, 1905), when she was laid up with a severe attack of pain, etc., which was diagnosed as appendicitis. Operation was advised, but refused. She was in bed four weeks; and during the ensuing six months, though doing no work, had several slight attacks of pain. The second severe attack occurred in March of present year. She was confined to her bed for 14 days, under medical supervision.

I carefully examined the abdomen, but could not detect any evidence of appendicular mischief. No swelling nor painful area nor rigidity of muscles. If there was any tender area at all it was at the level of and to the right of umbilicus. However, in spite of indefinite physical signs, I determined to explore.

Operation April 26th, 1906. I fortunately made the incision somewhat higher than usual, and on exposing appendix found it perfectly normal. The congested state of intestines and adherent omentum proved that I had to deal with something of an inflammatory nature, and further exploration detected a hard mass apparently in ascending colon. I enlarged the wound in an upward direction, fully expecting to expose a malignant stricture at the hepatic flexure of the colon. But, instead, I found the gall-bladder firmly adherent to the meso-colon; and when, with much difficulty, this was separated, I opened a loculus of bile-stained pus (about 1 oz.), and found a perforation of gall-bladder, due to the presence of three very large spiculated stones.

For the rest, I anchored the gall-bladder to the abdominal incision, scraped out the abscess cavity, sutured a small rent in colon, finally closing the abdomen after providing for efficient gauze drainage.

She made an excellent recovery, without a rise of temperature or pulse rate, and is now actively at work again.

The most interesting feature of this case was the almost entire absence of local physical signs in a condition of such gravity. It is also worthy of note that to two medical men the symptoms of her acute illness were apparently indistinguishable from those of acute appendicitis.

CASE 5.—R. H. E., æt. 49. Towards the end of 1905 commenced to have attacks of severe epigastric pains, accompanied by vomiting. In a short time he became quite jaundiced, and this persisted in spite of all remedies. A diagnosis was made of impacted stone in the common bile duct.

He placed himself under the care of Mr. Paul, who made an exhaustive examination, on more than one occasion, of the bile ducts, but no stone could be detected. A hard mass was felt in the head of the pancreas, and this organ seemed generally infiltrated. Diagnosis of chronic pancreatitis was made, and the gall-bladder drained for many months.

He left the Liverpool Infirmary about the middle of June, 1906.

When I first saw him he was free from jaundice, with a persistent biliary sinus discharging daily large quantities of bile. The abdomen was somewhat distended, with a painful tender area in epigastrium. The bowels were confined, but the motions showed evidence of some bile passing. The urine contained bile pigments. However, he was able to get about, seemed in fair health, except for the discomfort of the biliary fistula. His condition remained the same till Friday, June 29th.

Early in the morning of the 30th he had a most severe attack of abdominal pain and a rigor.

Unfortunately I did not see him till July 4th. I then found a very altered state of affairs. The fistula had suddenly healed up. He was incessantly sick, with persistent hiccough, a rapid pulse and high fever. I saw that any attempt to reopen the sinus without an anæsthetic would be futile, and at this point patient refused operation. The hiccough continued, only slightly relieved by injections of morphia. The motions were copious and full of bile, so that suddenly the long-obstructed common duct was free. Within three days a new symptom developed, which was very puzzling—viz., solid œdema from the left arm-pit to the middle of the left thigh, and in the left loin there was a very tender spot.

By July 12th, on deep palpation, a boggy mass could be felt in the left renal region, and œdema of both upper arms from arm-pits to elbows. I felt sure I had to deal with a big abscess in the loin, and admitted him to the infirmary.

Operation July 14th. I made a long oblique incision in the left loin, as if for exploring the kidney; and after opening the transversalis fascia I entered a large abscess cavity containing a quantity of foul-smelling pus and lumps of cheesy material. I explored with my finger as far as possible. The cavity seemed to extend in towards the middle line, and was evidently retro-peritoneal. The cheesy material proved to be cellular tissue, with areas of fat necrosis and much young inflammatory formation breaking down in the centre. It was clearly a sub-acute pancreatic abscess The subsequent progress was a gradual one, but eventually he made a good recovery.

Cases of subacute pancreatitis going on to suppuration are not common.

Mr. Mayo Robson, in his Hunterian Lectures (1904), mentions seven operations with two deaths in his own practice, and records seven others with three deaths, giving a mortality of 35.6 per cent.

When an abscess forms it may reach the surface above or below the stomach, in either loin—in the left iliac region under the diaphragm, or even in the pelvis.

It may also burst into the stomach or bowel. Mr. Mayo Robson, in one of his recorded cases, removed a stone from the common duct and so drained a pancreatic abscess.

The interesting points about the case recorded above are:—

(1) Such a long period of chronic pancreatitis producing complete obstruction of the common duct.

(2) The somewhat sudden formation of pus, which rapidly tended to point in the left loin. There is no evidence to prove that my patient had any symptoms of subacute pancreatitis till the end of June.

(3) The occurrence of such a widespread œdema, affecting both upper arms, pointing, I take it, to mediastinal pressure, probably glandular.

(4) Ultimate complete recovery.

My patient is at the present time, November, 1907, in perfect health.

PAINLESS HÆMATURIA. (a)

By ANDREW FULLERTON, M.D., F.R.C.S.I.,

Hon. Assistant Surgeon to the Royal Victoria Hospital and the Belfast Hospital for Sick Children.

THE patient whom we have just examined is a good example of a type of hæmaturia, which has, for a long time, been the subject of considerable discussion and difference of opinion amongst urologists. I have chosen him out of a number coming under our notice, as he has been examined and operated on by a distinguished exponent of this branch of surgery, Professor Rovsing, of Copenhagen, who has been good enough to inform me of the details of the case, down to the time of the patient's discharge from the Fredericks Hospital, at Copenhagen. The history is briefly as follows:—The patient, a sailor, æt. 30, enjoyed good health up to the commencement of the present illness. In the month of June, 1907, he fell from the poop of his vessel to the deck, a distance of about six feet, and bruised his right side. Two months later he noticed that his urine was "smoky," sometimes dark in colour, and sometimes of a lighter shade, but never entirely free from blood. Happening to be in Copenhagen, he took the opportunity of consulting Professor Rovsing, who examined him with the catheterising cystoscope, and obtained urine mixed with much blood from his right ureter, and perfectly normal urine from his left. He was, at this time, also examined with the X-rays, with a negative result. Professor Rovsing says that before the operation which he subsequently performed, the patient had a "steady and very abundant hæmaturia." The diagnosis then "vacillated between a double nephritis, and a traumatic bleeding," due either to a rupture of the kidney going into the pelvis, or an aneurysm of one of the branches of the renal artery. The operation took place on the 18th October, 1907, and it was found that the kidney was "adherent to the surroundings by a fibrous adhesive tissue," which was thought might have resulted from the injury. The bleeding stopped after the operation for some days, but began again and lasted for three weeks, diminishing gradually until, for the last few weeks of his stay in hospital, he was quite free of it. He now left Copenhagen, and set out on his return journey to this country. The hæmaturia reappeared during the homeward passage, and continued in varying amount until he was seen by one of my colleagues on the medical side, who referred him to me. This was early in February of this year. He was then passing dark, porter-coloured urine. On examination, the patient was seen to be fairly healthy-looking, but not robust. He was slightly anæmic. There were no cardio-vascular or other signs of kidney trouble. In fact, he stated that he was quite well, except for the anxiety occasioned by the loss of blood. He was also positive that exercise increased the quantity, the amount diminishing when he kept quiet. In the right lumbar region there was a scar, indicating the site of the operation, and the wound had evidently healed by first intention. I fully expected on cystoscoping him to find that the right kidney was again bleeding, but was surprised to see that the jets from the *left* ureter were tinged with blood. Catheters were introduced into both orifices, and the samples thus obtained carefully examined. The quantity of urine coming from the left side as obtained by catheter was rather more than that from the right, but I do not lay much stress upon this, as the calibre of ureteral catheters is not always the same, and, moreover, a few drops occasionally leak at each jet by the side of one which does not accurately fit the ureter. The specimen obtained from the left side was muddy and dark in colour, acid, sp. gr. 1020, and deposited urates when cold. After standing for some hours numerous blood corpuscles were found, as well as urates, a few oxalate crystals, and the usual clumps of ureteral epithelium rubbed off by the catheter. The specimen obtained from the right side (the side operated upon was clear, amber, acid, sp. gr. 1020, free from albumin and blood (an odd red cell was seen, due, probably, to slight trauma inflicted by the catheter). Epithelium from the ureter was present, but no deposit of urates took place on cooling. I did not discover casts in either specimen. As I have said, I was not prepared for this finding, and I therefore wrote to Professor Rovsing, who gave me the details I have mentioned, and now expressed the opinion that the patient was suffering from nephritis, and recommended an operation on the left side, similar to that performed on the right (nephrolysis). I was not certain, however, that when now examined, the patient might not be bleeding from the other side just as readily as from the left, and for this reason I brought him to-day in order to ascertain the present condition. As you have seen, the blood still comes from the left ureter, though, I believe, in less amount than when I examined him about a fortnight ago. The centrifugalised urine still shows no casts.

(a) Clinical Lecture delivered at the Royal Victoria Hospital, Belfast, Session 1907-8.

I confess that I am loth to operate on this patient again; first, because the quantity of blood lost is not great, and is apparently diminishing; and secondly, because in operating on these cases one is, as it were, groping in the dark, with no recognisable lesion presenting itself for rectification. How often in operating on kidneys do we find adhesions when there has been no hæmaturia? I cannot say that the evidence in favour of adhesions producing hæmorrhage is sufficiently conclusive, although, I understand, some such view is held by no less an authority than Professor Rovsing, who operated on this case. In discussing painless or symptomless hæmaturia, Mr. Hurry Fenwick(*a*) refuses to accept the terms "local hæmophilia" or "angioneurosis" as applicable or warrantable, and quotes Rovsing as pointing out that a distinct pathological change is present in most of the cases. He divides his own cases into five groups, as follows:—(1) Chronic granular kidney; (2) angioma, or capillary nævus of a renal papilla; (3) benign or malignant growths of kidney or ureter; (4) rare cases of embedded aseptic calculus; (5) submucous deposit of crude tubercle. It appears likely, therefore, that according to this classification the case before us would be considered as one of chronic nephritis in an early stage. Casper(*b*) says, "It has not been determined whether there is a local renal hæmophilia or bleeding from healthy kidneys." He also mentions that it is well known "that severe hæmorrhage may occur in chronic nephritis." He does not consider the existence of angioneurotic bleeding as proved. My own experience would lead me to the conclusion that not only is hæmaturia a fairly common occurrence in chronic nephritis, but that it may occur simultaneously on both sides. I have recently examined three such cases, and seen blood-stained urine issue from *both* ureters. I will reserve the further discussion of these cases for a future occasion.

The case I have just shown you is a good illustration of the difficulties attending a diagnosis, even when such accurate aids as cystoscopy and ureteral catheterisation are available.

With regard to treatment, I propose, in the first place, to try the effect of drugs such as ergot for some time. If the bleeding still continues, the question of operation will then arise. I have seen hæmaturia, presumably of this type, entirely cease after the kidney has been explored by palpation and incision, but the exact way in which this desirable result has come about is not very clear. Mr. Fenwick believes that the hæmorrhage issues from the lower calyces, and invariably cuts through the calyces of the lower half of the kidney. He also thinks fixation of the kidney is an important element in preventing a return of the hæmorrhage.

BACTERIOLOGY AS IT AFFECTS GENERAL PRACTICE.

By S. J. ROSS, M.D., Ch.B.,

Assistant Surgeon to the Bedford County Hospital.

A knowledge of bacteriology is essential for correct diagnosis, and also for successful treatment. I wish to illustrate these points by notes of some cases which have come under my notice.

Firstly, let me take examples of streptococcic poisoning.

I saw a patient who had been recently confined, who, on the fourth day after her confinement, had a rigor, and the uterine discharge lessened, and became offensive. Temperature 140°, pulse 130. I took away some of the discharge, and discovered that the offending organism was a streptococcus. I injected 30 cc. of antistreptococcic serum, in 3 doses of 10 cc. each. After the first injection the temperature fell to 101°. After the second injection the temperature fell to 99°; and after the third injection the temperature became normal, and the patient made an uninterrupted recovery. Locally, intra-uterine antiseptic douches were given; but these had been given three days before I saw her, and yet the patient was going steadily downhill; and, therefore, we can conclude that the serum saved the patient's life, as she began to improve after the first injection, and improvement followed each injection.

A female patient, æt. 45, had an attack of follicular tonsillitis. A throat sweep proved the presence of streptococci in large numbers, and staphylococci and microccoci. Now this patient was the subject of endocarditis of the mitral valve of 20 years' standing. Four days after the throat trouble was better she had a rigor, and her temperature rose to 104°. She subsequently developed septic thrombosis of her left femoral vein, and abscesses in both sterno-clavicular joints, and abscesses in both forearms, and finally, gangrene of the left leg. Doubtless she had an infective endocarditis. Her blood yielded streptococci, and also pus from one of the forearm abscesses. The origin, doubtless, was from the septic throat. My only regret in this case was that she refused serum treatment.

I saw a boy, æt. 12, with a discharging left ear, originating from an attack of scarlet fever. Examination of the pus proved the presence of streptococci. He complained of severe pain, and had some redness and œdema over his left mastoid. His mastoid was trephined, and a mastoid abscess evacuated. I mention this case to draw attention to the fact that a streptococci ear infection is the most virulent and dangerous infection with which we can meet.

Staphylococcic Infection.

I saw a youth, æt. 24, whose arms and forearms were covered with pustules. Examination of the pus proved the infection to be staphylococcic. I mention this case merely because it was at once suggested to me, Why not inject antistreptococcic serum? My answer was—It is useless to inject this serum unless we are sure that the offending

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(*a*) "A Hand-Book of Clinical Cystoscopy." P. 380.
(*b*) "Genito-Urinary Diseases." Edited by Bonney. P. 530.

organism is the streptococcus, or that streptococci are the predominating organism in the discharge.

Diphtheria Bacillus.

A boy, æt. 12, was brought to me on account of weakness in his legs, and an external strabismus. I inquired if he had had a sore throat recently, and his mother said, "Yes." Five weeks previously he had had a bad throat, but it was well in three days. I took a throat sweep, which yielded a positive result. Streptococci, staphyloccoci, and Klebs-Loeffler bacilli were present. He was isolated, and kept in bed for three weeks. Iron and strychnine were administered internally, and his recovery, as is usual in such cases, was complete.

Pneumonia.

A youth, æt. 20, and with a marked tubercular history, after a long cycle ride in a drenching rain, developed a left pneumonia, the whole of the left lung being solid. I examined his sputum, and readily demonstrated the presence of the pneumococcus. Crisis, however, never occurred, his temperature became very irregular, and I carefully overhauled him for empyema. There were, however, no signs of fluid in the chest. The character of his sputum changed, and became typically nummular. I again examined his sputum, and discovered tubercle bacilli. He developed acute tuberculosis, and died.

Mixed Infections.

I attended a youth, æt. 24, for pulmonary tuberculosis. When I first saw him, the disease was very advanced. His chief complaint, however, was not of cough, as so frequently happens, but of intense thirst and intolerable heat. His temperature was 104.6°. I examined his sputum and found tubercle bacilli and streptococci. I injected 10 cc. of antistreptococcic serum. The temperature fell to 101°, and the patient fell into a sound sleep, from which he awakened greatly refreshed. I repeated the injection with most gratifying results; and the patient, in the last stages of this most distressing disease, at least was rendered comfortable. I think many cases of phthisis might be benefited by the use of serum, when evidently we have asssociated with the tubercle bacillus septic organisms, and such organisms are proved to be streptococci, or streptococci predominate.

I was called to see a young man, æt. 24, who came from a very tubercular stock, on account of rapid emaciation and dysuria, and frequent micturition. He was evidently in the last stages of pulmonary pthisis. He had a large cavity at the apex of his left lung, and crepitations over the whole surface of both lungs. I examined the urinary deposit, and discovered tubercle bacilli. This proved to my mind two facts: (1) that he had tubercle of the bladder; (2) that the tubercular deposit was extensive, and breaking down. I say extensive, because repeatedly I have examined urinary deposits in cases of undoubted vesical tubercle, and have failed to isolate the organism. I think this difficulty arises chiefly from the fact that very clear symptoms of vesical tuberculosis are often present, before the tubercles have broken down, and until they have broken down we cannot expect to discover the organism. To return to our case. Operative interference was out of the question. Urotropine rendered the local condition tolerable for the three weeks which he survived after I first saw him.

A young man, æt. 19, sought my advice, on account of swelling of both knee-joints. The joints were distended with fluid, and I naturally suspected a blood infection. I asked him whether he had any urethral discharge, and he replied "No"; but as I have learned that my patients' words are not always reliable, especially upon questions of morality, I examined which I suspected was the offending organ, and found a tell-tale drop, which, received upon a cover slip, duly stained, revealed the presence of the gonococcus. I reminded my patient that we were more scientific now than we were 20 years ago, and could say with certainty, with the aid of the microscope intelligently employed, "You have sinned!" So he acknowledged the power of accurate scientific knowledge, and fully confessed his shortcomings.

These few cases out of many I could cite will prove the value of an ordinary knowledge of bacteriology—a knowledge which any general practitioner, really interested in his profession, may readily acquire.

I may add that, for staining ordinary organisms, methylene blue is generally most suitable. For staining tubercle bacilli, I always adopt the method taught to me by Kanthack. I stain the specimen in carbol fuchsin for five minutes, and then wash it and dry it with blotting paper; decolorise it with 1 in 4 nitric acid, wash and dry, then stain with methylene blue, wash and dry. The tubercle bacilli are stained red.

It appears to me to be the height of folly to grope in the dark, when light is so easily obtained. It is most unscientific to diagnose a diphtheritic throat. A patient has either diphtheria, or not. There is no intermediate state; and it is unwise to wait until soft palate paralysis and weakness of the legs, or other paralytic symptoms become manifest, before we make a definite diagnosis, or until that most tragic event happens, a sudden heart collapse ending fatally.

Great doubts have been repeatedly expressed as to the value of antistreptococcic serum. I think these doubts arise from an injudicious use of the serum. A high temperature, and other evidences of sepsis, lead the unwary to employ this serum in the hope of ameliorating the patient's condition, but antistreptococcic serum will not benefit the patient if he is suffering from staphylococcic poisoning. We must examine the discharge to discover the offending organism. If it be a streptococcus, then we can employ the streptococcic serum, and feel confident that benefit will arise from its employment. My experiences are not in any way unique, but I hope these notes may prove to any general practitioner who has not interested himself in bacteriology, that great help results from its employment in every-day work, and that the process of staining specimens is easy, and the recognition of organisms is a gift easily acquired. I may add that the growth of organisms upon media, and the recognition of their characteristic appearances are also easily learned.

OUT-PATIENT'S ROOM.

ROYAL FREE HOSPITAL.

Carcinoma of the Breast.

By Mr. JOSEPH CUNNING, B.S., F.R.C.S.

Amongst Mr. Cunning's out-patients was a woman, æt. 69, rather stout, but otherwise healthy-looking, who complained that she had noticed a lump in her breast for twelve months, but as it had given her no pain till recently she had not sought advice about it. The routine method of examination in all cases of breast tumour was then demonstrated: first, inspection—attention was called to the difference in the level of the two breasts, the affected breast was shown to be on a distinctly higher plane than the other. This at once gave some indication that the disease of the breast was of a constricting nature, and the common disease of the breast which caused shrinking was, of course, scirrhus; so that, quite early in the examination, without touching the patient, the surgeon has some very important diagnostic information. On further inspection it could be seen that the skin was dimpled out over an area the size of a florin in the lower and outer quadrant of the breast. On palpation a lump the size of a tangerine orange could be felt below the dimpled area, which was attached to the skin and could not be separated from the breast substance. The lump was solid and fairly well defined. To find out whether it was attached to the pectoralis major, the arm on that side was raised above the head so as to put the fibres of the muscle on the stretch; it was then seen that the lump in the breast could not be moved along the course of the fibres. Mr. Cunning pointed out the fallacy of trying to establish this point by moving the breast tumours at right angles to the direction of the fibres, as this only demonstrated that the tumour was not attached to the thoracic wall. The axilla was then examined and one large hard gland felt below the border of the pectoralis major. The supra-clavicular region was free from enlarged glands. Nothing abnormal was found in the opposite breast or axilla, and finally the liver was examined, but no secondary growths were perceptible. With regard to the diagnosis, Mr. Cunning said that an inflammatory origin to this tumour could be left out of account owing to the length of time it had existed, and the fact of the growth being solid excluded any form of cyst; therefore, the diagnosis lay between simple solid growth and malignant growth. There were many reasons for putting out of account that the growth was simple: first, its infiltrating character, for, as had been pointed out at the examination, the tumour involved not only the breast, but also the skin and the pectoralis major. The gland in the axilla was of a densely hard nature, whereas, even if enlarged glands were present in connection with a simple growth, they would be of a softer nature. There was, therefore, no reason for doubting that the case was one of scirrhous carcinoma of the breast. The treatment Mr. Cunning would advise was an operation the principles of which were based on a knowledge of the anatomy of the breast and the direction in which its lymphatic vessels ran. As regards the breast itself, an important fact to remember was that the prominence of the breast gave no real indications as to the extent of the organ, for there were outlying lobules extending upwards nearly to the clavicle inwards to the margin of the sternum, downwards to the seventh rib and outwards to the middle of the axilla. A carcinoma, no matter in what portion of the breast, was in lymphatic communication with every part of the organ, and as the growth extended by permeation of these lymphatics, which extension could only be demonstrated microscopically, it was of the utmost importance that the whole breast, including the outlying lobules, before mentioned, should be removed. The second consideration was the arrangement of the lymphatics, the three important sets to remember being: first, the set running from the breast to the skin in the suspensory ligaments; these were present over the whole of the prominence of the breast, and for this reason all the skin in this situation should be removed; second, the lymphatics from the deep portions of the breast run to the axilla in the substance of the pectoralis major fascia, and for this reason the pectoralis major muscle should be removed; the third set of lymphatics comprised those running from the lower border of the breast to the peritoneum, and for this reason the incision should be carried down to the upper attachment of the rectus. The operation, therefore, should consist of an incision which surrounds the whole of the prominence of the breast; the skin should then be reflected over the whole of the limits of the outlying lobules, as described, then the fat, the breast, the pectoralis major muscle, the pectoralis minor, and the fascia lying underneath should be reflected outwards in one mass, with the exception of the clavicular portion of the pectoralis major. The apex of the axilla is thereby exposed and all its fat, lymphatic vessels and glands are detached in one mass from above downwards; it only remains then to sever the insertions of the pectoralis major and minor and the mass is free. In this way there has been no cutting across of lymphatic vessels in which there may be carcinomatous growth, so infection of the wound by malignant cells is avoided.

OPERATING THEATRES.

FRENCH HOSPITAL.

Kronlein's Operation for Orbital Tumour.—Mr. G. W. Thompson operated on a man, æt. 30, who had been admitted with a history of having been struck three years ago with a swagger cane in the neighbourhood of the inner canthus of the left eye. Gradual failure of vision had dated from two or three months after this period, and at the same time the eye became gradually proptosed. On admission the left eye was enormously proptosed forwards and slightly upwards and outwards. Movements of the eyeball were somewhat diminished in all directions. There was some œdema of the lower bulbar conjunctiva, and the patient was only able to close the eye with some difficulty. The eye itself was perfectly blind, due to advanced optic atrophy. No swelling could be felt in or round the orbit. No pulsation or bruits could be detected over the eye. The neighbouring sinuses and cavities appeared to be normal. The patient had already taken anti-syphilitics elsewhere. It was proposed to enter the orbit by Kronlein's operation. The man having been anæsthetised a curved incision was made along the outer orbit, starting just above the external angular process of the frontal and terminating just above the middle of the zygoma; the frontal portion of the malar bone was exposed, and a large portion of the outer bone wall of the orbit was chiselled through and wedged out, the orbital periosteum having been previously lifted up from the bone. After slitting the latter membrane, the orbital contents behind the eyeball were exposed, the finger inserted, and a very large mass, rounded, well-defined and somewhat firm, although elastic, was found to occupy the whole of the retro-bulbar region. This was, as far as possible, separated from the orbital bone wall, but it was found impossible to deliver such a large mass through the somewhat limited opening, and besides Mr. Thompson could not free it from its deeper and further attachments to the apex of the orbit and its immediate neighbourhood. Under the circumstances, as the eye was already useless, an excentration of the whole of the contents of the orbit was carried out by the usual method. There was profuse bleeding, but this was readily controlled by firm plugging. The wedge of bone taken from the outer wall, which had been wedged out of the orbit at the early part of the operation, was replaced *in situ*. The skin wound was sewn up. The plugs, of stoutest gauze, used to arrest the hæmorrhage were left, and firm bandaging was applied. Mr. Thompson said that he thought Kronlein's operation was quite justifiable in such a case, as it gave him a chance of enucleating the tumour and retaining the eye; this, although the eye was blind, would have been a great advantage to the patient. Unfortunately, the tumour proved to be too large for enucleation. In his opinion, Kronlein's operation was an admirable one for the removal from the orbit of all non-malignant growths and cysts, excluding, of course, vascular tumours and meningoceles extending into the orbit; but he did not consider it of any avail in cases of malignant growths when these could be diagnosed beforehand. He pointed out that malignant growth might be suspected when the mobility of the eye was early affected, and, of course, when the tumour was of rapid growth. In chiselling through the bone wall of the orbit, he said that the surgeon should use a narrow thin chisel, one edge being angled off and blunted so as to prevent injury to the soft tissues in the zygomatic fossa; the chiselling, too, should be done very slowly and gently so as to avoid splintering the orbital wall. The tumour should be separated as far as possible with the finger, and where the tumour grows around the optic nerve, the nerve must be divided with curved scissors first between the eyeball and the tumour, and finally between the tumour and the apex of the orbit. The best plan is to divide the external rectus between two sutures at the beginning of the operation so that the two portions of the muscle may be picked up and brought together by stitches at the end of the operation.

Six days after the operation the patient was doing well. The orbit is being washed out daily with peroxide of hydrogen.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Obstetrics.

The President, Dr. E. H. Tweedy, F.R.C.P.I., in the Chair.

Meeting held Friday, April 10th, 1908.

A UTERINE TRACTOR.

Dr. Ashe exhibited a working model of an instrument which was, he said, intended to combine a sound with a tractor when necessary.

Dr. Neil spoke in commendation of the tractor.

PATHOLOGICAL REPORT ON ABNORMAL PLACENTA.

Dr. Spencer Sheill read the following pathological report by Dr. Rowlette on the abnormal placenta exhibited at the previous meeting of the Section, as some of the Fellows then present had stated that they had never seen a specimen similar to that exhibited by Dr. Sheill:—

"The placenta is slightly larger than normal, and quite firm. The umbilical vessels are very congested, and stand out prominently on the surface of the placenta. Completely surrounding the attachment of the cord, and at a distance of about two inches, is a raised ridge, varying from 1½ to 2½ ins. high; it bends towards the cord so as to form a deep fossa, the inner surface of the ridge being in apposition with the surface of the placenta. The membranes are closely adherent to the surface of the placenta, passing into the depth of the fossa and then over the ridge.

"Microscopically, the placental tissue is normal. At the ridge, however, the membrane is lifted from the tissue by a great mass of fibrinous coagulum, which is quite firm. The greater part of the ridge seems to be composed of fibrin. The condition must, therefore, be due to a sub-membranous hæmorrhage, for which I am unable to suggest any cause."

Sir A. V. Macan expressed the opinion that it was simply an exaggerated placenta circumvallata.

Dr. Sheill, in reply, said that although he was unable to suggest a probable cause for this placental abnormality, yet he could not agree with Sir Arthur Macan's opinion, inasmuch as he understood that the so-called placenta circumvallata invariably showed the chorion forming a rigid annular fold at the inner limit of the margin. Neither did he think it was a case of placenta marginata, for in these the chorion usually leaves the placenta before reaching its margin, thereby leaving a border free of membrane. In reply to a question of Sir Arthur's, Dr. Sheill said that in his specimen the chorion was attached all round to the placental margin in the usual way.

SMALL OVARIAN CYST, WITH COMPLETE DISAPPEARANCE OF OVARY.

Dr. R. D. Purefoy exhibited two pieces of the remains of a small cyst removed from a young unmarried patient. The particular point of interest in the specimen was that, notwithstanding the small size of the cyst, the ovary had disappeared, leaving nothing except a slight patch of thickening in one part.

A MYOMATOUS UTERUS.

Sir W. Smyly said his interest in the myomatous uterus—which he exhibited—was altogether technical. When he examined the patient he was unable to reach the cervix, owing to the extra-peritoneal development of the tumour on the right side of the uterus. When he operated he took the end of the tumour to be the cervix, and there was a depression in it which he took to be the os uteri. When he cut into the capsule there came a good deal of hæmorrhage, which astonished him. When he got it open enough to see where he was, he found he was in the capsule of the tumour, and had not opened the vagina at all. He then completed the operation—Doyen's method—in the usual way. The form of the tumour was exactly in the long axis of the uterus, and there was little wonder that he mistook it for the cervix.

Sir A. V. Macan said he was present at the operation, and could corroborate the difficulty of locating the cervix.

Professor Alfred Smith entirely approved of Sir W. Smyly's procedure.

Sir W. Smyly, in reply to a question by Dr. Jellett, said it was constantly stated that Doyen's operation shortened the vagina, but he himself had never seen any change in the vagina after the operation.

ADJOURNED DISCUSSION ON SIR A. MACAN'S PAPER ON THE OPERATIVE TREATMENT OF PUERPERAL INFECTION.

Dr. A. Holmes said it was very hard to make up one's mind, with a case not undoubtedly septic, as to whether an operation was justifiable or not. He had seen cases apparently at the point of death get perfectly well. Evacuation was of course, the best means of dealing with localised pus; and the opening through the posterior fornix—an easy operation which did not necessitate the removal of the patient from bed—had been followed by good results. When one considered the number of septic cases that existed, the mortality was really very small, and the number of cases of sepsis that recovered was very large, and he considered that it would be unwise to operate in all cases until differential diagnosis was more perfect.

Professor Alfred Smith said he knew of no uterine affection in which they seemed to be more at sea than in the treatment of puerperal fever; and while the Section was deeply indebted to Sir A. Macan for his thought-stimulating paper, he did not think that it showed any particular advance on the part of surgery in that line. They accepted generally the two great classes of infection—pyogenic and saprophytic; and they divided the former into the forms in which the infection was carried—(*a*) by the lymph ducts, and (*b*) by the blood stream. Bumm had demonstrated the fact that if a patient was infected by streptococcus, it developed and spread with such rapidity that there was no time for the surgeon to intervene. They were all in agreement as to the necessity of draining in cases of pus formation, though there was a difference of opinion as to the way in which they should reach the abscess. Sir A. Macan had proposed a special operation with a view to preventing the occurrence of general peritonitis; but he could not see the advantage of packing the entire pelvic cavity, seeing that the uterus, in a septic woman, after confinement, was almost up to the umbilicus, and that on the posterior wall of the uterus there was the great lymphatic plexus carrying large numbers of streptococci. On the Continent and in America cases had been successfully treated by ligation of the inflamed veins, but the whole difficulty one had to contend with was seeing when one should interfere at all by operation. He believed that the success of surgical procedures would be found in an early recognition of grave cases, and early operation. When they had more knowledge as to the type of bacillus that was causing the trouble, they might be able to do something to stem the fatal cases, and they might be able to devise methods to get a backward flow in the lymph-ducts, so as to prevent the invasion of the system.

Dr. Purefoy said he refused to believe that any examination of the contents of the uterus would enable them to make up their minds in every case, or even in any considerable number of cases, on the point of operative interference. In the cases of streptococcus infection, the spread of the disease was so rapid, and its diffusion through the system so general, that surgical measures did not hold out hope of saving life. They were unwilling to resort to early operation in these cases, because they were aware that apparently hopeless cases had recovered, and they were unable to determine the power of resistance in the patient.

Dr. Ashe spoke.

Dr. FitzGibbon said the great difficulty in treating by non-operative methods depended on diagnosing whether the condition was still localised or general, and anticipating general infection. If the infection had become general, it then became a question of whether the patient could fight the infection by natural resistance, and the only possible treatment they could adopt was the introduction of anti-toxins or vaccines to assist the system.

Dr. JELLETT said the more he thought about the subject the more hopelessly he seemed to be at sea. He could not understand where the operative treatment of acute puerperal fever came in. The operative treatment of local infections had been recognised for some time, but this was not what they were concerned with. Even if the presence of streptococci in the uterus was shown, the bacteriologist could give them no help as to the virulence of the organism until after injection into animals, and by that time either the patient was better or it was too late for operation. If the infection had not extended into the peritoneal cavity, it was contrary to all our present ideas to open up the cavity. If the infection had gone beyond the uterus, the analogy of limb-infection was fallacious, because the uterus was so intimately bound up with its connective tissue and lymphatics that the removal of the infection by removing the uterus seemed hopeless. If a patient got into a chronic condition of pyæmia, he could imagine that by removing the source of the infection in the uterus they might do a certain amount of good, as the extension of infection during the operation might be successfully overcome by the resistance set up by a long period of vaccination, so to speak. But in the early stage it did not seem possible to remove the uterus, with its load of infection, and open up the peritoneal cavity, without giving the patient such a dose of the organism as would do away with any good got by removing the prime source of the infection. Pryor, in America, had said, nine or ten years ago, that when there was a case of infection of the uterus that did not respond immediately to douching, they should open up Douglas' pouch straight away, and break down any adhesions and plug the pouch. His results were very good; but he (Dr. Jellett) could not help thinking that Dr. Pryor operated on many cases that would have got well without operation.

Dr. HORNE said it was comparatively seldom that one now saw a case of acute septic infection. The paper stated that the fifth rigor was an indication for operation, but in some of the very worst cases there was possibly only one rigor at the beginning, and to wait for the fifth would be to wait until too late. The plugging of the uterus and the opening of the posterior cul-de-sac was an admirable treatment, which he had adopted with very good results.

Dr. O'FARRELL said that Professor Sondern, (*a*) a New York pathologist, claimed that by means of a general and differential leucocyte count he was able not alone to ascertain the presence of a septic infection, but also to estimate the body resistance. Relative increase in polymorphonuclears indicates the presence of sepsis and the degree of leucocytosis the condition of the body resistance. It is not claimed that this is universally accurate, but Dr. Sondern considers it so important that he has an assistant on duty in his laboratory day and night, so as to be able to examine any patient's blood, and let the surgeon know without delay whether the blood conditions are such as to make operation desirable.

Sir W. SMYLY said it was very unlikely that any one of them would meet with more than a very few cases in which operative interference was required, and as it had been laid down that they could not judge the value of any particular line of treatment upon less than a hundred cases, it would probably take some centuries before any one institution would yield a sufficient number of cases. They had, therefore, to collect results from a great number of hospitals, and Sir A. Macan's paper was a valuable epitome of such results. He (Sir W. Smyly) objected to the title puerperal fever. In the old days it was restricted to acute lymphatic sepsis. Dr. Churchill had stated long ago that he had only seen seven cases of puerperal fever, and it was evident that the great majority of cases spoken of by Sir A. Macan were localised, not general, sepsis. In douching the uterus they were liable to do harm by opening up channels for the absorption of septic materials. One of the first things they had to do in a case of acute fever following child-birth was to try and clear the uterus with the finger, and he did not think there was any difficulty in doing so if they gave the patient an anæsthetic. He was not inclined to give up the flushing spoon-curette, and he thought the introduction of the brush would be more dangerous than the spoon. In treating puerperal fever, they should be careful not to take the part of the micro-organisms against the organism of the woman. The contest going on in her system was one of such great complexity that one felt very diffident to interfere; and it was very doubtful that a serum would not take the part of the bacteria against the tissues.

The PRESIDENT said his experience was that puerperal infection was common. Fortunately, in the majority of cases, it was of a mild type, and there was, in his experience, no complaint so amenable to surgical treatment. He divided it into the mild, acute and chronic types. The mild type was eminently suited for surgical interference. The chronic type was that dealt with for the most part by Sir A. Macan, and the acute type was outside the pale of all treatment. He divided operative treatment into the mild, the intermediate, and the drastic. Under the mild he put raising the bed, douches, exploration of the uterus, draining pus pools in the uterus, replacing a retroflexed uterus, the removal of pieces of placenta and membrane by the fingers. These could be undertaken without chloroform in the patient's own bed, and were highly successful. The intermediate (Pryor's) operation could be done in the patient's own bed, but required an anæsthetic; it could be conducted without fear of injuring the patient, and it was largely diagnostic as well as curative. The evacuation of pelvic pus through the vagina did not seem to give rise to septic infection. The more septic matter they got out of the system the better chance the leucocytes had to fight the remaining infection, and the opening through the posterior fornix nearly always let free a pool of turbulent peritonitic fluid in Douglas' cul-de-sac. If they could get a pelvic peritonitis well established the patient would probably worry through, and no procedure was more adapted to that purpose than plugging the whole pelvic cavity with iodoform gauze. He believed it impeded the circulation in the lymphatics. The anæsthetic was unfortunately very harmful when given to a septic patient. Until their knowledge was more precise, and their method of operation less calculated to bring about the dreaded shock, he did not think he would ever again open the abdomen above the pubes with the idea of tying off veins or removing a septic uterus. Anti-streptococcus serum was worthless when the disease had developed, though valuable as a prophylactic remedy. Where pus had burst into the abdomen, he gave the serum straight off. Vaccines were not applicable for such cases. Lactate of calcium would probably lock up the blood in the veins almost as well as by ligature.

Sir A. V. MACAN, in reply, said it might require a hundred cases to make statistics, but it did not require that number to enable them to have ideas on the subject. He had himself expressed his objection to the term puerperal fever, but there was no other term that embraced all the states including sepsis. The uterus had been recognised for a long time as the source of infection, and theoretically they must recognise a point at which—if they could settle it—the removal of the septic centre would be sufficient to stop the spread of the disease. The earlier they operated, the more successful they would be, but the more doubtful it would be as to the success of the operation. There was no finality in the operation; they were only at the beginning of it, and he believed there was a great future before it.

(*a*) Value of the Blood Counts in Sepsis." By Frederic E. Sondern, M.D., *New York Medical Journal,* June 16th, 1906.

THE portrait of Dr. Clement Dukes is to be presented to the Rugby Hospital, the President of the hospital having commissioned Mr. Harrison Dutton to paint it.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD

FRANCE.

Paris, May 3rd, 1908.

DRINK DIET IN CARDIO-RENAL AFFECTIONS.

DR. HUCHARD, in a recent communication before the meeting of the Académie de Médecine, recommended the cure of reduction of liquids in case of acute dilatation of the heart, accompanied with œdema. In such cases the usual cardiac and renal therapeutic agents fail miserably and place the life of the patient in jeopardy. The dilated heart has arrived at a period when resistance is no longer possible, while the congested kidneys invaded by interstitial œdema cannot support without danger the supplement of work imposed on them by diuretics. The rational therapeutic indication would be, on the contrary, to relieve these organs and thus facilitate their work.

For this reason Dr. Huchard allows only one pint of milk, and two pints of water, mineral or natural a day, and prescribes at the same time small doses of digitaline (1-10 milligs.).

Sol. of digitaline, 1-1000—50 drops.
Water, 5 ounces.

One tablespoonful a day, and theobromin (10 grs.) twice a day. After the third day of this treatment, abundant diuresis sets in, relieving the patient of the œdema.

Where the polyuria fails to be produced, the prognosis is fatal, as the dilatation of the heart is proved to be incurable.

Dr. Louis improves on this treatment by suppressing all liquid for a day or two, save a few tablespoonfuls of pure water to ease the thirst. By this simple means, the quantity of urine, which had not, perhaps, exceeded twenty ounces in the twenty-four hours, rapidly runs up to two and three quarts, secretion remaining abundant until all œdema has disappeared to the great astonishment of the patient, and those about him, who think the more a patient drinks the more he will urinate. When the œdema has disappeared, Dr. Louis administers digitaline, and theobromin in the doses recommended by Prof. Huchard, as excellent adjuvants in the subsequent treatment.

INTESTINAL ANTISEPSY IN CHILDREN.

Benzo-naphthol,
Lactose,
Salicylate of bismuth, } āā 10 grains.
Bicarbonate of soda,

Divide into five powders; one every two hours. (For child of six months.)

Benzonaphthol,
Salicylate of bismuth, } 2 grains.
Resorcine, 1 grain.

For one powder. No. 6. One every two hours. (1-2 years).

Salol, 2 grains.
Subnitrate of bismuth, 20 grains.
Bicarbonate of soda, 20 grains.
Syrup of gum, 4 drachms.
Water, 3 ounces.

A teaspoonful every two hours.

Lactic acid, ½ drachm.
Syrup of orange, 1 ounce.
Water, 3 ounces.

A teaspoonful every hour.

Oxygen water (12 vol.), 3 ounces.
Chloride of sodium, 1 drachm.
Phosphate of soda, ½ drachm.
Bicarbonate of soda, 10 grains.
Boiled water, 1 quart.

The whole to be given as an enema, and renewed twice a day in cases of enteritis of divers origin.

ORCHITIS.

Guaiacol, 4 drachms.
Lard, 2 ounces.

Rub gently over the inflamed organ. Apply cotton-wool, and a suspensory bandage. At the end of week of this treatment, prescribe:—

Mercurial ointment,
Belladonna ointment,
Ichthyol, } 1 drachm.
Lanoline,

MEDULLARY ANÆSTHESIA.

Regional anæsthesia by the introduction of a solution of stovaine or cocaine into the rachis in the lumbar region is no longer in favour on account of the divers accidents occasioned by this treatment. At the last meeting of the Surgical Society, M. Legueu related that he had hitherto been a great partisan of this kind of anæsthesia, having practised it over 300 times, but was now inclined to renounce it on account of the troublesome after effects he observed in many of the cases: malaise, feeling of anguish, fainting, cephalalgia, retention of urine, this latter lasting six months in one individual.

A patient operated on for hernia was seized with headache, vomiting, and paralysis; he died at the end of six weeks. Another presented the same symptoms, with retention of urine.

Several other members confirmed the danger of this method, which would only find its indication when chloroform could not be administered with safety.

M. Reclus said he never practised this method; he preferred employing local anæsthesia, with cocaine or associated with stovaine. He never had an accident, although the dose of cocaine injected attained sometimes six grains.

GERMANY.

Berlin, May 3rd, 1908.

THE *Deutsche Medizinal Zeitung*, No. 12, contains an interesting abstract of a paper by Dr. W. Siegel, of Bad Reichenhall, on "Chills as Causes of Disease." He first of all points to the general view that at present prevails—viz., that the simultaneous occurrence of a chill and the presence of bacteria are sufficient for the production of disease. The hyperæmia of the internal organs, proved to be a result of contraction of the cutaneous vessels caused by chilling, is supposed to excite the germs into action, to make them virulent (Hofbauer), and to favour their settlement (Lode). According to F. Müller, it was possible that the slowed circulation of the blood at the part cooled acted injuriously in some way, and that in this way poisonous material might be formed. Probably, however, the cooling only caused a diminished power of resistance to injury. Reduction of temperature could not favour the development of bacteria in any way, as the optimum of temperature of organisms injurious to the human subject was exactly that of the body.

Some authors considered an antecedent over-heating of the body to be unconditionally necessary to chilling. The statement in the general conception was not correct. Even if many colds arose in this way, we knew that in the spring time of the year, the time of melted snows, damp weather, warm, moist spring winds, numbers of people took cold without any previous over-heating. The moistness of the ground and of the air, with a low temperature, played an important part. Gentle and moderate breezes were of importance, whilst strong winds, with dry air and dry cold, were almost free from danger, and only led to colds—*i.e.*, of the nose, the ears, or chilblains. Wetting of the body, whether total or partial, was also of importance.

But, in spite of germs and the chance of taking cold, one was far from coming on in all cases. There must be another factor, therefore, and that lay in the individual himself. For the cold to come on there must be an individual disposition, and in some people this disposition was permanent, in others only transient and momentary, so that in the latter class of people the cold came on when the disposition at the moment favoured its onset; there was no such thing as absolute immunity.

The speaker then described his experiments on the cooling of dogs made in the Second Medical Klinik with a view of setting up acute nephritis. This disease had been thrust aside by the predominance of the views as to bacteria, and was not even looked at. The speaker had cooled dogs by applying ice to a surface of the back 4 to 5 cm. in diameter; other dogs he had made to stand with their hind-quarters in water of a temperature of 40° C. In all cases the clinical symptoms of acute parenchymatous nephritis came on, the diagnosis being confirmed by post-mortem examination. This proved experimentally the possibility of acute nephritis being set up by cooling and wetting. He had also observed that in time of snowfall and damp weather, nearly all the dogs brought to the laboratory showed traces of kidney irritation—a further support for his theory of chill.

In explaining the mechanism of the process, the speaker relied on the experiments of Wertheimer, who observed a vaso-constrictor action in the kidneys as a result of the application of cold. This anæmia, the opposite of the hyperæmia that took place in the lungs under similar conditions, in Siegel's opinion led to a disturbance of nutrition, which let loose the inflammatory process.

At the Silesian Society, Professor Küttner (Breslau), amongst a number of other cases, showed one of

Intermittent Hydronephrosis with Abnormally-placed Supernumerary Renal Artery.

The case was that of a man, æt. 28, who every three weeks for six years had had attacks of abdominal pain. It was at first attributed to the stomach, then to gall-stones; he had also been treated for rheumatism and other things. From the pain starting from the right testicle, attention was drawn to the right kidney, but chromocystoscopy showed that the kidney was acting. The absence of concretions as shown by the X-rays and negative palpation of the kidney region, together with exclusion of floating kidney, led to a diagnosis of "intermitting hydronephrosis in an ectopic kidney caused by congenital anomaly." At the operation it was found that the ureter was crossed transversely and kinked by a supernumerary artery. As a plastic operation seemed uncertain in its results and dangerous, and as the other kidney was healthy, the kidney was removed.

AUSTRIA.

Vienna, May 3rd, 1908.

Rhinogenic Retrobulbar Neuritis Optica.

Rethi presented a case he had operated on for retrobulbar neuritis by the intra-nasal operation on the ethmoid bone. It often happens that this thin sheath, no thicker than paper, that divides the optic from the cellular portion of the bone, becomes involved in the inflammatory process, which is in turn transmitted from the nasal cavity. The patient had been suddenly affected with blindness after a nasal catarrh, and, finding no relief, decided to submit to the operation, with excellent results. The vision is now fairly good.

Intra-Uterine Pessaries.

Natanson reported a case of a woman who had worn an internal pessary for five weeks with disastrous results. She now suffers from an obstinate catarrh of the cervix, which has impaired the strength and reduced the constitution. These foolish "Frauenschutz" ought to be condemned as a dangerous interference with the person.

Spasms and Dilatation of Œsophagus.

Zueig showed a patient who had suffered from severe spasms of the cardiac end of the œsophagus, with consequent dilatation of the œsophagus higher up. Zueig succeeded in relieving this spasm by means of a sound or catheter armed with a "condom," which he filled with air by means of an air-ball, and distended the contracted portion of the canal.

Lotheissen thought that Kausch's bougie was well adapted for this operation, where the "condom" could be filled with water for the dilatation of the stricture. In any case the prognosis of such cases is never very hopeful.

Orthostatic Albuminuria.

Steiskal next read a paper on the subject, and said 77 per cent. of these cases occurred among the young, and exhibited the following symptoms: weariness, headache, vertigo, fainting, rushing in the ears, palpitation, pain in the back, and was frequently associated with dyspnœa and constipation. The skin is usually pale, and the muscles flaccid, increased cardiac dulness and systolic murmur. There is also present accentuation of the second pulmonary sound, though more seldom the secondary aortic sound. After standing upright for a short time, the urine is found to contain albumin that is deposited by acetic acid, but no other nephritic sediment can be found in the urine. This orthostatic albuminuria usually persists from two to seventeen years, and is more frequent among young persons than is commonly believed.

As to the real ætiology of the disease, no unanimity can be arrived at. Some authors attribute this morbid condition to a suppressed or antecedent nephritis; others consider it a congenital anatomical abnormality, as Leube; another section of writers consider it constitutional enfeeblement or an insufficient innervation of the heart and blood-vessels. More recently Jehle has attributed this change to a mechanical cause in a deformity of the spine, such as an increased lordosis in the lumbar vertebræ, which, he contends, presses on the kidney in youth when the body is brought into the orthostatic condition, and thus produces pathogenic albuminuria. Whatever truth there may be in this latest hypothesis, Steiskal thinks that many facts are in favour of the theory. Within his own observation he has had recently five cases of severe lordosis which were confined to bed, but placing them in the erect posture for a quarter to a half-hour, and examining the urine immediately after, it was found to contain this peculiar albumin deposited by acetic acid. In others he has been unable to obtain the same results, and from the small number of positive cases he is disinclined to accept Jehle's theory, and believes that nephritis, puberty, or nervous disturbance is more likely to be the determining factor.

HUNGARY.

Budapest, May 3rd, 1908.

At the recent meeting of the Interhospital Medical Association, Prof. Preisich read a paper on

The Agglutination of Tubercle Bacilli in Animals.

According to him, the blood serum of healthy rabbits never agglutinates tubercle bacilli, but if rabbits are experimentally infected, as has been done first by Dr. Schvarzkorf, the test is positive in only one-half of the animals. The agglutination is most frequent about three weeks after infection, and gradually decreases as the tubercles surround themselves with connective tissue. This corresponds with the clinical experience that the phenomenon is more common with tuberculous patients in the first stage than with those in the third. Animals near death also failed to react. Animals infected with strongly virulent bacilli of bovine tuberculosis agglutinated less frequent than where less virulent germs of human origin were employed. Positive results were occasionally obtained where no pathological lesions were found. It seems very improbable from these experiments that the test will ever be of much diagnostic value in man.

On the Urine Ferments.

Dr. Kiss said that every urine contains proteolytic ferment. This is generally pepsin; while during the absorption of pathological infiltrates and exudates, and in diabetes mellitus, trypsin is occasionally found (Arany). By determining the critical temperature, the author could prove the gastric and urinary pepsin are identical bodies; furthermore, if the stomach in animals is extirpated, no more pepsin will be excreted. During fasting the amount is considerably higher than normally. It is probable that the excess of ferment is absorbed by the blood as zymogen, and is again converted into pepsin, where it encounters an acid reaction, as in the kidneys.

Cystoscopy of Exudates.

Prof. Kétly and Torday have, in a series of articles in the *Orvosi Hetilap*, dealt with the question of the value of cystoscopy in determining whether a collection of fluid will be absorbed spontaneously or not. Thus, in chronic pleural exudates, absorption can be looked for where the lowering of the freezing point is close to or less than that of the blood serum. This, however, applies only to those cases where there is no fever or other sign of pleural inflammation, since here an increase of effusion can be expected. In cases of hydrothorax secondary to nephritis, the freezing point of the serum must also be determined, and the figures are only of value if renal function is satisfactory. The rules for pleural fluids also hold for those depending on tuberculous peritonitis. In other peritoneal transudates, cystoscopic examination is in place only where there is no mechanical obstruction, and the heart's action must always be taken into account before giving a decision. It is often hard to distinguish between exudates and transudates, since the specific gravity and amount of albumin may vary within wide limits in both. The authors had hoped that cystoscopy might be of some help, but numerous experiments conducted in this direction were without result.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE RUCHILL HOSPITAL AFFAIR.—Last Thursday, the Glasgow Town Council met and had a very protracted and heated debate over Ruchill Hospital, and the medical officers responsible for its administration. Those involved were Dr. Chalmers, the Medical Officer of Health for Glasgow, Dr. Johnston, Physician Superintendent of Ruchill Hospital, the matron, and the assistant medical officers, who, having failed to get their grievances redressed, appealed to the Local Government Board, which led to an official inquiry and report. The Local Government Board found the grievances of the dismissed assistant medical officers were fully substantiated, and subsequently a subcommittee of the Health Committee specially investigated the matter and furnished two reports—a majority report and a minority report, to the Town Council, now discussed. The majority report exonerated Dr. Chalmers from any blame in regard to the administration of Ruchill Hospital, during the time its wards were overcrowded and its staff inadequate for the extra work created by the epidemics of measles and cerebro-spinal meningitis. The minority report, however, stated "that the facts that the medical officer of health regularly received from the physician superintendent daily returns of the number of patients in each ward and that the physician superintendent was placed under his control as well as the control of the sub-committee, imposed upon the medical officer of health the duty of carefully examining these daily returns and calling the attention of the sub-committee to the excessive overcrowding of particular wards." In regard to the physician superintendent, the majority report stated that "It is with the greatest possible regret that the sub-committee feel themselves obliged to recommend that the physician superintendent be asked to tender his resignation." They further stated that they were of opinion that "the physician superintendent lacked the administrative capacity necessary to the successful management of a great hospital." The minority report considered that to dismiss Dr. Johnston would be too great a punishment, and that in view of the exceptional circumstances of the case and his previous 15 years of approved service, that he be put on probation for six months. The vote in the Town Council was as follows:—(1) For the majority report, that Dr. Chalmers be exonerated from blame, there were 36 votes in favour, 30 votes against. (2) For the minority report, that Dr. Johnston's services be retained, there were 34 votes in favour, 31 votes against. (3) It was resolved to retain the services of the matron. (4) That the dismissed assistants be not reinstated, there were 36 votes in favour, 15 against. The practical upshot is that there is a return to the *status quo*, except that the dismissed assistants are not to be reinstated, which seems not only a lame and impotent conclusion, but one lacking in the elements of justice and good management.

FUNERAL OF THE LATE DR. C. E. UNDERHILL, OF EDINBURGH.—As a last token of respect to their late President, the Fellows of the College of Physicians attended the funeral ceremony, which took place in St. John's Church, Edinburgh, on April 27th. The Fellows of the College of Surgeons were also present, as well as a large gathering of the public, including representatives of the Edinburgh Corporation. The service was conducted by the Bishop of Edinburgh and Canon Cowley Brown.

GLASGOW MATERNITY HOSPITAL.—The new buildings of the Glasgow Maternity Hospital, recently erected in Rotten Row at a cost of £80,000, were opened on April 30th by the Duchess of Montrose. Among those present were Principal McAlister, Sir Halliday Croom, and Professor Murdoch Cameron. Sir J. Halliday Croom conveyed from his colleagues in Edinburgh their heartiest congratulations. He had gone over the hospital and found it second to none in the United Kingdom—indeed, he might say it was unequalled anywhere.

BELFAST.

BELFAST OPHTHALMIC HOSPITAL.—At the annual meeting of this hospital, held a few days since, the medical staff report was read by Dr. Cecil Shaw, and showed an increasing amount of work done in the hospital. The eye patients seen in the extern department during the last year numbered 1,372, and the throat and ear patients 703. In the wards 173 patients were treated, and 135 operations performed, besides numerous minor operations in the extern. An urgent appeal was made by the staff for funds to enlarge and remodel the extern department, and bring it up to date, for which purpose about £500 would be required. Dr. Walton Browne urged the necessity for this expenditure, and the Bishop of Down begged eloquently for the help the medical staff asked for. Several donations of from £5 to £25 were promised at the end of the meeting.

LETTERS TO THE EDITOR.

THE BRITISH MEDICAL ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In my letter published on March 25th I spoke of the enormous cost of the *British Medical Journal*, and suggested that the Association was falling into the position of a mere co-operative society for the publication of a cheap medical newspaper. In the Supplement to the *Journal* to-day are published the official accounts. From these it appears that the *Journal* is costing the Association over £30,000 a year. Of this vast sum more than £5,000 is spent on editorial salaries and editorial contributions. The *Journal* is three times too bulky in every department. If the members will not unite to make their voices heard, to assert themselves, and demand the minimum of political power which is their just due, no journal, however big and however well written, is of much use. On the other hand, if the profession could be roused to combined action, it would not matter how small the organ reporting their proceedings might be. If the Association is only kept together as a band of subscribers to a cheap paper, the sooner the connection is destroyed the better; at least, so it seems to me. The paper is cheap to members, but its production involves the waste of a vast sum annually.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

May 1st, 1908.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As a member and well-wisher of the British Medical Association, I would suggest that the money so generously subscribed to its funds by the profession should in a large measure be devoted to the interests of its less fortunate members, who, through illness or other adverse causes, are themselves in distress, or, through death, have left widows and children in dire need of help; instead of, as now, in the production of a huge *Journal* (which it is impossible for busy men to wade through week after week), and in building palatial offices in London which the Association can do perfectly well without. When I think of the enormous sums spent on these two items, and what could be done with, say, half the amount if judiciously administered as a "Relief Fund," I marvel that a Council of medical men should be swayed in their acts by such grandiose measures rather than by motives of common humanity.

I am, Sir, yours truly,
Harley Street.

London, May 3rd, 1908.

OBITUARY.

DR. WILLIAM AICKIN, OF BELFAST.

Last week another of the seniors of the medical profession in the Belfast district passed away. Dr. William Aickin graduated in the Queen's University in 1855, and practised as a family physician in Belfast till his retirement some five years ago. He was a singularly shy and retiring man, and took no active part in public or professional affairs, but he was universally respected as a capable physician, a kind friend, and an upright citizen. Outside his professional work, his chief interest lay in the affairs of the Methodist Church, of which he was a devoted member, and to whose funds he was a generous contributor.

DR. J. C. DALY.

Medical men, particularly those who are interested in athletics and who remember events of 20 years ago, will learn with much regret of the death of Dr. James Carroll Daly, J.P., of Borrisokane, which occurred last week in Dublin as a result of blood-poisoning. Dr. Daly's fame in the athletic world was won by him in early life. He was of powerful build—6ft. 2½in. in height; weight, 26st. For years he held the world's championship record for throwing heavy weights, and his record in pushing the 56 lb. off the shoulder holds good still. He was one of the Irish representatives in what was known as "the Gaelic Invasion of the U.S." in the eighties, and though he had never gone in for a regular course of athletic training, he astonished the athletic world by his great strength and agility. He was dispensary doctor for Borrisokane for more than twenty years, and J.P. of Tipperary County for the past ten years, being as popular as he was famous. The people of Borrisokane, among whom he lived for the past twenty years, will mourn his loss.

DEPUTY SURGEON-GENERAL W. S. OLIVER.

The death is reported of Deputy Surg.-Gen. William Silver Oliver, M.D., late Army Medical Department, at the age of 72. He entered the Army Medical Service in 1857, was promoted Surgeon in 1872, Surgeon-Major in 1873, and Brigade-Surgeon in 1882, retiring with the honorary rank of Deputy Surgeon-General in May, 1883. He served in the campaign in Rohilkund in 1858, including the actions of Bugawalla and Nugena, relief of Moradabad, action on the Dojura, assault and capture of Bareilly, attack and bombardment of Shahjehanpore, and various other Indian battles. He also took part in the Oude Campaign, including the actions of Pusgaon, Rissoolpore, Mehundee and Biswah, receiving the medal for distinguished bravery. His last campaign was in 1870, with the 60th Rifles in the Red River Expedition.

The Home Secretary has appointed a departmental committee to inquire into the operation of the law relating to inebriates and to their detention in reformatories and retreats. Among the members are the following medical men:—R. W. Branthwaite, Esq., M.D., H.M. Inspector of Inebriate Reformatories; H. E. Bruce-Porter, Esq., M.D.; H. B. Donkin, Esq., M.D., one of H.M. Commissioners of Prisons; C. A. Mercier, Esq., M.D., Physician for Mental Diseases to Charing Cross Hospital.

SPECIAL ARTICLES.

THE HEALTH OF THE ARMY.

The Report on "The Health of the Army for the Year 1906" (*a*) is arranged in somewhat a different form from that to which we have been accustomed. Formerly, the letterpress consisted chiefly of comments on the various tables and abstracts. In the present volume, while the statistical information is arranged much as heretofore, the letterpress is more independent of it, and is arranged so as to give a general history of the health of the Army, in its different stations, for ten years, mention being made only of the chief causes of disease, and of the general lines on which the problem of prevention has been approached. The result is that we are furnished with a more readable narrative than formerly; but, on the other hand, it is somewhat more difficult to obtain specific information on any desired point. Uniformity of arrangement is of great convenience in a series of public reports, and we are not sure that the advantages of the re-arrangement in this instance outweigh the disadvantages.

A distinct advance in the present volume, however, is the more extensive use made of curves and graphic methods of representing comparative figures. Also, where contrasts are made with the figures for previous years, the information goes back to 1890, and we are not furnished merely, as heretofore, with decimal averages. We are, therefore, able to see at a glance certain marked contrasts which previously were hidden in complicated tables. Taking the health of the Army as a whole, for the year 1906, and comparing it with that of previous years, there has been, on the whole, a distinct improvement. Thus, to begin with, the admissions to hospital have fallen steadily during the past 16 years from nearly 1,060 per 1,000 of strength, to less than 600. To a certain extent this has been due, no doubt, to the introduction of the system of treating a considerable number of the slighter cases of disease or injury as out-patients, but the fall commenced some years prior to the introduction of this system. In all probability the chief cause of this reduction in the number of admissions is largely due to a reduction in the admissions for venereal diseases. In the year 1890 the admissions from syphilis and gonorrhœa in the two most important divisions of the Army, namely, those stationed in the United Kingdom and in India, were 196 and 376 per 1,000; during the year 1906 they had fallen to 68 per 1,000 and 88 per 1,000 respectively.

Other diseases have also shared in the general reduction. Thus, in the group of general diseases (confining ourselves still to the troops serving at Home and in India, which are most continuously uniform in strength and composition of all the divisions of the Army), we find that there was a decrease in admissions of about 66 per cent. at Home and about 30 per cent. in India. Tubercle of the lung showed, in 1890, nearly 4 admissions per 1,000 of strength in the United Kingdom, and 3.26 per 1,000 in India. These figures had fallen in 1906 to less than 3 per 1,000 in the former case, and somewhat under 2 in the latter. Diseases of the nervous system accounted for 9.3 admissions per 1,000 in the Army serving at home in the year 1890, and for 10.3 in the Army of India in the same year. In 1906 this group of diseases showed an admission rate of only 6.25 and 9.88 in the two armies respectively. The admission rate for diseases of the circulatory system fell, in the 16 years under review, by nearly 75 per cent. at home and 25 per cent. in India. Diseases of the digestive system showed a decrease during the same period of 25 per cent. among the troops serving in the United Kingdom, and one of about 10 per cent. among those serving in India. The above facts show that the improvement in the general health of the Army, since 1890, cannot be attributed to a decrease in the incidence of one particular disease, but to a general improvement in all directions. It is probable that one great cause of this is the increase of temperance in the Army during late years, but the greater proportion of the improvement may fairly be attributed to improved sanitation, both as regards the housing and clothing of troops, and also as regards increased knowledge of how to combat disease, not only on the part of the Medical Department, but that of the Army in general.

It is of interest to compare the health of the British Army with that of foreign armies.

Taking all diseases we find that the United States Army heads the list with the enormous admission rate of 1,250 per 1,000. After this come the French, German, and Austrian Armies all above 600. Fifth in the list is the British Army, serving in the United Kingdom, and lowest of all, the Russian Army with the low figure of 324 admissions per 1,000. Too much stress must not, however, be laid on these figures when used for purposes of comparison. They are naturally to a great extent dependent on the regulations as to out-patient treatment and other service customs, which vary considerably in different armies. This comparison cannot be regarded as unsatisfactory from the British point of view, since there is no army which has to serve so much of its time on foreign stations as the British, and therefore none so exposed to disease.

Taking individual diseases or groups of diseases, we find that as regards enteric fever the French Army suffers by far the most of all the armies under discussion, its admission rate of 14.1 per 1,000 being not much below that of the British Army in India—viz., 15.6 per 1,000 for 1906. The Russian and United States Armies come next with 3.8 and 3.57 per 1,000, then the Austro-Hungarian and German Armies, while the British Army occupies the lowest place.

As regards venereal diseases, the American Army again comes first with the very high ratio of 178.72 per 1,000; the British Army second with 81.8. It is noteworthy, however, that in the case of the American Army the admission rate for these diseases has been steadily increasing for the last nine years, whereas in our Army it has been steadily falling for a considerable period. The French and Austro-Hungarian Armies come next, followed by the Russian Army at a slightly longer interval, while the German Army comes last with the very low ratio of 19.8.

The unsatisfactory condition of the British Army as regards these diseases rouses serious thought. It is useless to think of reviving the Contagious Diseases Acts, since—whether a wise step or not—public opinion is stubborn against such a measure. Nevertheless, we believe that by careful teaching of recruits, much might be done to protect them. Many of these lads are entirely ignorant of the dangers they run, and of the means by which they might to some extent protect themselves. Doubtless the improvement already noticed is due to an improved moral feeling, and there is hope for still further progress on the same lines. At the same time, it is folly to disregard the temptations to which "single men in barracks" are specially subjected, and to imagine that these temptations will always be conquered. In the German Army and Navy a careful teaching of and provision for personal hygiene has been one of the effective steps in reducing the incidence of venereal disease.

As regards tubercle of the lung, France and America head the list, England and Russia coming together with ratios less than one-half those of the two first-named nations. Germany and Austro-Hungary come last with ratios about one-half of the English and Russian Armies.

Cardiac affections are much more prevalent in the Army in the United Kingdom than in any other Army. America and Germany come next, France and Russia about level, and Austro-Hungary last of all. The high rate in the British Army is usually attributed to the poor condition of the recruit on enlistment, and the severity of the training through which he has, till lately, been put.

As regards the British Army, a comparison of returns from the various regions in which it serves is of interest. The admission rates per 1,000 are:—United Kingdom, 446.7; Mediterranean, 515.5; South Africa, 422.2; India, 871; on board ship, 761.3; all other stations, 693.8. The mortality rates vary from 2.92 per 1,000 at home to 10.81 in India.

One always turns to the sections on the examination for recruits for some information as to the condition of physique of the classes from which the Army chiefly replenishes itself. We find that the defect which caused the highest proportion of rejections was loss or decay of many teeth (59.63 per 1,000 of those inspected), and close to it came deficient chest measurement (49.48). Defective vision caused 28.46 rejections per 1,000, disease of heart 30.74, varix 11.75, varicocele 12.78, defects of lower extremities 21.37, under height, 10.85, under weight 11.27.

THE SOCIAL CONDITION OF DUBLIN WORKING-CLASS FAMILIES.

Mr. C. D. La Touche and Dr. T. J. Stafford publish, under the date May, 1907, a "Note on the Social Condition of Certain Working-Class Families in Dublin," which, however, seems only to have seen the light within the past few weeks. For our copy we are indebted to the courtesy of the Medical Commissioner of the Local Government Board for Ireland, but the note bears no information as to publisher or where it may be purchased. This is the more unfortunate, as the subject-matter is of much interest to all concerned in sociological inquiries.

The object of the inquiry was to determine how the typical Dublin labourer lives, what are the conditions under which he and his family are housed and fed, and what are their average family earnings. It was not intended to investigate the circumstances of the very poor. In the pursuit of the inquiry the authors have collected particulars of the earnings, spendings, housing, family, and diet of a large number of labourers.

The first table, which deals chiefly with housing questions, is based on an examination of 1,254 families, consisting of 4.950 persons, giving an average of 4.12 persons per family. They occupied 1,903 rooms. Barely 12 per cent. of these had accommodation satisfactory as regards sanitary convenience, air-space, and cleanliness. 87 per cent. suffered from unsatisfactory sanitation; 60 per cent. of the families were confined to single-room tenements. In the case of 5 per cent. the housing conditions were in all respects unsatisfactory.

The earnings varied from under 5s. to over 60s. a week, the average being 22s. 2d. per week per family, and the average rental was 3s. 0¾d. per family. As regards the incidence of consumption, the authors found that disease present in 12 per cent. of the families.

The second table is based on 21 families, and deals with the expenditure and earnings, or what the authors term the "family budget." The average number of persons per family was 4.57, and the average weekly earnings 23s. 2½d. Taking them as a whole, it was found that 98.35 per cent. of the total income was expended, while it would appear that in the case of ten out of the twenty-one the expenditure exceeded the income. Of the different items of expenditure, food absorbed 63.38 per cent. of income, and rent 14.51 per cent.

In the study of the diet, the authors have carefully calculated the protein value and the fuel-value of the different dietaries they found in use. Adopting Mr. Rowntree's arbitrary poverty-line, it was found that twelve out of the twenty-one families fell below that line.

The authors seem to have got no information as to expenditure on alcoholic liquors, but they find a considerable contribution to revenue under the heads of sugar and tea. In 1904 this contribution amounted to 2.99 per cent., and in 1907 to 2.31 per cent. of the family's weekly earnings.

The authors suggest a more satisfactory dietary, related to the tastes of the people, which would give a reasonable variety of food, and yield sufficient nutriment at the rate of 125 grammes of protein per man per day.

The Fourteenth Chemists' Exhibition was opened at the Royal Horticultural Hall, Vincent Square, Westminster, on Monday, May 4th. No doubt a great deal of interest will be taken in this Exhibition by medical men, who will find ready for inspection all the latest and best practical advances in the art of pharmacy.

REVIEWS OF BOOKS.

PREVENTABLE BLINDNESS. (*a*)

No more important subject could have been chosen by the author for a monograph than this, seeing that more than one-third of the blindness found amongst school children is due to ophthalmia neonatorum, and therefore preventable. In his historical introduction the writer refers to Biblical and other examples of persons "blind from birth." The causes of blindness form a subject for very careful study in the next chapter. Ophthalmia neonatorum, we find, heads the list, and represents a very high percentage (36.36) of cases of blindness. The incidence of this disease in London is very great. Out of every 100 children born, one suffers from purulent inflammation of the eyes in the first few days of life, and of every 2,000 children born, one child is blinded or partially blinded by this disease.

The clinical characters and the bacteriology of the disease are very fully treated in this volume. Most cases are undoubtedly due to invasion by the gonococcus, although other organisms are sometimes found in the stained film. A somewhat lengthy chapter on treatment is given, as well as one on the prevention of the disease. The writer suggests that ophthalmia neonatorum should be added to the list of notifiable diseases under the Act of 1889, in order to prevent, if possible, its spreading to others and to minimise its risks to the individual. With this suggestion we cordially agree, although there are difficulties in the way of carrying it out under the existing state of our municipal machinery.

This small book will repay careful perusal, and it certainly supplies a large amount of important information on a subject which, undoubtedly, is one of great national importance. The printing, binding, and general get-up of the volume call for a word of special praise.

NATURE'S HYGIENE. (*b*)

THIS well-known work has now reached a fifth edition. The volume is one of great interest, containing, as it does, an excellent account of matters affecting the public health, such as ventilation, drinking water, sewage disposal, germ diseases, and disinfection. Although it can hardly be termed a manual of hygiene in the strict sense, this volume, nevertheless, supplies the reader with a great deal of useful and practical information not readily found elsewhere. The author, for example, has brought together a number of interesting facts and figures in his chapter on sewage and sewage disposal. He incidentally refers to his proposed method of treating sewage by means of powdered coke, which has the property of absorbing ammonia, sulphuretted hydrogen, and other offensive gases. The sludge which results can be easily pressed and constitutes a fairly good manure.

The second part of the volume deals with the chemistry of essential oils and their oxidation products. Eucalyptus, pine, and camphor forests are also referred to, and their hygienic influences fully considered. In this edition several pages have been added concerning the more recently discovered chemical elements and other matters of present-day interest. Taken as a whole, this book affords much interesting material for the medical officer of health, who will find its pages full of suggestiveness. The author puts his facts before the reader in a clear and practical manner, so that the volume forms very good reading for those interested in matters pertaining to hygiene. In its present form this work is sure to find many readers, not only amongst the medical profession, but also amongst those who have to deal with municipal affairs.

LITERARY NOTES.

THE "Formulaire des Médicaments Nouveaux" for 1908 (J. B. Baillière et Fils, Paris), which is now in its twentieth edition, is a most serviceable compilation. The present volume contains a large number of additions, many of which are quite new to us. Among them are assuredly some that have come to stay, while others, it may be apprehended, are mere motes floating in the therapeutical sun. In the former category we should place arbeol, the active principle of sandalwood oil; atoxyl, the new arsenical compound of which so much is hoped; bromiase, a compound of bromide of potassium and levurine which, it is claimed, never gives rise to "bromism"; chloretone; vanadic acid and mercurial vasogene. Then, too, there are the colloids—sometimes called the electric colloids from their mode of preparation. These appear to be possessed of really remarkable therapeutical properties. The appendix, or "Dictionary of Synonyms," will often be found useful in the present transitional state of nomenclature. Altogether a very handy little compendium of current materia medica.

THE second edition of Dr. George Oliver's "Studies in Blood Pressure" (London, H. K. Lewis, 1908) bears evidence of further careful work on this interesting subject. It is largely due to the author's teaching that the clinical value of observations of the blood pressure is now more generally appreciated; indeed, as the apparatus becomes simplified, a hæmomanometer is likely to be found as indispensable as a thermometer. This process of simplification is going on, and the author figures his latest modification, the compressed air hæmomanometer, which, it is claimed, eliminates certain fallacies due to abnormal resistance on the part of the arterial walls. We are reminded that it is easy to misinterpret the significance and exaggerate the importance of variations of blood pressure, which, after all, is only one factor in determining the physiological conditions. Considered in its proper relationship to other indications, arterial tension, however, is one of unquestionable value, and, like the sphygmograph and the thermometer, will often confirm or suggest the existence of pathological states. We know of no more complete and straightforward guide than this well-thought-out little treatise on the subject.

THE Committee of the National Children's Home and Orphanage have issued, in pamphlet form, an account of their recent London Mansion House meeting. Their immediate object is to provide a sanatorium for children who are threatened with consumption. In making this attempt they are falling into line with the teaching of modern medical science, which regards prevention as the crucial aim, far exceeding in importance any merely curative organisations, however necessary and desirable the latter may be. Every medical man knows that in tuberculosis, above all other human maladies, to be early in the field is half the battle. The National Orphanage Committee, therefore, have, so to speak, hit the nail on the head when they are offering a good environment to children who are either predisposed to the disease or who are suffering from its early manifestations.

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AT the Mansion House the Lord Mayor, Sir John Bell, presided, being supported by the Lady Mayoress and the Sheriffs. Among others present may be mentioned Alderman Sir Thomas Crosby, M.D., Sir John McDougall, and a number of distinguished persons, both lay and medical. Sir Douglas Powell made an eloquent appeal on behalf of the children. One of his most striking points was the demonstration that, while some 25 per cent. of the infantile population were born of consumptive parents, only 10 per cent. were definitely tubercular, and required sanatorium treatment. Sir Thomas Barlow followed with a full and exhaustive review of the position, and referred to the advisory position of Dr. Kelynack with regard to the Children's Home. Mr. Sheriff Wakefield, Sir Horace Marshall, and others also addressed the meeting. It appears the Committee have purchased some ten acres of land at Harpenden, Herts., for the further-

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(*a*) "Preventable Blindness: An Account of the Disease known as the Ophthalmia of the New-Born and of its Effects: With a Plea for Its Suppression." By N. Bishop Harman, M.A., M.B. Cantab., F.R.C.S.Eng., Ophthalmic Surgeon to the Belgrave Hospital for Children, etc., etc. London: Bailliere, Tindall and Cox. 1908. Price 2s. 6d. net.

(*a*) "Nature's Hygiene and Sanitary Chemistry." By C. T. Kingzett, F.I.C., F.C.S., Past Vice-President of the Society of Public Analysts, etc. Demy 8vo. Pp. xvi., 527. 5th Edition. London: Bailliere, Tindall and Cox. 1908.

ance of their excellent scheme. This effort is well worthy the help of philanthropists. It forms part of the greater movement which for some years past has been organised with a view of checking the excessive infantile mortality which constitutes so great a blot on modern civilisation. Contributions may be sent to the Treasurers, of whom one is Mr. C. C. Wakefield, Sheriff of the City of London, Stafford House, Cannon Street, London, E.C.

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WE have been favoured with a copy of the *Ophthalmoscope* for April. It contains a number of illustrations, all reproduced in the best possible style. Indeed, the Editors may be congratulated on having eclipsed all previous issues in the amount and the high standard of the contributions. Dr. Sinclair Thomson begins with an interesting article on the frequency of orbital manifestations of nasal sinusitis. This is followed by another on the ocular and orbital complications of disease of the accessory nasal sinuses by Dr. Jameson Evans, of Birmingham. Dr. Fish, of Chicago, contributes a learned notice of thirty-six consecutive cases of optic neuritis. Mr. Sidney Stephenson describes three cases of malignant disease of the accessory sinuses, with some specially good plates of microscopical sections. The abstracts of special articles relating to ophthalmology is wide and varied. It may be said of this journal that its 111 pages are full of excellent matter, and the production is most creditable to medical journalism in this country.

LABORATORY NOTES.

SOME NEW DRUGS.

THE well-known firm, Messrs. A. and M. Zimmermann, have lately introduced some new drugs and new preparations of old drugs which are sure to have a patient trial from those who are acquainted with the firm's products. One interesting novelty is a synthetic camphor prepared by Messrs. Schering, which appears, from the observations of Professor Langgaard, of Berlin University, and of Professor Grawitz, of Charlottenburg Hospital, Berlin, to be identical with natural camphor in all chemical and therapeutical respects, but it has this additional advantage—that it is capable of being manufactured now at a rate lower than that of the natural article.

Cellotropin (mono-benzol-arbutin) is a drug which appears to act on the principle of increasing the number of tuberculous anti-bodies in the blood, and thereby assists the organism to overcome tuberculosis by a natural method of cure. Herbanin is an iron preparation which is derived from vegetable sources. It is said to have a pleasant taste, not to injure the teeth, not to disturb the digestion, nor to cause constipation. As, moreover, the reports of the benefit derived from it in cases of chlorosis and similar affections are very favourable, probably medical men will be glad to give it a trial.

The history of Nastin, another of these new drugs, is a little remarkable. Professor Deycke, of Hamburg, was experimenting with leprosy, and was struck by the numbers of a certain streptothrix which appeared in cultures. Cultures of this organism seemed to benefit leprous patients when injected hypodermically, and further trial showed the value to depend on the presence of certain fatty substances, to which the name "Nastin" has been given. These bodies were isolated and used and now the Nastin is put up into tubes containing a crystallisable and neutral fat (ester of glycerine), combined with a benzoyl-chloride, and called Nastin-B. Its credentials cannot be set aside.

A new weapon is placed before us in the treatment of diseases of the bladder in Fomitin, which is made by extraction from two plants parasitic on the plum tree, namely, *Hymmomycetin fomes* and *Fomes igniarius*. Fomitin is a reddish-brown, rather bitter liquid, with mushroom-like smell. It has been employed with advantage, it appears, not only in diseases of the bladder, but in dysmenorrhœa, menorrhagia, and hæmorrhoids.

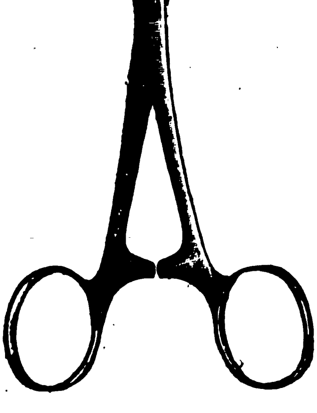
Finally, in Bilitin the firm think they have a specific for gall-stones, and if further trial warrants the conclusion, it will be a good day for everybody when it is established as such. The present remedies for gall-stones are far from being "specifics."

THE Bayer Company, Limited, are introducing a drug named novaspirin to the notice of the profession. It is claimed that novaspirin passes unchanged through the stomach and is free from any risk of gastric disturbances, and that in the intestines it decomposes into nascent salicylic acid and methylene-citric acid, without giving rise to irritation or unpleasant by-effects. Chemically, novaspirin is methylene-cytril-salicylic acid. It is a white, odourless powder of faint acidulous taste, easily soluble in alcohol, soluble with difficulty in chloroform and ether, and almost insoluble in water. It contains 62 per cent. of salicylic acid. One of the indications for its use lies in influenza, in which it has been found to relieve the pains, to reduce the fever, and in general to promote the comfort of the patient. It is also useful in the treatment of coryza, tonsillitis, pleurisy, neuralgia, nervous headaches, tabes and carcinoma. The administration of novaspirin is not followed by profuse perspiration, because the drug is absorbed so slowly, a matter of importance when diaphoresis is not desired, as in cases of weak patients, grave cardiac affections, chronic wasting diseases, and danger of severe hæmorrhages, nor has ringing in the ears been observed to follow the use of the drug. It is an efficient and agreeable remedy in the various forms of rheumatism, both articular and muscular, as well as in gouty conditions. The average dose for adults is 15 gr. several times a day. This may be increased to 30 gr. in rheumatic and gouty troubles. Owing to its insolubility in water it is best administered in powders, wafers, or in the form of tablets.

MILK OF MAGNESIA (PHILLIPS').

THIS compound is by way of being a model of elegant pharmacy. It is well-known in America under the name of Phillips' milk of magnesia, and latterly its admirable properties have become appreciated on this side of the Atlantic. It is useful in all cases where the administration of alkalies is indicated, and a special field of usefulness is claimed in morbid conditions connected with uric and lactic acid. There is always room for a really good preparation of magnesia for children, and the nursery could hardly be provided with a better one than that under notice, which we have put to a practical test and found to answer the claims put forward on its behalf.

A NEW TONGUE FORCEPS.



DR. RODERICK, of Cambridge, has devised an improved clip to pull the tongue forward during the administration of an anæsthetic. It consists of Spencer Wells' handles and catch with Liston's Artery Forceps Blades, slightly arched outwards so as to allow for the thickness of the tongue. Compared with the ordinary tongue clip, which compresses a considerable area of tongue tissue, thus causing pain and discomfort to the patient for several days, this instrument only produces a minute puncture, which soon heals up. The makers are Messrs. Arnold and Sons, West Smithfield, London.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Calcified Fibroma of the Ovary.—Casalis (*Journal of Obstetrics and Gynæcology of the British Empire*, April, 1908).—Under this heading the details of a rare condition are given. The patient, a fat, coloured woman, æt. 42, sought advice and treatment for menorrhagia and metrorrhagia, accompanied by severe pains in the lumbar and hypogastric regions. The pains had become continuous, and the patient was seldom more than a week free from hæmorrhage. Examination proved the presence of a fibroma of the uterus, and what was thought to be a second pedunculated growth rising from the fundus uteri. On opening the abdomen an ordinary interstitial fibroma invading the whole uterine body was found about the size of a cocoanut. The pedunculated tumour proved to be a calcified left ovarian fibroma as big as a cricket ball, quite distinct from the uterine tumour to which it preserved its usual relation. This ovarian growth was white and stonelike on section being made by a fine saw, showing complete infiltration with lime salts. The capsule was fibrous, and practically no other fibrous tissue was present. The Fallopian tube was hypertrophied, but otherwise normal. The weight of the ovary was 1 lb. 4 oz. The right ovary, though microcystic, and the right tube, were left. H.

A Case of Chancre of the Cervix Uteri.—Ivens (*Journal of Obstetrics and Gynæcology of the British Empire*, April, 1908).—A report of a case is given, occurring in a married woman, æt. 32, who complained of backache. She was a iv.-para. The first child was stated to have died of "consumption of the bowels"; the second was still-born; but the remaining two were healthy. The patient had been in good health until three months prior to her coming under observation, when she had consulted a doctor for backache, and a Hodge pessary had been inserted for its relief. Micturition for a few weeks had been painful and frequent, with some blood. Husband had recently been treated for a "discharge." A blood-stained purulent discharge was noticed on examination. There was no ulceration of the vulva, and no enlargement of the inguinal glands. The uterus retroverted, but movable. The external os somewhat patulous, and an ulcer the size of a shilling situated slightly to the right side of the cervix, but extending over both lips, was discovered covered with a grey slough and having an indurated base. A linear ulcer was found in the urethra near the neck of the bladder, and the mucous membrane intensely congested. The author believes this latter condition to have been due to gonorrhœa, but no microscopical or bacteriological examination was made. The cervical ulceration suggested malignancy, but was more typical of syphilis. A small portion was excised for examination, which showed the surface of the ulcer to consist of exudation and necrotic granulation tissue, the connective tissue to be hyperæmic and densely infiltrated with round cell and extreme cellular proliferation, the intima of the vessels being thickened. The treatment consisted in antiseptic douching while waiting for secondary symptoms to appear. Five weeks later typical secondary symptoms appeared, sore throat, etc. The cervical ulcer looked cleaner, but was in no way diminished. Mercurial treatment, general and local, was adopted, and in a few weeks the sore throat disappeared, and in three weeks' time the chancre had gone. The urethra was treated with nitrate of silver. The author points out the great difference of opinion among gynæcologists as to the frequency of the occurrence of chancre of the cervix, Sir W. Japp-Sinclair believing it to be extremely rare, McCann stating that it is not rare, while Pernet, supporting McCann, quotes Fournier, who found 13 cases out of 249 cases of genital chancre. H.

Ear Disease in Infancy and Childhood.—Kenefech (*Amer. Jour. Obst.*, April, 1908).—The otitis of children may be roughly divided into two classes—the first arising within the tympanum from causes brought to it by morbific agents in the circulating blood; and, second, those comprising infectious processes set up by inflammatory and congestive conditions in the immediate neighbouring structures. The first class is associated with some concomitant general disease, such as syphilis or tuberculosis; the second embraces by far the greater number and most frequently met with—*i.e.*, hypertrophied lymphoid tissue in the pharyngeal vault and hypertrophied and diseased faucial tonsils. An adenoid mass, both on account of its own circulation and the pressure it causes on the neighbouring structures, keeps up at the mouth of the Eustachian tube a constant vascular engorgement which extends to the tympanic cavity and its contents as well. There is another class of case in which adenoid growths within the fossæ behind and above the Eustachian cushion seriously impede physiological action of the muscular structures of the Eustachian cushion concerned in opening and closing the pharyngeal tubal orifice. While the child is in the upright position by day, this growth gives scarcely any evidence of its presence, but at night it becomes engorged even to the extent of impeding respiration, producing damage to the general health and special harm to the hearing apparatus. To treat acute cases of otitis so that the process may be checked, the tympanic membrane preserved intact, and its function restored, the writer's practice, when the diagnosis of acute otitis is made, is to slit, not pierce, the drum posteriorly, and thus drain from the lowest point. This is done whether or not spontaneous rupture of the tympanic membrane has occurred. Irrigation frequently with salt solution is followed by healing, in most cases, in from ten days to two weeks. The naso-pharynx and fossæ of Rosemüller should be cleared out as soon as the age and strength of the child will allow. F.

Symptoms, Diagnosis and Treatment of Tubal Gestation in the Early Weeks.—Tate (*Brit. Med. Jour.*) considers there is an increasing frequency in this form of gestation, symptoms usually commence before the tenth week, most commonly from the third to the eighth week, and their onset is usually an indication of some change taking place in the gestation sac, *e.g*, hæmorrhage. The typical symptoms are often absent, although two symptoms are invariably present, irregular hæmorrhage and attacks of abdominal pain, amenorrhœa was present in only 56 per cent. of cases. The conditions most commonly mistaken for tubal gestation are pelvic inflammation and ordinary miscarriage. As regards treatment, operation is indicated when hæmorrhage is moderate or severe, and of recent origin, and when symptoms and physical signs indicate that the gestation sac is still within the tube, when a hæmatocele has already formed, and when the patient has been free from any symptoms for a week after the initial attack of pain, expectant treatment is safe. F.

The Induction of Labour for Visual Indications.—Pooley (*Amer. Journ. Surg.*, March, 1908).—The changes in the eye in the albuminuria of pregnancy are essentially the same as in chronic nephritis. These may be (1) a sudden, more or less transitory or complete loss of sight, without appreciable changes in the fundus oculi; (2) a gradual failure, with characteristic changes in the retina and optic nerve, which in time may lead to blindness. Evidence of disease of the kidneys not infrequently show themselves in the eye before they do in the urine. In uræmic amaurosis, without changes in the eye visible to the ophthalmoscope, even should the usual symptoms, dizziness, nausea, and threatened convulsions be absent, their occurrence is soon to be feared, and labour should be induced without waiting until the life, as well as the sight of the patient is in danger. Prognosis as to the recovery of vision is better in cases in which chronic nephritis does not already exist. F.

Dysmenorrhœa Membranacea.—In the opinion of Hitschmann and Adler (*Monatssch. für Geb. und Gyn.*, Bd. XXVII., Hft. 2) dysmenorrhœa membranacea is not an exfoliative endometritis. It is a type of menstruation in which the usually detached portions from the surface of the endometrium assume greater dimensions. The predisposition to this lies in the special development of the menstruating mucous membrane, real or relative, narrowness of the os internum favours obstruction, and thus uterine contractions are set up which cause pain and perhaps further separation of the mucous membrane. The cases of dysmenorrhœa membranacea are only a small group in the great province of dysmenorrhœa. On the other hand, while we know practically nothing about the ætiology of the other forms of dysmenorrhœa, the picture of dysmenorrhœa membranacea revealed by the author's investigations is fairly clear. Since there is no endometritis, curettage is useless, and therefore not to be employed. We can only rely on palliative treatment of which the authors prefer the systematic premenstrual dilatation of the os internum. G.

Rest in Bed During the Puerperium.—F. Martin *Monatssch für Geb. und Gyn.*, Bd. XXVII., Hft. 2), to estimate the advantages which, according to Küstner, are associated with early rising from bed during the puerperium, experimented with one hundred lying-in women. By this early rising he only means that the patient sits up quietly out of bed with a tight binder on the abdomen. The women were chosen without considering the number of their previous labours or their age. Those who were not considered fit for the treatment were patients who had had prolonged labour, intra-partum fever, operations, injuries, or when there was disease of the heart, lungs, kidneys, or blood vessels. The women got up for the first time 15 to 24 hours after labour was completed. During the next seven days they were out of bed for two hours in the forenoon and two hours in the afternoon. The puerperal morbidity was 13 per cent. Involution of the uterus was normal in every case and in no case was ergot necessary. The uterus on the seventh day was always found anteflexed. There was no case of embolism among the hundred cases nor among another series of eight hundred treated in a similar manner. The author can, therefore, recommend this treatment when one can be, as far as possible, certain that no infection occurred during labour and the time at the disposal of the mother for recovery after labour is short. As regards well-to-do people, one can conclude that it is not necessary to keep healthy women lying for as long a time as formerly, and that we can more often put them in a different position when they feel well enough.

Medical News in Brief

The British Association for the Advancement of Science.

The Executive Committee, which is making preparations for the meeting of the British Association to be held in Dublin in September next, is inviting subscribers and guarantors to come forward in order to meet the necessarily large expenses which must be incurred. It is estimated that a sum of at least £3,500 to £4,000 will be required, and of this more than half has been already promised. The work of the Society will be transacted in twelve sections, which, with their respective Presidents, are as follows:—Mathematical and Physical Science.—W. N. Shaw, F.R.S. Chemistry.—Professor F. S. Kipping, F.R.S. Geology.—Professor J. Joly, F.R.S. Zoology.—S. F. Harmer, F.R.S. Geography.—Major E. H. Hills, R.E. Economic Science and Statistics.—W. M. Acworth, M.A. Sub-Section, Agriculture.—Right Hon. Sir Horace Plunkett, K.C.V.O., F.R.S. Engineering.—Dugald Clerk, M.I.C.E. Anthropology.—Professor W. Ridgeway, M.A., D.Litt. Physiology.—J. S. Haldane, F.R.S. Botany.—F. F. Blackman, F.R.S. Educational Science.—Professor L. C. Miall, F.R.S. These sections will meet at Trinity College, the Royal University, the Royal Colleges of Physicians and Surgeons, the Royal Irish Academy, and the Royal Dublin Society. The reception-rooms and administrative offices will be situated in Trinity College. Amongst the social functions which have been already arranged are garden parties by their Excellencies the Lord Lieutenant and the Countess of Aberdeen, by Lord and Lady Ardilaun, and by the Provost and Senior Fellows of Trinity College. Evening receptions are also to be held by the Viscount and Viscountess Iveagh, and by the Royal Dublin Society. The Lord Mayor and Lady Mayoress will be "At Home" at the Mansion House to members of the Association on the afternoon of the opening day of the meeting.

Trinity College, Dublin, School of Physics—Post-Graduate Classes.

The first classes in Ireland for systematic post-graduate instruction were established by Trinity College four years ago. Since then Trinity College has given each summer a three weeks' course, open to all qualified medical men. This year, in addition to the summer course, which will be held from June 8th to June 27th, there will be an autumn course from September 21st to October 10th. The subjects dealt with include Medicine, Surgery, Gynæcology, and special departments such as Diseases of the Skin, Throat, Nose, Ear and Eye. There are also classes in Pathology, Physiology, Anatomy, Cystoscopy and X-ray work. The time-table is so arranged that each member can, if he desires, attend all the classes. The hospitals embraced in the scheme are within easy walking distance of Trinity College, so that little time need be lost in going from one institution to another. As in former years, arrangements have been made by which a limited number of members of the class can reside in college rooms and dine on commons. Further particulars, including expense of course, will be found in our advertising columns. A syllabus can be obtained from the hon. sec., Dr. Parsons, 27, Lower Fitzwilliam Street, Dublin.

Royal College of Surgeons.—Post-Graduate Courses.

We publish in our advertising columns particulars of the two post-graduate courses which the President and Council of the Royal College of Surgeons have arranged to conduct during the months of June and September. The object of these courses is to render available the whole of the clinical material in the City for the post-graduate student, so that he may see as much as possible during the brief time at his disposal. The intending student will note from the list of hospitals that this object has been accomplished, seeing that the ten general hospitals are included, as well as the various hospitals devoted to special subjects. Those conducting the courses will be careful to make them as practical and helpful to the varying needs of the practitioner as possible. In the event of the post-graduate students exceeding a certain number at either of the courses, arrangements will be made to divide up the classes into practical working groups.

The New Irish Universities.

The draft charters of the new Universities have been issued during the past few days. One of the most interesting paragraphs relates to the appointment of Professors in the constituent colleges. The Senate of the University to be formed in Dublin will have the appointment of these Professors, subject to the following conditions:—

(*a*) In the case of a Professorship or Lectureship of a constituent College, to which the University, by the Charter or Statutes of the College, is entitled to appoint, the Senate must invite and consider the representations of the governing body of the College as to the filling of the vacancy; and if the number of candidates be more than three, the governing body of the College shall be entitled to select not less than three candidates from amongst whom the Senate must make the appointment.

(*b*) The Senate must in every case obtain and consider the advice of the General Board of Studies given upon a report which that Board must obtain from the Faculty to which the vacant Professorship or Lecturership belongs.

It remains to be seen how far this arrangement will meet the views of the representatives of the constituent Colleges in Cork and Galway, and it is already evident that the degree of autonomy possessed by these Colleges will be a matter for some considerable discussion.

The names of the Senates of the two Universities have also been published, and amongst them we find those of many well-known medical men. In the case of the University in Dublin, Dr. D. J. Coffey, M.B., is named as the President of the Dublin College, and on the Senate are Sir C. Nixon, Bart., M.D., Drs. Cox, McArdle, O'Carroll, P. A. O'Sullivan, C. Y. Pearson, J. P. Pye, Sigerson, B. C. Windle (President of the Cork College). In the case of the University in Belfast, the followng names appear in the list of the Senate: Drs. Johnson Symington (Registrar), P. R. O'Connell, Sir William Whitla, Drs. T. Sinclair, J. W. Browne, P. Redfern.

"Medical Specialist."

LAST week, before Mr. Horace Smith, Bertram Mortimer, *alias* Henry Sylvester, described as "Professor" Mortimer, medical specialist of Berkley College, Boston, U.S.A., and his son, Herbert Sylvester, student, of the same town, were brought up in custody, the first-named in charge of a warder from Exeter, accused of being concerned together in stealing a portmanteau and contents, value £10, from the Victoria Station of the London, Brighton and South Coast Railway.

The elder prisoner had been committed for trial from Exeter charged with obtaining money by false pretences. It was stated in evidence that on April 2nd a gentleman, an X-ray specialist, left his portmanteau in the cloak-room at Victoria. The valise was, by a porter's mistake, handed over to a person who produced a ticket relating to another deposit—two parcels tied together. This last-mentioned property was claimed by and subsequently given up to the elder prisoner. On the part of the prosecution witnesses were called to prove that both the prisoners were at different times in possession of the prosecutor's bag and its contents. It was found at the younger prisoner's lodgings at Swansea by Inspector Badcock, of the railway police.

The defendants cross-examined at great length, and, after a long hearing, the prisoners were remanded.

Royal College of Surgeons in Ireland.—General Meeting and Election of Officers.

A MEETING of the College will be held on Saturday, May 30th, at 1 o'clock, to receive the annual report of the Council. Notices of motion received by the Registrar on or before Tuesday, May 19th, will have priority of consideration over any others which may be submitted. A meeting of the College will also be held on Monday, June 1st, at 1 o'clock, pursuant to the provisions of the charters, to elect a President, Vice-President, Council and Secretary of the College for the ensuing year. Fellows who may desire to have their names printed on the list of candidates for office will please signify their wish by letter to the Registrar, at the College, on or before Tuesday, May 19th, as it is necessary to include the names in the voting papers which are forwarded to the Fellows, and no candidate is eligible unless his application is received within the date specified.

PASS LISTS.

The Royal University of Ireland.—Medical Degrees Examinations.

THE following candidates have passed the Third Examination in Medicine:—Upper Pass.—*George Cooper, William Hamilton, B.A., Arthur V. J. Harrison, *Melville C. Irwin, Denis Lynch, *John M. McCloy, John P. J. McGivern, *Walter Mooney, B.A., *Charles J. Simpson, *William W. D. Thomson, B.A. (Those marked with an asterisk may present themselves for the further examination for Honours.)

Pass.—William Boyd, Francis J. Burke, James Byrne, Patrick J. Campbell, John B. Crawford, Patrick J. Cullinane, John J. Dennehy, Michael G. Devine, Edmund Doherty, George S. Glass, B.A., William E. Graham, John L. Jackson, Sarsfield P. Kerrigan, Bertram C. Letts, Barkley McCullough, B.A., Thomas P. McMurray, Harold D. Manderson, Michael Moloney, Henry C. Mulholland, William M. J. O'Connor, Joseph E. O'Sullivan, William Prendivale, Alfred H. Rentoul, Thomas W. Ruttledge, Gerard Sheridan, Rupert A. Smith, Bernard Teeger, Robert W. Vint, Espine F. Ward, Timothy Woulfe.

THE following candidates have passed the undermentioned examinations:—

The M.B., B.Ch., B.A.O. Degrees Examination.—Upper Pass.—Donal Barry, Arthur R. Boyd, Thomas A. Carson, James K. P. Clarke, Thomas J. Hollins, B.A., Marshall F. Huston, Joseph G. Johnston, Arthur H. Joy, Robert G. Kevin, Thomas P. Linehan, George H. Martin.

Pass.—Thomas Arnold, Raphael N. Berman, William Bradbury, Thomas G. Buchanan, Robert J. Clarke, Mary Cowhy, B.A., Edmund H. Flanigan, William S. Graham, Hugh J. Grant, Patrick J. Grogan, Richard G. C. M. Kinkead, Robert J. Leslie, Solomon Levy, John C. Macaulay, Joseph McCausland, B.A., Michael McNiff, James F. Neary, John F. Neary, John F. O'Brien, Michael Waldron, George P. White, Michael White.

The following candidates may present themselves for the further examination for Honours in the groups set after their names:—Donal Barry, Medicine and Surgery; Arthur R. Boyd, Medicine; Thomas A. Carson, Medicine; Thomas J. Hollins, B.A., Midwifery; Marshall F. Huston, Medicine; Joseph G. Johnston, Medicine and Midwifery; Arthur H. Joy, Surgery; Robert G. Kevin, Medicine and Surgery; Thomas P. Linehan, Surgery.

The M.D. Degree Examination.—Pass.—James G. Campbell, M.B., B.Ch., B.A.O.; William H. Davis, M.B., B.Ch., B.A.O.; Joseph P. Dee, M.B., B.Ch., B.A.O.; Denis J. Keane, M.B., B.Ch., B.A.O.; Thomas D. Luke, M.B., B.Ch., B.A.O.; William Rice, M.B., B.Ch., B.A.O.; John Thompson, M.B., B.Ch., B.A.O.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

THE following candidates have passed the Second Professional Examination, April, 1908:—F. W. Warren (with honours), A. A. Russo (with honours), T. M. Thomson (with honours), R. J. Barlee, J. Brereton Barry, D. F. Curran, C. A. Farrell, E. E. Holden, J. T. Hill, A. Kennedy, L. A. Moran, T. J. McDonnell, P. J. O'Reilly.

Faculty of Physicians and Surgeons of Glasgow.

AT the recent examinations of the Board of the Royal Colleges of Physicians and Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow, the following candidates passed their respective examinations:—

Five Years' Course—First Examination.—Arthur L. Edwards, James A. Frost, George A. Macvea, Cyril S. Owen, William Shorten, Valentine H. Wardle.

Second Examination.—John Paxton, Hugh F. Williams.

Third Examination.—Conrad J. Arthur, Herbert C. Bankole-Bright, Denis Cogan, James D. Collins, John A. Irwin, Angus C. Livingston, Patrick J. Taaffe, Frank W. White.

Final Examination.—Ishwar Das, Punjab; Charles J. C. Faill, William R. Griffith, Maurice E. Kayton, James W. M. Hunter, Les S. Machado, Ceylon; John M. Muir, Manec B. Patel, Bombay; Sécossène Piarroux, Mauritius; Patrick Reid, Bildev Singh, Lahore.

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Small announcements of Practices, Assistancies, Vacancies, Books, &c.—Seven lines or under (70 words), 4s. 6d. per insertion; 6d. per line beyond.

Cigaretto.—There are several organisations of the kind, but we believe the one you refer to is called The British Anti-Tobacco and Anti-Narcotic League. We understand that members can also pledge themselves against drinking, gambling, and profane language; but we are not in a position to state this from personal knowledge.

A BRASS HEART.

The latest triumph of surgical skill is a mechanical brass heart, which enables a man to go on living when without it he would be dead. The heart is invented by an American professor. Now the gentleman's silly old heart can take a rest when ever it likes, for the professor has only to fix the double tubes to the larynx and nose of the patient, set the pumping arrangement at work, and the otherwise dead gentleman will soon be all alive and possibly kicking. The professor himself managed to stop breathing for ten minutes—the onlookers thought his demise was as satisfactorily completed as that of Queen Anne, but he had a card up his sleeve. He touched the button, or took the necessary steps to set the brass heart beating. Away went the machinery, pumping life-giving oxygen into the learned gentleman, and in a very short time he sat up, noticed things, and then remarked to the folk who were about to buy wreaths, "Got the grin of you this time, I guess." And it was so. He is now scheming solid wooden heads for public men, and great results are anticipated.—*Morning Leader*.

Norwich.—Unfortunately, your city does not enjoy an envious reputation for salubrity. We have been informed by an authority, who should know something of the locality, that the nature of the soil is a factor in the higher death-rate when compared with towns similarly situated, but of this we have no personal knowledge. According to the Registrar-General's return, the mortality last week in Norwich was 23.3 per 1,000 of the population. In London it was only 14.7.

Meetings of the Societies, Lectures, &c

Wednesday, May 6th.

Royal Society of Medicine (Neurological Section) (20, Hanover Square, W.).—8.30 p.m.: Papers:—Sir William Gowers, F.R.S.: The Mechanism of Nystagmus. Dr. E. Farquhar Buzzard: A Note on the Occurrence of Muscle Spindles in Ocular Muscles.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. J. Clarke: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. E. T. Collins: Convergent Strabismus.

Thursday, May 7th.

North-East London Clinical Society (Prince of Wales's General Hospital, Tottenham, N.).—4.15 p.m.: Clinical Cases.

Harveian Society of London (Paddington Green Children's Hospital).—8.30 p.m.: Clinical Evening.

Ophthalmological Society of the United Kingdom (11, Chandos Street, Cavendish Square, W.).—8 p.m.: Mr. E. E. Henderson, Mr. E. Green, Mr. C. Hailes, and Mr. J. H. Tomlinson: Card Specimens. Dr. F. Fergus: Ptosis Operations. Mr. E. Clarke and Sir A. Wright: Tubercle of the Choroid cured by Tuberculin Mr. E. Clarke and Mr. S. Mayou: Tubercle of the Iris cured by Tuberculin. Mr. P. E. H. Adams: An Epidemic of Contagious Conjunctivitis due to the Pneumococcus. Dr. G. Mackay: (1) A Case of Arterio-venous Aneurysm treated by Ligature of the Common Carotid; (2) A Case of Phlyctenular Keratitis and Pustular Episcleritis treated by Antistaphylococcic Injections.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Sir Malcolm Morris: Pruritus Ant.

Friday, May 8th.

Royal Society of Medicine (Clinical Section) (20, Hanover Square, W.).—8.30 p.m.: Cases:—Mr. Watson Cheyne: Spontaneous Disappearance of Recurrent Carcinoma of Breast. Sir Thomas Barlow and Mr. C. A. Ballance: Suture of the Brachial Plexus for Birth-palsy. Dr. Purves Stewart: Meningo-cortical Lesion illustrating Astereognosis. Dr. J. Barnes Burt: Three Cases of Gout showing Destructive Changes in Bone. Mr. C. H. Fagge: (1) A Case in which for Recurrent Sarcoma Parts of the Femoral Artery and Vein were Excised; (2) A Case of Aneurysm of the Common Femoral Artery, Excision of Aneurysm and of the Common Femoral Vein. Dr. G. A. Sutherland: Scleroderma. Mr. Albert Carless: Multiple Diffuse Lipomata. Mr. P. Maynard Heath: Caries of Spine with Clubbing of Fingers and Toes. Short Papers:—Mr. C. A. Ballance: A Case of Arterio-venous Anastomosis for Senile Gangrene. Dr. Norman Dalton: A Case of Leucoderma dying with Symptoms of Addison's Disease.

Society for the Study of Disease in Children (11, Chandos Street, Cavendish Square, W.).—5 p.m.: Dr. O. K. Williamson, Dr. Carpenter, Dr. P. Parkinson, Mr. Lett, Mr. R. Howard, and others: Cases and Specimens. Dr. W. Ewart: The Empty Bronchus Treatment by Posture in the Bronchiectasis of Children.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. S. Stephenson: Clinique. (Eye.)

Appointments.

Mill, G. Robertson, M.D.Edin., Honorary Medical Officer to the Birkenhead Maternity Hospital.

Reese, David William, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health by the Warmley (Gloucestershire) Rural District Council.

Vacancies.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary, £150 per annum, with board apartments, attendance, and washing. Applications to the Medical Superintendent.

Bucks County Lunatic Asylum.—Assistant Medical Officer. Salary, £150 per annum, with board and furnished apartments in the Asylum. Applications to the Medical Superintendent, the Asylum, Stone, Aylesbury.

Clinical Research Association.—Assistant Director of the Laboratory. Salary, £250 per annum. Applications to the Secretary, Clinical Research Association, Ltd., Watergate House, Adelphi, W.C.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

Lincoln General Dispensary.—Resident Junior House Surgeon. Salary, £175 per annum, with furnished apartments, fire, and gas. Applications to the Secretary, R. H. Lynn, 2, Bank Street, Lincoln.

King Edward VII. Sanatorium, Midhurst, Sussex.—Senior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance Applications to the Hon. Secretary, 19, Devonshire Street, Portland Place, London, W.

Carlow District Asylum.—Resident Medical Superintendent. Salary £350 per annum. Applications to John Keenan, Secretary, Joint Committee.

Benenden Sanatorium.—Medical Superintendent. Salary, £250 per annum, with board, lodging, and attendance. Applications to the Secretary, 54, Gray's Inn Road, London.

London County Asylum, Horton, Epsom, Surrey.—Assistant Medical Officer. Salary, £150 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London, S.W.

Births.

Toland.—On April 30th, at 18, Addington Road, Bow, London, the wife of C. K. Toland, M.B. (Hilda Bush), of a son.

Marriages.

Dodwell—Robertson.—On April 30th, at All Saints', Upper Norwood, Philip Rashleigh Dodwell, M.D., to Jessie, widow of Lieut.-Colonel F. W. Robertson, Royal Sussex Regiment.

Harris—Taylor.—On April 29th, at St. Edmund's Church, Rochdale, Herbert Harris, M.D., of Wellfield and Oaklands, Rochdale, to Edith Maud, only daughter of Edmund Taylor, of West Bank, Rochdale.

MacGregor—Brittan.—On April 30th, at St. Cuthbert's, Philbeach Gardens, Alexander Pendarves, son of James MacGregor, sometime Chairman S.E. Rly., and M.P. for Sandwich and Deal, to Mabel, younger daughter of the late Frederick Brittan, M.D., Clifton and Gwynfryn, Cardiganshire.

Welsh—Hearn.—On April 29th, at St. Michael's Church, Bray-on-Thames, Alfred P. Welsh, Alberta, Canada, to Edith Anne Olivin (Ida), youngest daughter of the late George M. Hearn, M.D., Woodville, Bawnboy, co. Cavan.

Deaths.

Beatty.—At Rockfell, Sutton, on April 30th, Frances Eleanor (Fanella), wife of Wallace Beatty, M.D., 38, Merrion Square, Dublin, and daughter of the late Samuel Edge, M.D., Granstown House, Queen's County.

Ellis.—On April 29th, at Halford House, Attleborough, Carteret George Ellis, L.R.C.P., M.R.C.S., aged 88.

Littlewood.—On May 2nd, at The Ropewalk, Nottingham, Joseph Littlewood, J.P. and M.R.C.S.

Newington.—On April 30th, at Uxbridge, John Siddle Newington, M.B., C.M., L.S.A., son of the late Robert Samuel Newington, M.R.C.S., L.S.A., of Gonahurst, aged 45 years.

Torry.—On May 1st, John Cooper Torry, M.D., M.R.C.P. Deeply mourned.—In Memoriam: In loving memory of Sarah, wife of the above, who died Oct. 25th, 1897.

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NOTES AND COMMENTS.

An Indignant Authority. IT is good to know that the fine old race of high Tory who objects to innovation in principle is not yet extinct, as it exercises a drag on the feverish progress of a restless age. We recollect with satisfaction that when the question of medical inspection of school-children was before Parliament, even in the highly-contentious Education Bill of 1906, not a soul was found in either House to oppose the clause enjoining on local authorities the duty of providing for such inspection. But the representatives of the nation reckoned without the Glendale Rural District Council. This important body has recently had under consideration the duty thus inconsiderately thrust upon it, and indignantly it recoils from the imposition. "The members of this Council," runs a resolution unanimously carried, "view with extreme disfavour the proposals of the County Education Committee with regard to the medical examination of children. They consider such a system would entail a large and useless expenditure of the ratepayers' money; they think it would be distasteful to very many of the parents; and they are, moreover, of opinion that if Parliament makes such an order, the funds to pay for the working of it should be provided out of the Imperial Exchequer, and not out of local rates. They hope the County Council will not adopt the proposal, and suggest a strong protest should be sent to Parliament against such a method of legislating." Thus speaks the thorough-going reactionary. We agree with the Glendale Rural District Council that innovation *quâ* innovation is to be resisted; but what a fine spectacle the gallant little body makes thus brandishing its oratorical fireworks in the face of the Mother of Parliaments!

Glendale contra Mundum. FAR be it for us to suggest a course of action to this indignant body, bleeding from St. Stephen's rods, but we can hardly imagine that the Front Benchmen on either side will be even as much impressed by this fiery protest as by the intimidating tactics of the Women's Social and Political Union. Still, there are times when "wisdom's triumph is well-timed retreat," and, considering the healthy state of public opinion which has been created in this subject, we fancy the Glendale Council would consult its own reputation best by pocketing the indignity which it is called upon to face, and submitting to the distasteful inevitable. There is much significance in the fact that educational authorities all over the country have gladly welcomed the addition to their burdens which the medical inspection of children entails. Though they have generally, in our opinion, followed a short-sighted policy of economy in the matter, they have only taken their marching orders from the Education Board which set its face so firmly against making medical inspection what it should be, namely, a dignified and fully-effective instrument for promoting the health and physical development of the rising generation. To make the service of medical officers to schools a subordinate one, catering only for recently-qualified men, and offering them no prospects, is an error that may yet bring the glow of triumph to the cheek of Glendale Rural District Council.

Crowner's Law. A MOST unpleasant incident occurred at Grantham last week. Dr. Sidney Firth, of that town, had under his care a three-months-old child whose mother had previously been attended at her confinement by a midwife, and on the child's death he gave a certificate to say that death was due to "premature ligature of the umbilical cord by an unqualified midwife." The Registrar refused the certificate and communicated with the Coroner, who ordered an inquest, detailing two other medical men to make the post-mortem. These gentlemen found that the umbilicus was healthy, but that the child had died of pneumonia. From the report of the case it is not quite clear if Dr. Firth was in agreement with his colleagues, and, if in agreement, he considered the pneumonia was due to any septic or other trouble connected with the cord. However, when asked in Court why he gave the certificate in the form quoted, he said he thought the matter ought to be brought to notice, and also that it was a subject to which he had given special attention in the course of 4,000 confinements attended by himself. Therefore, whether actually right or wrong, nothing surely could be plainer than that he acted in good faith and for the public good. The Coroner, however, accused him of the offence of giving a false certificate of death, and, in spite of Dr. Firth's protest, refused to withdraw the expression.

The Autocrat at the Inquest. IT is difficult to write with patience of such conduct on the part of the Coroner. That a petty official is given free licence to insult in the grossest manner a member of a learned profession, even assuming for the sake of argument, a mistake had been committed, is intolerable; and still more so that there is no remedy. The misuses of the coroners' position have gone beyond all bounds, and the need for appeal against their censures and their conduct is urgently needed. We believe coroners are the only judicial officers whose decision is final. By a curious constitutional anomaly they are independent persons responsible to nobody, except in a shadowy way to the Lord Chancellor. Even the judges in the

House of Lords can only arrive at a judgment when three members are sitting together, and the Lord Chancellor himself is responsible to Parliament. But the coroner, who is often a local man of no particular education or prestige, is a law unto himself, and before his authority everyone must bow. When the subject of death-certification is before Parliament, as it is bound to be sooner or later, the powers of these functionaries must be closely investigated—and curtailed. Unlimited power is good for no man, and it is not a little extraordinary that the coroner's should be, perhaps, the only position under the Crown which has escaped democratisation.

Fortunes in Medicines.

The will of Mr. A. B. Scott, senior partner in Messrs. Scott and Bowne, Ltd., proprietors of Scott's Emulsion, was proved last week at £174,947 in England, and 55,000 dollars in America. These handsome sums were accumulated, presumably, chiefly through the profits on the emulsion which bears the owner's name, and the circumstance has produced many comments on the fortunes which attend on advertising businesses in drugs and proprietary preparations of foods. With Mr. Scott's fortune have been compared those of Mr. Epps (of Epps's cocoa), £735,837, Senator the Hon. G. T. Fulford of Canada (of Dr. Williams' Pink Pills) £1,311,000, Mr. Charles E. Fulford (of Bile Beans) £67,187, Mr. Benger (of Benger's Food) £420,807, Mr. Mellin (of Mellin's Food) £114,812, Mr. Owbridge (of Owbridge's Lung Tonic) £112,214, Mr. Handyside (of the "Consumption Cure") £147,860, Mr. Beecham (of Beecham's Pills) £86,680, and Mr. Commans (of Areca Nut Tooth Paste) £119,218. We do not think it fair to class these names together, for whereas some, whom readers will recognise, are those of gentlemen of responsibility and upright standards, some of the others have been scoundrels of the most heartless character. But, taking the fortunes left by them all, they cannot but suggest comparison with fortunes left by medical men. Sir Andrew Clark is the only medical man of the last fifteen years who has from his earnings left a sum approaching these figures, and his fortune was as nearly as possible that of the poorest of those mentioned above, namely, Mr. Beecham. The pessimist, looking on the exiguous earnings of medical men, will be inclined to ask, *Cui bono?*

Malvern Hydro Again.

The "Malvern Hydro" case has entered on a new phase. Whereas after a lengthy trial Dr. Fergusson eventually obtained a verdict of the jury in his favour, with £7,500 damages, last week the Court of Appeal reversed the judgment into one in favour of the Malvern Urban District Council. This decision is very unfortunate for Dr. Fergusson. It is clear that the jury sided with him, but, owing to misdirection of the Judge and other circumstances, the verdict was not upheld, and now we suppose the House of Lords will be appealed to. What the costs of this trial are already we can only conjecture, and even their present magnitude will be considerably added to by further appeal. It is events and issues of this kind which keep private persons from litigation; indeed, many lay to heart the advice of the late Mr. Commissioner Kerr, to bear any injustice rather than go to law. The strain on the finances of public bodies is severe enough; in the case of the Malvern Council it is known that a special rate will be necessary, but in the case of private individuals the amounts are ruinous.

LEADING ARTICLES.

OUT-PATIENTS AT GENERAL HOSPITALS.

The question of the relation of the out-patient hospital system to the general practitioner has been before the profession for many years. In spite of much discussion, however, it cannot be said that any material alterations have taken place. Signs are nevertheless to be seen on all sides that ere long efforts of a strenuous and comprehensive nature may be made to settle this vexed question upon a common-sense basis. The cry of the public is naturally for free and easy access to the benefits afforded by the medical charities. The complaint of the general practitioner is that he is robbed of a legitimate field of practice by the indiscriminate charity of the hospitals, and, above all, by their adoption of the "pay system." The medical charities themselves are engaged in a competition—apparently reckless—wherein success is measured by the revenue brought to their individual coffers and by the number of patients whom they relieve. Surely there should be some way of ascertaining where the truth lies amidst these conflicting interests, and in arriving at some grounds of reasonable readjustment. Probably one of the most important discussions upon this subject that has ever taken place was held last week in South London, on April 30th last, attended by some 150 medical men. The occasion arose out of a letter by Dr. Silk, Secretary of the Watching Committee of the King's College Hospital, asking the British Medical Association to inquire locally as to the best means of protecting the interests of practitioners in the conduct of the out-patient department to be built at Denmark Hill, and of the admission of in-patients, and to secure an expression of the views of the practitioner on the question of paying patients. It is hardly necessary to remind readers that King's College Hospital some years ago determined to shift from its central position to a densely-populated South London suburb. As a result of negotiations, a South London Hospital Committee was formed, and they passed resolutions which were approved by the King's College Committee, as follows:—"That there be no issue of subscribers' letters; that sickness and poverty be the qualification for hospital treatment; that no charge be made for the treatment of any patient of the hospital, or for the supply of medicine or dressings; that urgent cases receive attention without inquiry; that each application for treatment, on his first visit, be seen by a registered medical practitioner, and attended to; and that the name, age, address, occupation, or position be entered on a register." At the meeting of April 30th a resolution was moved strongly disapproving of paying patients in hospitals, and expressing a hope that King's College would not adopt that system. This was carried *nem. con.* The next resolution urged King's College to adopt the system of admitting patients only on certificates from medical practitioners. This was shelved by an amendment:—

> "That this meeting of South London registered medical practitioners understanding (1) that at the present time a Royal Commission is inquiring into the Poor-law system; (2) that the King Edward Fund has decided to inquire into the system prevailing at the large general hospitals of London with regard to the

admission of out-patients; and (3) that for the uses of the sick poor resident in Camberwell and district there are already provided 26 hospitals, 5 infirmaries, 18 dispensaries, and 9 other institutions; considers that there has been no evidence offered of the necessity for any out-patient department at the proposed King's College Hospital on the lines of those at the large London general hospitals; regrets that a contract for £65,000 for such a department has been placed; and is of opinion that a small out-patient department to which will be admitted either for consultation or treatment only those recommended as suitable by registered medical practitioners as suggested in resolutions 6, 7, 8, 9 and 11, would amply meet the needs of the district; would fulfil all requirements for the education of students, and should be given a fair trial.

"That the Lambeth, Norwood, and Wandsworth Divisions, the Metropolitan and South-Eastern Branch Councils, as well as the Central Council and Representative Body of the Association, be urged to approve and support this resolution, a copy of which shall also be sent to King Edward's Hospital Fund, the Hospital Saturday and Sunday Funds, the Charity Organisation Society, King's College Hospital Board, the *Lancet* and *Journal*, and the Press generally."

The resolutions referred to in the above are:—

(6) That, on a second application for treatment, a patient bring with him a recommendation signed by a qualified medical practitioner, stating that such patient is a suitable person for hospital treatment.

(7) That such certificate be written on a form supplied by the hospital.

(8) That such certificate, duly filled up, be appended to each patient's prescription paper or attendance card.

(9) That the following be submitted to the authorities of King's College Hospital as the ordinary form to be supplied to patients attending the hospital for the first time.

(Medical certificate appended.)

(Reverse side of certificate):—

In signing this certificate, the practitioner is requested to keep in view two points:—

(1) That the applicant is not in a position to pay for treatment;

(2) That the case is, from a hospital point of view, suitable for treatment.

(11) That it would be satisfactory if a system could be arranged whereby obscure and interesting cases might be brought or sent with a note by practitioners for an opinion when a consultation fee cannot be paid.

This amendment was adopted, with seven dissentients, and on being put as a substantive motion, was carried unanimously. Space forbids further comment here, but it seems sufficiently obvious that an enormously important precedent has been established, both in the recognition of the rights of general practitoners to have a say in a matter so closely affecting their interests in the establishment of a huge local out-patient department in their midst, and, further, the establishment of a general organisation of all members of the local profession for the purpose of presenting their views in clear and articulate form.

FLIES AND DISEASE.

One of the problems of the future will assuredly be how to deal with flies in relation to disease. For years past it has been repeatedly demonstrated that flies can, and do, act as agents in the distribution of pathogenic bacteria. The peculiar habits of these insects have long been recognised with regard to food and *habitat*, more especially as concerns the deposition of ova, and their ubiquitous invasion of dwelling-houses. At the same time, a great deal remains to be learnt in this particular matter before it can be regarded as having been brought within the range of practical sanitation. The appearance of a report dealing with the subject by so able an authority as Dr. Hamer, Assistant Medical Officer of the London County Council, is, therefore, particularly valuable. We are now on the threshold of summer, the season in which the flies breed and multiply. The inquiry originated in a complaint made in a certain Education Committee as to the use of a piece of land near one of the schools as a depôt for street sweepings. It was found that in this case a nuisance was undoubtedly caused by the breeding of innumerable flies and their diffusion among neighbouring dwellings. These observations were extended so as to include such premises as cow-houses, a knacker's yard, stables, manure depôts, and so on. Observation centres were established at distances of 50 and of 200 yards, and at these spots flies were caught on pieces of paper smeared with honey-gum. The conclusions are definite enough on the point that the most productive centre for flies is in collections of horse manure, but that all other dust and refuse heaps act in a similar but minor degree. Their influence is felt inversely to distances up to 200 yards and more. Local difference of condition in individual houses determine the extent of their visitation by flies. Thus, rooms with dirty walls and ceilings, or where crumbs are scattered about and act as food, the presence of children, warmth, nearness to ground floor, open windows, are all favourable factors. Dr. Hamer draws no definite conclusions as to the relationship of flies to epidemic diarrhœa, on the ground of insufficient data. It is true that the flies and the disease increase together and attain their maximum about the same time, but the curve of the disease falls while the number of flies still remains excessive. Dr. Hamer remarks that, "on the whole, while it is not easy to reconcile the behaviour of the curves with an hypothesis that flies transmit diarrhœa, it must be admitted that the phenomena accord quite well with the supposition that both flies and diarrhœa stand in close relation with temperature." Sir Shirley Murphy, who presented the report, remarks aptly that, even in the absence of direct proof of disease-dissemination, the well-known habits of flies compel us to regard them with disfavour. We could go further than that and say that, in the light of numerous experiments and observations, it is impossible to doubt that flies in some cases convey disease directly or indirectly to man. In any event, the practical lesson in prevention is that no accumulations of filth or refuse of any kind should be permitted in towns or near houses in the country, and that flies should as far as possible be excluded from our dwellings.

CURRENT TOPICS.

The Apotheosis of the Spectacle maker.

When Charles I. granted a royal charter to the Worshipful Company of Spectaclemakers, in 1629, that body represented a well-defined craft. As a matter of fact, the science of ophthalmology, more especially that part dealing with errors of refraction, was as yet unborn. By degrees an accurate knowledge of visual optics and of the physiology and pathology of the complex structures and phenomena concerned, has been gradually evolved by the labours of medical men. There is probably no branch of medicine which more nearly approaches the level of an exact science than that of the ophthalmic surgeon, and no study that demands greater special aptitude and assiduous study. Yet the spectaclemakers have claimed the right to follow on the heels of the scientific ophthalmologist, and to be experts not only in the making of good spectacles, but also in the many abstruse fields of study with which the ophthalmic surgeon must be familiar. From a recently-published syllabus, it may be gathered that the Company hold three examinations. The first is a preliminary devoted to mathematics (including trigonometry), and to general optics, including the use of the ophthalmoscope, perimeter, chromometer, making of lenses—in short, a general survey of ophthalmic practice. In the final examinations the candidate has to show a knowledge of various instruments, such as the microscope and barometer, and a number of scientific points necessary to the scientific understanding of the human eye, which we should have thought absolutely unnecessary for the man who is to make our lenses and fit our frames. The Worshipful Company, however, is not content until it has imposed a high standard test which would strain the capabilities of many a well-trained medical man to satisfy, even after a long course of special study and experience. The subjects set forth are: "Static and dynamic refraction of the eye. Accommodation and convergence. The movements of the eyeball and muscles employed. The near and far points. The range and amplitude of accommodation and convergence. The course of light through the media of the eye alone and modified by spherical and cylindrical lenses and prisms. Emmetropia, hypermetropia, myopia, astigmatism, amisometropia, aphakia, presbyopia, asthenopia, amblyopia, orthophoria, heterophoria, strabismus, diplopia, the fields of vision and fixation, stereoscopy. Chromatism of the eyes—tests for the same—colour vision and blindness." We venture to assume that any spectaclemaker who mastered the foregoing—supposing that were possible for a man without careful medical training—would have little time to devote to his lenses. It would be no less absurd to demand of the ophthalmic surgeon a knowledge of the theory and practice of making spectacles. One of the most curious features of the whole farce is the presence of a member of the Ophthalmological Society upon the board of examiners. If the Society be content, who can differ?

Midwives in Chicago.

DURING the past year an important investigation into the training and conduct of the midwives of Chicago has been carried out by the Chicago Medical Society. In Chicago some 47 per cent. of the births are conducted by midwives, the highest proportions being among the Italian, Slav, and German communities. In the investigation particular attention was paid to the question as to whether the midwife was engaged in criminal practice or not. Of 223 licensed midwives, no less than 49 responded to the suggestions of the detective by promising to perform illegal operations! 41 others were regarded as giving rise to suspicion. It appears that whereas midwives must obtain a licence from the State Board of Illinois in order to practice in Chicago, yet once they have received their licences they are under no further control. Of course, the practice of abortion is in the United States, as in most other countries, a crime, yet it is treated with greater laxity there than elsewhere. Lombroso, years ago, referred to this toleration of abortion in America, stating that abortion was generally regarded as a perfectly justifiable, even laudable, method of limiting a family. The general education and fitness of the women for their duties was very unsatisfactory, many of them being dirty in the extreme. It is interesting to note that the highest efficiency was found among women trained in European schools and maternities. We are accustomed to grumble at the conditions of practice by midwives in these countries, but, at any rate, they have not reached the level of Chicago.

Asleep at his Post.

THE theory which has been put forward by Colonel Yorke, the Board of Trade Inspector, to account for the recent accident at Shrewsbury, has caused, naturally enough, a considerabie sensation among the travelling public. The suggestion is that the engine-driver was asleep at his post. There is, of course, in this particular case, little to support the theory as a positive explanation beyond the absence of any other explanation, and the fact that the driver had been on duty the previous night. However, if we are to believe Professor James and the Pragmatists, any explanation is true till a better is found, and so in the absence of another we may admit the truth of Colonel Yorke's hypothesis. Judged in the abstract, indeed, there is nothing improbable in it, for even in such a position as on the footplate of an engine a man may for a moment be overcome with sleep, and that moment may happen to be the critical one. Many of us can recall sleep suddenly overpowering us even during moments of fixed attention, the sleep, perhaps, only lasting for a few seconds, and being unnoticed by others. For instance, on horseback, or even in teaching a class, one recalls lapses into unconsciousness of probably a few seconds' duration. To a man accustomed to the somewhat monotonous work of driving an engine there is nothing to prevent a sudden lapse of the sort. The practical lesson to be learnt is that greater precautions are necessary to prevent the possibility of railway servants, while suffering from severe fatigue, being permitted to undertake duties of great responsibility.

Arsenite of Copper Poisoning.

OF late years a vast amelioration has taken place in the condition of workmen engaged in "dangerous" trades. That there is room for improvement, however, is unfortunately only too obvious, in spite of the unwearied efforts of the Home Office and its inspectors. A coroner's inquiry into the death of a man engaged in some colour works points to an unfortunate laxity somewhere along the line of prevention. Deceased had been engaged in grinding colours for one firm during the past six years, and for some weeks had been working overtime on green paint, otherwise arsenite of copper. The verdict of the jury was that deceased "died from coma and convulsions, and gastro-enteritis, set up by his work with arsenite of copper." It appears that some time before he was compelled to leave off work he complained of a sore on the foot and of his nose being affected. It seems pretty clear that under any efficient system of supervision a man working on so dangerous a material would have been promptly suspended from his occupation. The situation becomes more than ever inexplicable after the admission of the foreman of the works that ten or twelve men had been invalided since Christmas last through working on the same stuff. No doubt the circumstances will receive due attention at the hands of the Home Office.

The New Fellows of the London College of Physicians.

Some time ago we felt it our duty to criticise somewhat adversely the methods, or what appeared to be the methods, of the Royal College of Physicians of London in the allotting of their Fellowships. It was pointed out that this purely honorary distinction was in many instances conferred upon comparatively young or little known men having strong College influence, to the exclusion of members of recognised standing in the provinces. We are glad to note that a fresh policy appears to have prevailed in the councils of the College, if we may judge from the recently announced list of Fellows. The names are:—

> The following members were elected as Fellows of the College: Robert Charles Brown, M.B. Lond.; George Ogilvie, M.B. Edin.; Charles Henry Cattle, M.D., Lond.; John Elliott, M.D. Lond.; Guthrie Rankin, M.D. Glasg.; Theodore Fisher, M.D. Lond.; Robert James McLean Buchanan, M.D. Vict.; Arthur Francis Stabb, M.B. Camb.; William Henry Butter Stoddart, M.D. Lond.; Arthur Latham Ormerod, M.D. Oxon; Walter Langdon Brown, M.D. Cantab.; Alfred Ernest Russell, M.D. Lond.; Reginald Cecil Bligh Wall, M.D. Oxon; Thomas Wardrop Griffith, M.D. Aberd.; and Leonard Stanley Dudgeon.

The College is to be congratulated on this change of policy, which can hardly fail to stimulate a somewhat flagging interest. The existence of a purely honorary diploma, conferred without examination, constitutes a curious anachronism which it would be hard to defend seriously when the whole question of medical qualification is brought under the searchlight of public inquiry, as must one day happen.

PERSONAL.

The King of Norway has conferred the Grand Cross of the Order of St. Olav on Sir Francis Laking.

Lieutenant Colonel Falvey, R.A.M.C. (retired) has been placed on the Commission of the Peace for County Donegal.

Dr. Egeberg, Physician in Ordinary to the King of Norway, has been created a Commander of the Royal Victorian Order.

Dr. A. J. Laird, late medical officer for Crewe, has been appointed medical officer for Cambridge, at a commencing salary of £500 a year.

Dr. Ian Macdonald, who resides in Spain, has been elected a corresponding member of the exclusive Société de Pathologie Exotique of Paris.

Private C. W. Wirgman, of the London Scottish, who won a first prize in the competition for the *Daily Telegraph* Cup, is a medical man in practice as an ophthalmic surgeon.

The Edmonton Education Committee has appointed Dr. F. E. Rock, assistant medical officer of health at Huddersfield, as medical inspector of schools, at a commencing salary of £250 a year.

The salary of Dr. Bostock Hill, of Birmingham, has been increased by £250 a year in respect to his duties in connection with the medical inspection of school children.

Dr. T. W. H. Garstang will open a discussion on the "Inspection of Dairies and Cowsheds" at a provisional sessional meeting of the Royal Sanitary Institute to be held at Shrewsbury on Saturday, May 23rd.

Dr. Meredith Young has been the recipient of no less than five presentations from colleagues at Stockport, on leaving that town to take up his new duties as Medical Officer of Health of Marylebone.

Dr. B. W. Housman has been presented with a handsome rose-bowl and other gifts by his colleagues of the Stockport and District Medical Society and the local Division of the British Medical Association on leaving the district.

A number of persons connected with the Hertford General Infirmary have presented Dr. J. T. Trasker-Evans with a handsome tea and coffee service and a cheque for £42 on his resignation after 29 years' active work at that institution.

Mr. Watson Cheyne, C.B., F.R.C.S., will deliver the Wightman Lecture before the Society for the Study of Disease in Children on Friday, the 22nd inst.; his subject will be "The Defensive Arrangements of the Body as illustrated by the Incidence of Disease in Children."

Lord Cheylesmore has received from an anonymous donor, through Mr. William Hern, dental surgeon to the Middlesex Hospital, the sum of £500 in response to his recent appeal on behalf of the fund for the maintenance of the Cancer Investigation Department of the hospital.

Professor David W. Finlay, M.D., LL.D., F.R.C.P., will take the chair at the dinner of the Glasgow University Club at the Trocadero on Friday, May 29th. The hon. secretary of the club is Mr. Craig Henderson, of 2, Paper Buildings, Temple, E.C.

Sir Frederick Treves, Bart., has promised to take the chair at the jubilee dinner of the Royal Dental Hospital, Leicester Square, to be held next month at the Hotel Cecil. The debt of £47,404 on the building weighs heavily on this institution, and Sir Frederick is making a public appeal on its behalf.

The will of Dr. Henry R. Silvester, author of the Silvester method of resuscitating the apparently drowned, has been proved at £25,415. The deceased was on the committee of the Royal Humane Society, in which he took an absorbing interest.

A series of lectures under the auspices of the Women's National Health Association was inaugurated on May 6th by her Excellency the Countess of Aberdeen in Dublin. There was a large attendance. His Excellency the Lord Lieutenant presided. Their Excellencies were accompanied by Captain Coates, A.D.C., and Sir W. J. Thompson, M.D.

Dr. A. W. Martin, the medical officer of health for Gorton for 21 years, has issued his yearly report to the District Council, and this will be his last, seeing that the district becomes a part of Manchester in November.

The Council of the Manchester University having decided on the appointment of a second Professor in the Department of Medicine, one of the Chairs will be devoted to Clinical Medicine and the other to Systematic Medicine. Dr. Graham Steell, now Professor of Medicine in the University and Senior Physician in the Royal Infirmary, will hold the Chair of Clinical Medicine.

Dr. George R. Murray, who till recently held the Heath Professorship of Comparative Pathology in the Durham University, has been appointed Professor of Systematic Medicine. Under the agreement entered into between the University and the Royal Infirmary, Dr. Murray becomes on his appointment a member of the honorary staff of the Royal Infirmary.

A CLINICAL LECTURE
ON
EARLY DIAGNOSIS IN SURGICAL DISEASES OF THE KIDNEY, WITH SPECIAL REFERENCE TO PHYSICAL METHODS OF EXAMINATION.

By **DAVID NEWMAN, M.D., F.F.P.S.G.,**
Surgeon, Royal Infirmary, Glasgow.

(Concluded from page 498.)

4.—Cystoscopy.

The objects in view in making a cystoscopic examination in renal cases are:—

(1) To eliminate lesions of the bladder from the diagnosis.

(2) To reveal the presence of any foreign body, calculus, plug of muco-pus or blood-clot impacted in the mouth of the ureter.

(3) To compare the appearance of the ureteral orifices.

(4) To observe the size, character and frequency of the urinary shoots from each ureter.

(5) To detect the absence of a ureter orifice on one side, or of a flow of urine from one ureter only.

The following observations have a very direct bearing upon cases where important questions require to be answered very definitely and clearly when operative interference is contemplated.

In a case where the evidence points to a renal lesion, but neither the symptoms nor the physical signs clearly indicate the organ involved (for example, hæmaturia from a small tumour in the kidney), the cystoscope will show the side from which the blood is escaping. When there is a doubt whether the disease is limited to the kidney or also involves the lower urinary organs (tuberculosis), the cystoscope will show the extent of the lesion in the bladder. In some cases of renal calculus the pain is referred by the patient, not to the kidney containing the stone, but to the position occupied by its healthy neighbour (reno-reflex pain). When hæmaturia is present, blood will be seen escaping from the ureter corresponding to the kidney containing the calculus, and when there is no bleeding, an irritable condition of the lips of the ureter will betray the site of the disease.

One kidney is known to be diseased. Is the other functionally active and fit to do double duty when called upon? By watching the character, size, and frequency of the shoots from each ureter, a very clear idea can be arrived at as to the activity of each kidney.

The majority of surgeons recognise the use of the cystoscope in its application to vesical disease, even although they may not practise its use; but few fully appreciate its value in gaining information regarding renal lesions. It should be a routine practice to make an examination of the bladder of all renal cases prior to operation, almost as regularly as examination of the urine. By so doing many fallacies in diagnosis and errors in treatment will be avoided.

In relationship to diseases of the kidney, examination of the bladder with the cystoscope has proved of great practical value, not only in a negative way by eliminating lesions of the bladder from the diagnosis, but also by giving positive evidence of the presence of disease in one or both kidneys. When nephrectomy is contemplated on one kidney, a knowledge of the presence and functional activity of the other is of primary importance. From ocular inspection, if carefully carried out by an educated eye, exact conclusions may be drawn which cannot be arrived at by other means, and the course of treatment can be decided upon early in the course of the disease. By so employing this method, most valuable time may be utilised, which would otherwise be wasted, waiting for other evidence to prove the nature of the renal lesion. Too often, when we wait until the symptoms are sufficiently significant to form a basis for diagnosis, the disease has advanced beyond our power to remedy.

Cystoscopy, when conducted with aseptic precautions, is unattended with danger, and is comparatively easily carried out in both sexes, but, for obvious reasons, with greater facility in the female.

Prior to a cystoscopic examination, careful inquiry should be made into all the circumstances of the patient. In those suffering from serious disease, and in whom the introduction of an instrument is likely to be followed by aggravation of the symptoms, cystoscopy should not be resorted to unless the patient is prepared to submit to an immediate operation, should it be deemed necessary.

In health the urine collects slowly above the closed sphincters at the orifices of the ureters, and at intervals is thrown by squirts with considerable force into the bladder. The length of the intro-missions depends upon the activity of the kidney. Under favourable circumstances, about 10 to 15 drops are ejected alternately from each ureter every 30 or 40 seconds. By carefully watching the line of the ureter, the portion coursing through the wall of the bladder, the part immediately above the sphincter, will be seen gradually to distend.

Immediately before the urinary squirt appears, the expanded duct, looking in form not unlike a miniature engorged leech, is drawn slowly upwards and outwards. It gives a sudden wriggle, its muscular fibres contract, the sphincter is forced open, and the contents are ejected. The urine, as it is thrown into the bladder, forms a distinct jet which shoots downwards and inwards. The spurt occupies about two seconds. The form of the spout can be seen most easily in cases of renal hæmaturia. The aspect of the orifices of the ureters individually, and in relation to each other, is important to observe. It may be stated as a general observation that when the appearance of the orifice of one ureter is altered, while that of the other is normal, the renal lesion is on the side of the morbid ureter. And, again, if the number of urinary shoots be counted within a given time, as they occur from each side, and a marked difference is observed, the side on which most shoots are seen is either the site of considerable local irritation or is the most active organ functionally. When due to morbid irritation, the shoots not only succeed one another rapidly, but they are of short duration, and the urine which escapes is small in quantity; whereas in increased functional activity the shoots, in addition to being frequent, are prolonged, and the amount of the urine is large. Instead of coming in regular and distinct jets every 20 or 30 seconds, the force of the shoots may be diminished. The manner in which the urine enters the bladder may be so slow as to be hardly perceptible. In stricture of the ureter, or when its lumen is obstructed by a stone, the urine may dribble into the bladder, just as it dribbles out of it in enlarged prostate or in stricture of the urethra. In describing the orifices of the ureters we may speak of the inner and outer lips, and the upper and lower angles. In many cases the orifice of a ureter may not be visible, but it is not necessarily to be concluded that the orifice is absent or displaced; it may be merely hidden—at one examination easily seen, at another not to be found.

In some cases certain facts can be ascertained regarding surgical renal lesions by an examination with the cystoscope. For example, in many cases of renal hæmaturia, and in some cases of pyuria, the escape of blood or of pus from a ureter can be readily seen by the cystoscope. When the amount of blood present is small, but still sufficient to perceptibly stain the urine, the cystoscope is, in the male, more reliable than the ureter catheter, the introduction of which into the inflamed ureter may cause a little bleeding and so vitiate the value of the observation. Pus may escape in different ways, according to the consistency of the fluid In many cases the quantity of pus discharged from the kidneys is small, and its escape so irregular that the cystoscope fails to establish from which kidney the purulent urine flows. When, however, the diseased kidney is secreting little urine, and the quantity of pus is considerable, the discharge may be readily seen escaping from the ureteral orifice. In some instances it is forced out of the ureter in form and appearance not unlike a cheese maggot, and little masses of purulent discharge may be seen on the floor of the bladder curled up like dead maggots, unmixed with the solution introduced for the cystoscopic examination, but when the bladder contracts to expel its contents, the force required to drive them out causes the purulent masses to lose their form and become intimately mixed with the fluid. In this way they are deprived of their characteristic form, which can be observed only while they are within the bladder. The appearance of more or less slight effluxes indicates that the kidney from which they come has ceased to be functionally active. On the other hand, when the pus is seen to escape in distinct shoots, the kidney may be presumed to be still secreting a considerable quantity of urine.

From what has been said, it will be seen that many of the objects aimed at by using ureter catheterisation may be obtained more easily and with greater safety by skilful use of the cystoscope.

Cystoscopic diagnosis of renal disease may be summarised in the following conclusions:—

(1) When one ureteral orifice is altered, while the other is normal, the renal lesion is on the side of the morbid ureter.

(2) When the urinary shoots are more frequent on one side than on the other—(*a*) greater functional activity is indicated by the shoots being uniform in size and regular in rhythm; (*b*) undue irritation of the kidneys is to be inferred when the shoots, while more frequent than normal, are irregular in rhythm, unequal, and small in size; (*c*) stricture, stone or chronic ureteritis should be suspected when the shoots are distorted in form or irregular in amount.

(3) When the urine does not escape in distinct jets —(*a*) dilatation of the ureter without paralysis of the sphincter is indicated when the urine dribbles into the bladder at intervals; (*b*) destruction of the sphincter action is shown by the urine flowing into the bladder almost continually.

(4) The character of the morbid fluids escaping from the ureter, or of clots, etc., occupying the opening, denotes the morbid changes taking place in the corresponding kidney.

(5) The deformity of the orifice also indicates the character of the renal disease—(*a*) pin-head contraction (chronic inflammation or impacted calculus); (*b*) elongated and distorted (distension of renal pelvis or infected nephritis); (*c*) swollen or pouting (prolonged but not acute inflammation or renal parenchyma); (*d*) dilated (advanced tuberculous or calculous pyonephrosis); (*e*) U-shaped (significance doubtful—usually denotes prolonged irritation of renal pelvis).

5.—THE METHYLENE BLUE TEST

is of value not only in enabling the observer to more readily see the urinary shoots, but also in testing the functional activity of the excreting organs.

The relative functional activity of the two kidneys can most easily be ascertained by employing the cystoscope. When methylene blue is administered by subcutaneous injection of 1 c.m. of a 5 per cent. sterilised solution of methylene blue, the blue colour should first appear in the urine about an hour thereafter, and increase in depth for about six hours, and then, gradually diminishing in intensity, disappear entirely within 40 to 42 hours. When the kidneys are diseased the colour takes a longer time to appear, the colouration is not so intense, but lasts much longer. Elimination is delayed. This may apply to one or both kidneys. A healthy, active kidney eliminates the blue rapidly and in large quantities, whereas a defective or diseased organ excretes it in small quantities or not at all, chromogen alone escaping, the presence of which may be detected by boiling the urine, after acidulating with acetic acid. By comparing the colour of the shoots from each ureter, say, three hours after the injection has been given, an estimate of the functional activity of each kidney may be obtained.

6.—RADIOSCOPY.

The service rendered to the surgeon, not only in detecting the presence of a stone, but also in locating the concretion in the kidney or ureter by the employment of Röntgen rays, is too well-known to require remark. At first the results were disappointing, but now improved methods of working, together with larger experience in interpreting what is seen through the fluorescent screen, enables correct conclusions to be arrived at.

Many substances opaque to ordinary light, such as wood, cardboard, cloth, and the soft tissues of the body, are translucent to these rays, but while the rays pass through such substances, to the unaided eye they do not affect the sense of vision, although they at once act upon the ordinary photographic plate, and they produce fluorescence in certain substances, such as the platino-cyanides. In searching for renal calculus, we take advantage both of the photographic plate and the fluorescent screen. These methods have the advantage that they not only demonstrate the presence of stones, but they also afford valuable information as regards their number, position, shape and size. All matter is transparent to X-rays, and, roughly speaking, the penetration is in inverse ratio to the density of the substances. Dense, heavy materials, such as lead and silver, are almost impenetrable, while aluminium is translucent. Bone is opaque compared with soft tissues, but transparent as compared with a stone or metallic substance. So it is with renal calculi. Some are more opaque to the rays than others. We find that those composed of oxalate of lime give the deepest shadow, uric acid the faintest, while the shadow of phosphatic stones occupies an intermediate position. Hence the chemical composition of the stone, and the greater or lesser opacity associated with it, are most important factors, upon which the success or failure of the skiagraph depends. By improvements in apparatus and in *technique*, now even uric acid calculi can usually be detected by the fluorescent screen, which is more accurate in the hands of the skilled observer than the skiagraph. The skiagraph, however, has the great advantage of being a permanent record, while the other is literally a fleeting shadow. There are many dangers of obtaining false shadows which are liable to be mistaken for those of stone, and we must admit that the difficulties of obtaining a shadow of calculi *in situ* in the kidney or ureter are due to many causes. It is by recognising these difficulties that we have practically overcome them, and steadily the percentage of our failures is becoming less.

In each individual case the tension of the rays and the length of exposure must be carefully considered, and before the shadow photograph is taken, or, better still, while it is being taken, the penetrating power of the rays must be observed through the fluorescent screen. Before taking a photograph of the shadow, it should be carefully located by the fluorescent screen and its position marked by crossed wires which come out in the radiograph. The wire can then be removed and the relation of the stone to the cutaneous surface fixed by markings with nitrate of silver.

Errors in diagnosis may be considered in two divisions—those in which a shadow is discovered and believed to be due to stone, but the surgeon fails to find it, and those in which the stone is removed by the surgeon, but no shadow betrays its presence. The most common cause of false shadows is the presence in the abdomen or its walls of substances with a high absorptive index, such as fæcal matter, fruit stones, the presence of bismuth salts, enlarged and calcified glands, old purulent accumulations, cicatrices and phlebolites.

The most common and characteristic position for a stone is in the angular space formed by the eleventh rib and the spinal column. Very often the shadow of the stone is covered by the last rib. A clearly defined shadow in this position is almost certainly due to calculus, but it must also be borne in mind that tuberculous material may give a shadow. The margins of the shadow, however, are indistinct, although the central portion may be as deep as that given by a stone. It is when shadows are found in other regions that doubt arises. Those due to calculous matter may, of course, be found in any part of the urinary tract, and the more closely the situation of the shadow corresponds to the anatomical position of the pelvis of the kidney and the ureter, the greater the suspicion of stone.

It is, therefore, useful in doubtful cases to pass a metal catheter into the ureter, and photograph it along with the stone But, on the other hand, a shadow well outside the line of the ureter may be caused by a stone, although this is a rare occurrence.

NOTE.—***A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Robert A. Fleming, M.A., M.D., F.R.C.P.Ed., Physician to the Edinburgh Royal Infirmary, Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School, Examiner in Medicine, Aberdeen University. Subject: "Sciatica."***

ORIGINAL PAPERS.

FOUL BREATH: ITS CAUSES, PATHOLOGY AND TREATMENT. (*a*)

By ANDREW WYLIE, M.D.,

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MR. PRESIDENT AND GENTLEMEN,—Having received the honour of an invitation to read a short paper, it has occurred to me that some remarks on the subject of foul breath might possibly interest the members of this Society.

I hardly dare lecture on any disease connected with the throat or ear in the presence of our President, more especially after his able address before this Society at the beginning of the session. The subject of foul breath, however, although closely allied to the work of the laryngologist and rhinologist, is also one which closely concerns many other forms of practice.

Foul breath is such a source of annoyance to the individual, such a discomfort to friends, acquaintances and fellow-workers, that to be able to treat it, not only temporarily, but to get rid of it altogether, you will confer, not only a boon on your patients and your fellow-men, but you will also earn their gratitude.

Twenty minutes is a short time in which to discuss this important subject, and the fringe of it can only be touched. Arising, as this symptom does, from many different causes, I propose briefly to consider these, and to indicate the treatment appropriate to the several conditions.

Fœtor of the breath may be either purely subjective or entirely objective, or the odour may annoy both the patient himself and those with whom he is brought into contact.

When subjective it is, of course, experienced by the patient alone. Examples are met with in the peculiar sensations of smell experienced by patients suffering from perityphlitis, chronic constipation, obstruction of the bowels, liver abscess, malignant disease of the intestinal canal. Of the same order also is the "curious burning smell" noticed by patients suffering with disease of the brain and associated with abscess or tumour in the vicinity of the temporo-sphenoidal lobe. (*b*)

Objective fœtor is observed by persons associated with the patient. In most instances the patient is himself also conscious of the odour. This is due to many causes which we may now discuss.

There are different types of fœtor.

(1) The putrefactive type is the commonest. Its odour is like decomposing cheese. It occurs in such diseases as that form of rhinitis in which the pus has become hard and cheesy, a condition associated usually with disease of the antrum, and called caseous rhinitis. A similar odour is found also when decomposing material collects in the naso-pharynx, pyriform fossæ and tonsil crypts, and in tertiary specific disease of the nose and pharynx.

(2) The sulphuretted hydrogen type, which we all know from old association with chemical laboratories, is peculiarly obnoxious, and for this reason it is a favourite implement of warfare at political meetings. It occurs in gangrene of the lung, in bronchiectasis, etc., and it is often so pungent as to cause the friends and even the nurse to avoid the sufferer.

(3) The garlic type, which every traveller knows who has visited Spanish or Italian countries, or who has associated with individuals who eat onions. This odour is also apparent in those who take such drugs as bismuth and arsenic regularly. Ladies who take arsenic for cosmetic purposes should be warned of its deleterious effect.

(4) The sweetish type is one of the diagnostic signs of glycosuria, and is generally associated with the presence of yeasts, etc., in the throat and nose; also in beer drinkers.

(5) The toxic or hepatic type is associated with various forms of bacteria, such as the bacillus butyricus, which is found in the mouth, nose and fauces of dyspeptic "bilious" people and also in those who do not properly masticate but "bolt" their food in an irrational manner, or in those who do not clean their teeth.

Fœtor of the breath may further be classified according to the different regions which are responsible for its source. These are the mouth, nose, naso-pharynx, larynx, and lungs. Fœtor is also due to general constitutional disturbances.

The common causes of foul breath may thus be briefly summarised:—

(1) Diseases of the nose and its accessory cavities, causing nasal obstruction and mouth breathing.
(2) Imperfect deglutition.
(3) Oral and lingual affections.
(4) Diseases of the teeth and gums.
(5) Diseases of the tonsils.
(6) Chronic suppuration of the middle ear.
(7) Affections of the naso-pharynx.
(8) Diseases of the lung.
(9) Foreign bodies in the mouth, nose, pharynx or larynx.
(10) Constitutional causes.

Nasal obstruction, or mouth breathing, may be due to adenoid growths, enlargement of the turbinal bodies, deviations of the septum, and spurs or outgrowths on the septum. All these cause not only imperfect ventilation through the nose, and the collection of more or less putrid secretion, but they also give rise to mouth breathing, perverted secretion, and dryness of that region.

Some diseases of the nose cause a specially pronounced odour—for example, rhinitis sicca, which arises when the secretion is impaired or diminished in quantity and quality. A similar condition is found in atrophic rhinitis, where actual structural degeneration of the mucous membrane has taken place; in caseous rhinitis, where the pus and *débris* are charged with various forms of moulds, yeasts, and putrefactive bacteria, such as *Aspergilli torulæ* and the *Bacillus butyricus*. In chronic diseases of the accessory cavities where pus is lodged in the maxillary antrum, or the ethmoidal, frontal, or sphenoidal sinuses, and in tertiary syphilis with necrosis of the ethmoid or vomer. In septal perforations, whether from operations, from tuberculosis or syphilis, there is also fœtor, and the same is found when polypi and sinusitis co-exist. Generally speaking, fœtor may be present in any malformation of the nose which interferes with free discharge and proper ventilation.

Another disease attended with fœtor is chronic epistaxis, especially the "leaky" form, which is occasionally found in plethoric individuals and in those suffer-

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(*a*) **Paper read before the West London Medico-Chirurgical Society March 6th. 1908.**

(*b*) **Hughlings Jackson and Purves Stewart, "Brain," 1899; Campbell Thomson, *B. M. J.*, December, 1907.**

ing from portal obstruction, also in dysmenorrhœa. This form of epistaxis also occurs in cases where fibroma or sarcoma are present. The blood adheres to the mucous membranes, soon becomes septic, and so creates an unpleasant odour.

Before dismissing nasal disease as a cause of foul breath, I wish to mention a form of nasal obstruction common in adolescents which is not a real obstruction. The patient experiences the sensation of blocking. This condition arises from desiccation of the mucous membrane in roomy or wide nostrils, whereby its sensitiveness is lost, and the friction of the air current cannot be felt. It may be the result of a too energetic treatment of the turbinals by the galvano-cautery, or it may be due to constitutional causes, such as anæmia; it also arises from neglected infantile snuffles, or there may be an unusually patent channel. In all these conditions there is deficient secretion or exudation, and in this way there is afforded full opportunity for bacterial growth.

Imperfect deglutition causes accumulation of food in the mouth, round the teeth, in the buccal pouch, the tonsils, behind the soft palate, in the pyriform fossæ of the larynx, and in the glosso-epiglottic and hyo-epiglottic fossæ. Such conditions generally arise from paralysis of the muscles, especially that form which follows diphtheria or any of the fevers. It may also occur from habitual carelessness in swallowing. Some people do not completely empty the mouth before refilling it, and are very inattentive to oral hygiene. In all these instances the retained food undergoes decomposition, and the fœtor so produced contaminates the breath.

Oral causes of fœtor should be divided into two great classes—viz., those connected with the tongue and those connected with the teeth.

As regards the lingual causes, first may be mentioned a furred tongue. This may be merely a local manifestation of disturbed digestive functions, or it may be a local trouble by itself. There are several varieties of furred tongue.

(1) The hypertrophied condition of the papillæ seen in "black tongue" is a pigmentary deposit in elongated papillæ which are undergoing keratinoid degeneration. The cause of this condition is not known.

(2) The conditions in which accumulations of bacteria, such as yeasts, proteus vulgaris leptothrix, etc., congregate on the tongue.

(3) The state in which a superficial thickening of the epithelium has taken place, and which varies very much in character. When this condition is pronounced we have what is called leukoplakia, recognised by Fournier, Butlin, and others as frequently precancerous.

There are also:—

Ulceration of the tongue, which may simply be due to the irritation of a tooth or a symptom of digestive disturbance; when deep ulceration is present, is most likely due to the breaking down of a malignant growth or to tubercle or syphilis. The diagnosis in some cases is difficult, but as a rule tubercular ulceration of the tongue is shallow and not deeply excavated. It has well-defined edges and occurs without much pain, while specific and malignant ulcerations are generally painful. Histological examination of the scraping from these ulcerations will settle the diagnosis. (*a*)

As regards the dental causes, we have:—

(1) *Pyorrhœa alveolaris* (Rigg's disease), which may be acute or chronic, and often exists without actual disease of the teeth, being generally referred to as "spongy gums."

Tartar, and, later on, pus is formed and collects between the gum and the tooth, and little pockets result which lead to recession of the gum. The roots of the tooth are exposed, and the affection may result in caries. Administration of mercury often causes this condition. Pyorrhœa is associated with various bacteria, of which *Spirochæta refringens* and *B. fusiformis* are the most prominent.

(2) Decomposing food, tartar or pus between the teeth and at the seat of caries.

(3) Caries of the teeth and retained stumps.

(4) Imperfect and cheap artificial dentures and neglected hygiene.

As regards the tonsils:—

(1) The most common cause for tonsillar fœtor is a change which takes place in the lacunæ or follicles. These become filled with pearly masses of dead epithelial *débris*, and loaded with bacteria or particles of decomposing foods. Such lacunar accumulations can be expelled by pressure, and are thus distinguished from a keratosis which is closely adherent; in this latter also there is not necessarily any odour.

(2) Acute ulceration of the tonsils is not associated with any definite type of fœtor; it is in the more chronic forms where the odour is so unpleasant.

(3) Malignant growths and tertiary syphilitic disease of the tonsil itself do not cause fœtor at first, but these diseases soon invade the surrounding structures, which interferes with deglutition and favours bacterial activity; the fœtor then becomes pronounced.

As regards chronic suppuration of the middle ear, this often causes a fœtid breath by the stinking pus getting into the naso-pharynx through the Eustachian tube, and keeping the naso-pharynx (which in healthy states is sterile) in a septic condition.

Affections such as adenoid growths, simple and malignant neoplasms in the naso-pharynx, cause a fœtid breath by interfering with the proper movement of the parts, by accumulations of secretions and by obstructing the natural ventilation and drainage.

In the lungs putrefactive changes take place in such diseases as bronchiectasis and pulmonary gangrene, causing a most pungent and offensive odour. The smell of bronchiectasis is a mixture of sweetness and stink.

Foreign bodies in the nose, pharynx and larynx cause a most offensive odour, since they obstruct ventilation and drainage and excite inflammatory processes and sepsis. A familiar cause is that of foreign bodies, chiefly fish and splinters of meat bone, becoming embedded in the tonsil or pharynx. Pieces of shells, buttons, beads, plum stones, etc., in the nose cause discharges, crusts and odours; especially is this true if foreign bodies are allowed to remain and become encrusted so as to form rhinoliths. Foreign bodies in the larynx also cause a most offensive odour; typical examples of false teeth in the larynx are described in several text-books, and some years ago, in my own practice, a gentleman, after having several teeth extracted, experienced for three months a peculiar offensive smell, until one morning during a paroxysm of coughing, some pus and a stump of a tooth were expelled.

The last series of causes which I will enumerate are the constitutional ones, and under this heading I place:—

(1) Gastro-intestinal derangements and dyspepsia, especially those which are associated with dilatation of the stomach.

In patients troubled with severe chronic constipation there is a peculiar sickly, almost fæcal odour from the breath.

Spirit drinkers have quite a different odour from beer drinkers; the former is of a vinegar type, while the latter have the characteristic smell of stale malt liquor.

The breath of cigar and pipe smokers has a different smell according to the favourite form of using tobacco.

(2) Different varieties of glycosuria cause a sweetish odour to the breath.

(3) Menstruation always causes some change in the breath; in some individuals it is so pronounced that they can hardly mix with society during that period.

(4) During lactation also in some patients there is a marked odour from the breath.

(5) Drugs have a great influence on the breath, and it is one of the signs to watch for in their administration. Bismuth and arsenic have been already referred to. Lead and mercury produce a well-known effect on the gums, and in extreme cases much fœtor. All preparations of sulphur cause a characteristic sulphuretted hydrogen smell of the breath. Copaiba and valerian have a cats'-meat smell; iodoform a

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(*a*) See case reported by Author, Medical Press and Circular, December 12th, 1906.

rancid smell; and belladonna and opium diminish secretion and cause a dryness of the mucous membrane to which bacterial activity may be superadded.

(6) Occupations have also a great deal to answer for as regards foul breath. Milkmen, or those continually working in milk, have a peculiar odour owing to constant contact with the *B. butyricus.* The reason of this is probably the direct transference of the bacillus by the fingers to the nose, with consequent rhinitis. The same theory applies to workers among skins and furs who have a peculiar animal odour. Those who work with phosphorus, lead or brass, have a peculiar metallic odour from their breath, which is associated with rhinitis and "spongy" gums.

(7) Many nervous diseases cause an odour from the breath, such as is found in paralysis and apoplexy. With the foul breath which frequently follows a hemiplegic attack you are doubtless quite familiar. Mental dulness and physical disability prevents proper cleansing of the lips, teeth, and tongue; thus sordes accumulate and fœtor is produced.

Note, therefore, the importance in such cases for regular cleansing by the nurse.

The pathology of foul breath caused by conditions other than organic disease and foreign bodies is somewhat complicated. It can be considered under three heads:—

(1) Imperfect secretion of the glands, both mucous and albuminous. This occurs in atrophic rhinitis, rhinitis and pharyngitis sicca, in glycosuria, and under the influence of drugs such as belladonna, opium, etc.

(2) Deficient leucocytosis and absence of lymphoid elements such as occurs in atrophic rhinitis, a disease characterised by complete disappearance of all the normal lymphoid structures and loss of the phagocytic action of the leucocytes. Under such conditions bacteria grow rapidly, and fœtor results.

(3) Action of bacteria. Some are present in every variety of fœtor. I am indebted to Dr. Wyatt Wingrave, who has exhaustively studied these and other discharges at the Central Throat and Ear Hospital, for information regarding the different micro-organisms which are responsible for fœtor.

The *B. proteus vulgaris* is of frequent occurrence whenever decomposition is taking place, as in caseous rhinitis, lacunar accumulations in the tonsils, pyorrhœa alveolaris, and in all dental troubles, together with ulcerations of the mouth and in chronic suppuration of the ear.

The *S. refringens* (*S. fœtida*), accompanied by fusiform bodies (Vincent's bacilli), are associated with all fœtid accumulations in the throat, nose and ear.

The *B. butyricus* is very common in milk-fed patients and in those engaged in dairy work, also in infants fed from the breast.

The *B. coli communis* and the *B. subtilis* are very rarely absent from oral and pharyngeal infections, while yeasts and torulæ give the peculiar odour to beer drinkers and those subject to glycosuria.

Other fœtor producing organisms are:—

B. fœtidus ozæna.
B. pyocyaneus.
B. lactis erythrogenus.

Since most of these bacilli flourish best without oxygen, it is, therefore, essential to curtail their activity by a free ventilation of the parts. The *B. proteus vulgaris* is a most active cause of fœtor and of ptomaines.

Many of these bacilli are associated with different odours or fœtors. This fact depends to a great extent upon the material or nutrient on which they grow, also upon the conditions of heat, light and air.

Most ulcerated surfaces give rise to fœtor, and it depends on the nature of the bacteria, the scavenging power of the leucocytes, and the implication of bone or cartilage, whether the fœtor is pronounced or not.

Malignant disease may be present in the nose, pharynx, or larynx without much, if any, fœtor, but as soon as ulceration occurs, or the bone or cartilage is attacked, then the fœtor becomes very offensive.

Treatment.—Successful treatment of fœtid breath depends, first, upon a clear recognition of the cause; secondly, on the persistent and thorough employment of the methods adopted; and, thirdly, on the intelligent co-operation of the patient. Remedies to overcome fœtor must not be taken in hand in a half-hearted manner; they must be persevered with most thoroughly, and the patient should be instructed in every detail of the *technique*, whether this includes a douche, spray, or insufflation. A mere temporising by the use of "deodorisers" only results in disappointment, if the *fons et origo mali* remains untouched.

The first aim of the physician is to discover the cause of the trouble, and the second to remove it. It is not my purpose to discuss all the intricate surgical procedures involved in the alleviation and the cure of fœtor, but any sinusal disease *must* be seen to. Any nasal obstruction, whether due to hypertrophy or to new growth, should be removed, so that free drainage and ventilation are established. Any abnormality in deglutition should be corrected. Hasty mastication should be forbidden. When the trouble is of dental origin the aid of the dentist is indispensable, and must not be postponed. Hygienic measures should be enforced before and after each meal; the tooth-brush should be thoroughly employed at least twice a day, but especially after the last meal, in order to remove the accumulations which if left *in situ* naturally tend to ferment during the night. The brush should be used with a vertical rotatory movement to sweep the interstices between the teeth. Lacunar accumulations in the lingual or faucial tonsils should be evacuated, any ulcers should be touched with pure "phenol," and, if extensive keratosis be present, the tonsil should be removed, either *en masse* or by *morcellement.*

Suppurations of the middle ear must be treated by antiseptic drops; rhinoliths, foreign bodies in the nose, pharynx, or larynx must be removed. Causes, whether following the use of drugs, or those which are dependent upon occupations, or upon diet, must be attended to, and constitutional and gastro-intestinal diseases must be thoroughly treated.

The chief aim in overcoming foul breath is to treat and remove the immediate cause, which, we have seen, is usually bacterial in origin, whether primary or secondary. With the object of clearing away fœtid accumulations in the nose and naso-pharynx, "solvent" douches must be employed. It is useless merely to employ antiseptics which do not possess the power of dissolving mucin, albumin, and the constituents of crusts. The best ordinary solvent is sodium sulphate (1 per cent. solution), or sodium biborate or carbonate (in 0.5 per cent. solution). The nose should be thoroughly douched with this until the breath-way is free from crusts and caseous matter. Antiseptics can be employed afterwards direct to the membrane by means of sprays. In mild cases, when the fœtor is not severe, and when the mucous membrane is still sensitive, the olfactory function not being destroyed, an atomiser of liquid paraffin containing menthol, oil of cinnamon, or eucalyptus, is preferable, but, if the fœtor be very intense, Dobell's alkaline solution of phenol may be sparingly used.

We must next restore a healthy secretion by gentle stimulation. This can be done in mild cases by using a snuff composed of boracic acid with otto of roses, but, when the disease is very atrophic and secretion scanty, 5 per cent. of lysoform should be added as a powerful stimulant and antiseptic. It need scarcely be added that intra-nasal douching should be employed with the greatest care, and not persisted in for too long a period, owing to the danger of infecting the middle ear through the Eustachian tube. Severe cases of atrophic rhinitis are very tolerant of douches, and require such treatment at frequent intervals. Sea water, boiled and decanted, forms an excellent douche, especially when combined with a visit to the sea air. The nasal and pharyngeal mucous membranes, except in cases of atrophic rhinitis, are very sensitive, and will not tolerate antiseptic solutions of anything like the strength and intensity which the mouth does. Densely hard crusts are painlessly removed by inhalation of steam, camphor being added to the hot water as a stimulant. To facilitate oral hygiene, solutions of lysoform (1 per cent.), sanitas, peroxide of hydrogen, etc., are most beneficial; permanganate of zinc (1 in 500), or zinc chloride (½ per cent.), is recommended in cases of "spongy gums."

Lozenges containing formic aldehyde should be used frequently; they are non-poisonous, and act as powerful deodorants and antiseptics.

It is important in many cases of subjective foul breath, such as ozæna, etc., to get your patient's confidence by reducing at least, if not overcoming, the fœtor. With the help of a snuff composed of lysoform, boracic acid, and otto of roses, the unhappy sufferer from ozæna may often be rendered fit for the society of his fellow-men and enjoy life.

The treatment of such conditions as bronchiectasis, pulmonary gangrene, gastro-intestinal and other diseases causing fœtor of the breath, fall under the province of the general physician, and is beyond the scope of this paper.

NEURITIS CONSEQUENT UPON CIRRHOSIS OF THE LIVER.

By MAURICE KLIPPEL, M.D.,

Physician to the Paris Hospitals.

[Specially Reported for this Journal.]

Peripheral neuritis in the course of alcoholic cirrhosis of the liver occurs at two stages: In some instances it supervenes during the development of the cirrhosis, even quite at its apparent onset, while in others it only occurs at the terminal period when cachexia is imminent. The first group of cases are specially interesting on account of the severity of the symptoms.

Neuritis associated with hepatic cirrhosis presents very severe symptoms and well-marked lesions. The victims are usually old-standing alcoholics, or are, at any rate, addicted to the abuse of alcoholic beverages. The toxic agent is the undoubted factor, whatever may have been the particular variety of beverage: wine, spirits, bitters, etc. Even wine and beer, when taken in excessive quantities, may determine the disease. In a case reported by Porot and Froment the patient drank two or three quarts of wine a day, and a patient of ours took about the same. It may be remarked, however, that it is often impossible to determine exactly what share must be credited to the essences (absinthe, vermouth, etc.) that enter into the composition of the beverages.

It follows that the mode of intoxication cannot be subjected to any hard and fast rule, but the soil on which the cirrhosis and the polyneuritis develop possesses special importance. In most instances the patients are young women between thirty and forty years of age, and the question arises whether this fact is due to their being more addicted to drinking liqueurs such as absinthe, mélisse, etc., than mere spirits or wine. This seems hardy probable.

The further question arises whether the frequency of neuritis in young women is to be ascribed to a peculiar vulnerability of the nervous system in the female sex; but here, again, no proof is forthcoming. There is, however, one other factor that prepares the soil in conjunction with alcohol, viz.: pulmonary tuberculosis, although the way in which it acts has not so far been explained.

Alcoholic hepatic cirrhosis is frequent enough, as we all know, yet polyneuritis is much less common, so much so, indeed, that Dr. Guillaumot in a recent thesis was only able to find eighteen cases in medical literature, though, since attention has been called to it such records may be more numerous.

Our first case is that of a woman, æt. 37, who indulged in wine and various other alcoholic drinks, especially rum and bitters. She had in all probability suffered from syphilis, for she had had three miscarriages and had been treated with mercury. For twelve years previously she had been suffering from digestive disturbances, with pain in the right hypochondrium, which had become much more prominent of late. The symptoms of neuritis only made their appearance about a month before her admission to the Tenon Hospital. They consisted in fatigue and increasing weakness of the lower limbs. Her legs gave way under her, and she was unable to stand. The paresis steadily became more marked, she became quite impotent, had to take to her bed, and complained of lightning pains in the limbs. On examination we found that she was quite unable to stand or walk, the legs were limp and could not be raised from the level of the bed. There was some diminution of muscular strength in the upper limbs with slowness of movement. She could not grasp objects. Marked loss of sensation and painful sensations in both lower limbs. No sensorial disturbances. Memory was enfeebled with slight cerebral torpor, but no delirium.

The greatly hypertrophied liver reached down to the umbilicus, it was tender on palpation, which gave rise to a spasmodic cough. The collateral circulation was very marked, but not much ascites or œdema. The spleen was hypertrophied, no jaundice, no loss of colour of the fæces. She passed a quart of urine in the twenty-four hours, of a reddish colour and hæmapheic reaction. Pulse 120, temperature 100° F.

She died three months after from progressive cachexia without any particular change in the symptoms.

Post-mortem, we found ten or twelve pints of ascitic fluid of a lemon-yellow colour, marked hypertrophy of the liver and spleen, and adhesions of the abdominal organs to each other. Under the microscope the liver displayed the usual lesions of hypertrophic cirrhosis, with fatty degeneration. Diffuse sclerosis of the pancreas. The sciatic, median, external saphenous, and anterior tibial nerves were found to exhibit the ordinary lesions of alcoholic neuritis.

The second case was that of a woman, æt.38, who had been especially addicted to wine. In this case the symptoms began with hæmorrhages—hæmoptysis and metrorrhagia associated with digestive disturbances: loss of appetite, frequent vomiting, and slight malleolar œdema.

She was admitted on February 6th, 1906, in the following state:—Slight icteric tint of the skin and mucous membranes, a furred tongue, spongy gums, and marked emaciation. The greatly hypertrophied liver came five fingers' breadth below the false ribs in the nipple line. It was hard to the touch, but not deformed. No hypertrophy of the spleen, nothing in the lungs. Pulse 120, nothing in the heart; urine scanty, highly-coloured, contained much pigment and indican. Fæces somewhat pale. Abolition of tendon reflexes, cutaneous reflexes intact. Marked hyperæsthesia in lower limbs, with hyperæsthesia of the upper limbs and thorax. Great loss of muscular strength in the lower limbs which, when raised, fell flaccid on the bed. Pressure of the muscles caused severe pain. Incontinence of the sphincters. No psychical troubles, though at night there was mild delirium and intense restlessness.

She improved to a slight extent, then the upper limbs became paralysed in their turn, the amyotrophy increased, and she had visual hallucinations during the day. A fortnight before death this woman fell into a semi-comatose state, which persisted till the end. Post-mortem there was pronounced hypertrophy of the liver, which was cirrhotic and was undergoing fatty degeneration. The nerves of the lower limbs displayed the usual lesions of alcoholic neuritis: segmentation of the sheaths, multiplication of the nuclei, with marked sclerosis of the connective tissue.

Neuritis that makes its appearance at the ultimate stage of hepatic affections, especially cirrhosis, is less frequently met with than the preceding. The reason is, doubtless, that the neuritis in question is not well marked and requires to be carefully looked for, indeed, it may be quite latent, its existence only being recognised on microscopical examination.

A woman, æt. 56, much emaciated, no ascites, merely some peri-malleolar œdema, was suffering from generalised amyotrophy, most marked in the lower limbs. Motion was retained, but was imperfect. The reflexes were normal and there were practically no sensory disturbances.

In this case, therefore, the most striking symptom is the muscular atrophy, which is usually limited to the extremities and never attains the severity of the amyotrophy in the cases described above. Moreover, the cases differ also in their pathological anatomy. In these cases the nerve fibres do not show the central disaggregation of the myeline sheaths, but merely a thinning and fragmentation of the myeline; in other words, there is segmentary, but attenuated, degeneration. It sometimes happens that segments of nerves undergo degeneration and completely disappear. The vessels are thickened and are not infrequently the seat of obliterating endoarteritis.

Neuritis of the cachectic period of hepatic cirrhosis differs from the other cases not only in the symtomatology, but also in the lesions, and in all probability it is not due to ethylic intoxication at all, but to the nutritive disturbances associated with the cachexia.

It will be seen that the clinical picture of poly-neuritis associated with cirrhosis of the liver strikingly resembles that of classical alcoholic neuritis, but on scrutinising the cases more closely certain differences will be perceived.

In this form of neuritis we witness rapid extension of the polyneuritic phenomena, which do not remain limited to the lower limbs, but soon attack the upper limbs, causing almost complete functional impotence. Even the cranial nerves may become involved, and in one of their cases Porot and Froment mention an instance of ptosis which appeared to form part of the nervous changes. Disturbances of the pneumogastrics have also been met with as in our second patient. Disturbances of the sphincters, giving rise to incontinence or retention of fæces, are more frequent here than in uncomplicated alcoholic neuritis. It must be admitted that these disturbances have not always the same significance, some being the outcome of psychical changes associated with the polyneuritis, while others are due to lesions of sympathetic nerves or of nerve filaments innervating the striated sphincter of the urethra. This distinction is necessary because vesical incontinence is not, in most instances, due to mental disorder, whence it follows that sphincter troubles are fairly peculiar to associated neuritis. We must also insist on the distressing nature of the polyneuritic pains in question. The pain may be spontaneous or provoked, and is practically never wanting in cases of cirrhosis associated with polyneuritis. With regard to the psychical troubles, all authors are agreed in considering them of frequent occurrence. When characterised by delirium they are particularly grave, and are sometimes accompanied by convulsions that culminate in the terminal coma.

The liver symptoms are classical—increase in size of the organ, the lower border whereof may reach down to the anterior superior iliac spine, and usually comes at least five fingers' breadth from the edge of the false ribs, but is not deformed. Marked jaundice is exceptional, but there is often a yellowish tinge. The urine is rather scanty, and is sometimes albuminous, is laden with modified bile pigments, and contains urobilin and indican. Paleness of the face is tolerably frequent. The digestive disturbances are not peculiar, but mention must be made of hæmorrhage, early in point of date and grave in point of amount. The blood may come from the gums, œsophagus, or even the uterus, or we may have purpura or profuse epistaxis.

Hepatic inadequacy is manifested by a certain number of symptoms; there is almost always urobilinuria and indicanuria, but alimentary glycosuria, on the other hand, is rare.

As a rule, polyneuritis associated with cirrhosis occurs in connection with the hypertrophic form of the liver affection, but it may also be met with in the atrophic form, as in the case of an old man who presented atrophic paralysis of the lower limb muscles, in whom, in addition to the neuritis, the liver was diminished in size, and displayed microscopical lesions like those of Laennec's atrophic cirrhosis. It may also be mentioned that ordinary alcoholic polyneuritis is accompanied by a slight increase in the size of the liver, due, not to cirrhosis, but to fatty degeneration of that organ—a fact which had escaped observation until the polyneuritic pain led to the patient being closely examined.

Our observations lead us to believe that the liver lesions and the neuritis do not progress hand in hand. While in some instances the phenomena of neuritis set in first, the cirrhosis only becoming appreciable later on, in others it is the symptoms of hypertrophic cirrhosis, especially hæmorrhages, that attract attention. But the commonest signs, after all, are disturbances of liver function, more or less discrete, more or less ill-defined, that usher in the pathological state.

Polyneuritis associated with hepatic cirrhosis runs a definite course. In contrast with that of simple polyneuritis, it looks grave from the onset. The trophic disturbances and the symptoms of paralysis steadily progress, and death usually supervenes in a few months from hepatic inadequacy or extension of the neuritis. Acute tuberculosis may precipitate the fatal issue. Less frequently, after an acute period of variable duration, we get progressive improvement, which may go on to complete recovery. Unquestionably, the generalised neuritis of cirrhotic subjects presents certain peculiarities (rapidity of the paralytic phenomena and amyotrophia, sphincter troubles, delirium, etc.), but these peculiarities do not suffice to distinguish it from the polyneuritis of non-cirrhotic subjects. As a matter of fact, these symptoms may be met with in the course of ordinary polyneuritis, and even the evolution of this neuritis is not pathognomonic; in short, the gravity of the condition is due to the changes in the liver, and not to the polyneuritis.

Similarly, this cirrhotic polyneuritis cannot be differentiated from simple alcoholic neuritis by the anatomical lesions. In almost all cases the liver lesions are those of hypertrophic cirrhosis with fatty degeneration, and the constancy of the lesion in question is confirmed by all writers on the subject. In Hudelo and Ribierre's case, which appeared to be an exception to this rule, the polyneuritis did not take place in a cirrhotic subject, but in a patient suffering from intense jaundice, and the liver presented fatty degeneration similar to that met with in hypertrophic cirrhosis. In these patients both lobes of the liver are uniformly enlarged; its weight varies from 4½ to 7 lbs.; it is usually hard, and on section its parenchyma shows yellowish nodules closely packed in a much thickened fibrous stroma. Perihepatitis is also frequently met with in this association.

The microscope shows diffuse lesions involving the constituent elements of the liver; the connective tissue forms big fibrous bands separating the islands of fragmented parenchyme, in the middle of which are the sub-hepatic veins and the porto-biliary spaces. In our own cases we found changes in the biliary canals, the portal veins, and even in the branches of the hepatic artery. There were, in addition, newly-formed biliary canals and numerous embryonic cells, many of which were undergoing fatty degeneration, with some that contained an excess of bile pigment.

In cases where it was possible to examine the nerves microscopically, we found the same changes in the myeline sheaths and axis cylinders as in cases of alcoholic neuritis. These lesions had indirectly set up changes in the anterior root cells of the cord, which displayed chromatolysis, either central or diffuse. Lastly, the muscle fibres of the atrophied muscles were diminished, and the connective tissue cells increased in size and number. In subjects who had presented cerebral disturbances, we found toxic neuro-cerebritis, but the vessels and meninges were intact. It will be seen that the neuritic lesions in question are in every respect identical with those of purely alcoholic polyneuritis.

We now come to the pathogenesis of polyneuritis accompanying hepatic cirrhosis. The neuritis has been attributed to auto-intoxication produced by inadequacy of the hepatic functions. But is this really the case? Dr. Hayem records the case of a patient, æt. 48, who presented symptoms of neuritis characterised by pain in the upper limbs and paresis of the hands, soon followed by similar symptoms in the lower limbs. Simultaneously he noted abolition of the reflexes, with disturbances of the sphincters and subdelirium. These clinical features, as well as the course of the disease, prove that it was really a case of neuritis complicating cancer. On the other hand, Dr. Gouget's observation also fails to show the dependency of the neuritic lesions on auto-intoxication of hepatic origin. The case was that of a woman, æt. 23, suffering from paresis of the extensor muscles of the hands and feet, who had reached an advanced stage of cachexia. The liver and spleen were both hypertrophied, but there was little ascites. The neuritic manifestations followed the liver disease, for they did not make their appearance until two months after her admission to hospital, so that they could not be put down to alcoholic intoxication, especially as the woman had given up drinking some time before. Dr. Gouget therefore thinks that, although alcohol may have prepared the soil in this instance, the neuritis ought rightly to be ascribed to organic poisons. It must, however, be borne in mind that in this case the nerves did not present the lesions of true neuritis, but only degenerative changes. This case must therefore be classed among the cachectic neuritis, and not with those obviously associated with hepatic cirrhosis.

Confronted by these divergencies, Drs. Castaigne and Sainton decline to regard the cirrhosis as the principal factor in the production of the neuritis, although they conceded that it may exert an indirect influence in that direction. They hold that the cirrhosis hampers more or less the antitoxic functions of the liver, and thus facilitates the action of alcohol on the peripheral nerves, whence the neuritic manifestations. This enables us to explain the infrequency of neuritis in the course of hepatic cirrhosis, the patients suffering therefrom becoming aware of the gravity of their plight, or, following their doctors' advice, often desisting from further alcoholic indulgence.

To sum up, generalised polyneuritis supervening in association with cirrhosis of the liver does not differ in any way from non-complicated alcoholic neuritis. The liver affection, by hampering the antitoxic function of this organ, renders the peripheral nerves more vulnerable, and allows the neuritic changes to progress with a rapidity proportional to the gravity of the hepatic lesion.

RECENT ADVANCES IN
THE SURGICAL KNOWLEDGE AND TREATMENT OF SYPHILIS. (a)

By D'ARCY POWER, F.R.C.S.Eng.

There is an obvious advantage in reviewing the knowledge of every scientific subject from time to time, inasmuch as advances in one branch often lead to progress in others which appear at first sight to be remote.

In the case of syphilis, the diagnosis and treatment of diseases of the bones and joints have been greatly helped by progress in optics leading to the production of better microscopes; by advances in physics resulting in the discovery of Röntgen rays; and by the rapid progress of pathology, which is itself based on physics, chemistry and biology.

Histology has enabled cases of tumor albus or white swelling of joints to be classified as tuberculous and gummatous. The distinction between these two forms was thought at first to be absolute. Modern views tend to show that, in some cases at least, a gummatous synovitis is really a tuberculous inflammation infecting the joints of those who inherited syphilis. Instances are given, and the conclusion is reached that, whereas, a few years ago a chronic arthritis presenting the characters of a white swelling could be spoken of dogmatically as tuberculous or gummatous, it is now necessary to form intermediate groups due to the microbic infection of tissues modified by the action of the spirochæte pallida whether this organism has been acquired or inherited. Tubercle and syphilis form the most frequent combination, but some varieties of pneumococcus and staphylococcus show a special liability to invade syphilitic tissues, whilst an attack of influenza may prove to be the starting point of a gummatous arthritis in syphilitic patients.

The Röntgen rays have enabled important advances to be made in the knowledge of syphilitic inflammations of bones and joints. The skiagraphic appearances in syphilitic osteitis and arthritis differ from those seen in analogous inflammations produced by tubercle and rheumatism. Radiographs, too, show that syphilitic inflammation of the bones may begin at a much later period than has hitherto been thought possible, and in persons who might reasonably have supposed themselves free from any taint of inherited syphilis.

Attention is further drawn to the interaction of tubercle and syphilis by the narration of a series of cases in which young persons have presented the appearances characteristic of a leukoplakic tongue and have died afterwards of tuberculosis. The peculiar characters of a leukoplakic inflammation, it is contended, would not have been impressed upon the tongue in these cases if the patients had not inherited syphilis; indeed, in the absence of any syphilitic taint the tongue might entirely have escaped inflammation, for primary tuberculosis of the tongue is not of common occurrence. It would be extremely interesting to ascertain whether these children were the "healthy" offspring of parents who had been "cured" of syphilis before marriage, whether they were born after a series of miscarriages due to syphilis, or whether they had suffered in their youth from other signs of inherited syphilis.

The advances in the surgical treatment of syphilis have proceeded along two main lines. First, a thorough belief in the curative value of mercury when properly administered, the object of treatment being to cure the disease and not merely the symptoms complained of by the patient; secondly, a clear comprehension of the limitations of treatment by iodides. It is impossible for the tissues to rid themselves of large masses of inflammatory syphilitic products even with the help of iodides. It is better therefore to remove gummata, mucous patches, condylomata and similar masses by ordinary surgical means rather than trust to their absorption by Nature. Iodides may then be given with very satisfactory results, but they should always be followed by a mercurial course.

CLINICAL RECORDS.

CASE OF ERB'S PARALYSIS FROM TRAUMATISM. (a)

By G. HAMILTON, F.R.C.S.,

Surgeon, Liverpool Royal Infirmary.

Four months ago, J. M'C., æt. 38, fell down five steps on to the tip of his shoulder, violently stretching the whole of the structures between the neck and shoulder. His doctor states that there were bruises about the shoulder, but no fracture or dislocation. He was X-rayed when he came under my care four weeks ago, and no evidence of injury to the shoulder-joint or clavicle was found. There is marked wasting of the following muscles—deltoid, infraspinatus, supraspinatus, biceps (coraco brachialis?), brachialis anticus, supinator longus. The pectorals, trapezius, latissimus dorsi, flexors and extensors of wrist-joint are unaffected.

His symptoms came on immediately after the accident, when he found that his right arm hung helplessly by his side. There is inability to raise the shoulder, paralysis of the external rotators of the shoulder, inability to flex the elbow or to supinate.

Although carefully tested in the manner advocated by Head and Sherren, no loss of sensation has been found except in an area about the size of a five-shilling piece to the outer side and a little above the insertion of the deltoid. Here the patient had some difficulty in distinguishing the head from the point of a pin, and when gently brushed with cotton-wool he feels everywhere except over this area, so that it is a change in, rather than a total absence of, sensibility. The impaired area for distinguishing heat and cold is just a little larger than that of touch. Another interesting feature is, that the supra- and infraspinatus, detoid, clavicular portion of pectoralis major and biceps act to a mechanical stimulus. The triceps jerk is present.

(a) Abstract of a paper read at a meeting of the Medical Society of London, May 11th, 1908.

(a) Paper read before the Liverpool Medico-Chirurgical Society.

Dr. Bradshaw kindly undertook the electrical changes, and reports absence to Faradic current in all the paralysed muscles and reaction of degeneration in several, notably the deltoid. The "upper arm type," or Erb's paralysis from traumatism was described by him, mostly in connection with obstetrical palsies. In the case under discussion we are forced to the conclusion that the motor fibres of part of the fourth and those of the whole of the fifth and sixth cervical nerves have been torn. If we admit this, it is most difficult to explain the almost total absence of afferent nervous phenomena. It is unlikely that motor fibres *alone* have been torn.

In a somewhat similar case to this, reported in "Brain" by Warren, the fifth and part of the sixth nerve was found at an operation to have been torn, and absence of contraction of the paralysed muscles was proved by stimulating the lower end of the torn nerve.

As Head and Sherren have pointed out, when the median nerve is divided, sensation is lost over a considerable part of both the index and middle fingers, but over the palm, the area said by anatomists to be supplied by this nerve, sensation is usually *diminished* and not completely abolished. Similarly, division of the ulnar nerve produces complete insensibility of the little finger and of a variable portion of the ulnar aspect of the palm, but *partial* loss is found over a larger area of the palm; the explanation generally given being that there the nerves overlap.

The overlapping theory has not, however, been found to explain the unequal sensory phenomena in the case of the ulnar and median nerve, when divided separately. In our case the man could not appreciate cotton-wool gently rubbed over the small area above described, or heat and cold, or two points of a pair of compasses, and yet he could feel some pain. By the overlapping theory, he ought to be able to appreciate these higher forms of stimulation as well as pain.

Operation (five months after accident).—A curved incision about six inches long was made following the posterior border of the sterno-mastoid and upper border of clavicle, and a flap was thrown backwards. It was soon found that the upper cords of the brachial plexus had been dragged through the fibres of the scalenus anticus, and that the chief injury was to the cord formed by the fifth and sixth nerves. This cord appeared to be much larger and thicker, and part of it was replaced by fibrous tissue. Unipolar excitation with the Faradic current gave a response only in the lower half. The strength of the current was deemed efficient since stimulation of the also exposed fourth nerve produced unmistakable movement. Accordingly, about an inch and a quarter of this fibrous material was removed and its place taken by a graft from a fox terrier's sciatic. The graft was fixed in position by two fine silk sutures at each end. The wound was closed without drainage, and healed by first intention.

On examination the morning after the operation the cotton-wool test seemed to be better marked over the small insensitive area above mentioned, but this area soon became as before the operation. The patient was carefully examined four and a half months after operation, and distinct improvement in his biceps flexion was found; otherwise he remained as before. The graft had given him no trouble.

OUT-PATIENT'S ROOM.

METROPOLITAN HOSPITAL.

Cases of Retroflexion.

By EARDLEY HOLLAND, M.D., M.R.C.P., F.R.C.S.

Amongst the out-patients were two cases of retroflexion which presented special features. The first was a woman, æt. 25, who had had one child two years ago. Since then she had had five miscarriages, all about the second month. She also complained of minor symptoms, such as profuse menstruation and backache. On examination a fixed and somewhat tender retroflexion was discovered. The appendages were free from disease. Dr. Holland said that the retroflexion in this case undoubtedly arose during the puerperium two years ago. On more careful inquiry into the history of this puerperium, the patient said she got up on the tenth day, but had to return to bed almost immediately for two or three days because of slight bleeding, which her doctor treated with hot douches. Dr. Holland thought this a most important case. The majority of retroflexions arise in the puerperium. The time of their appearance is most constant about the tenth day, when the uterus has again entered the pelvis. The only symptom caused is bleeding; this is never profuse, and is usually quite transient, resembling the early lochia; it is very different from the sudden hæmorrhage which may also arise about this time from a retained piece of placenta. The patients are usually primiparæ. He pointed out that these cases usually escape recognition, which is most unfortunate, because a fixed retroflexion, as in the case under consideration, may be one of the most troublesome affections from which a woman may suffer, and which, when it has been allowed to become established, is difficult and wearisome to treat. If a woman in the puerperium, therefore, has a slight hæmorrhage, she should be examined at once for retroflexion, and since in many of the cases this one symptom —bleeding —may even be absent, he considers it advisable to examine all puerperal patients as a routine on the fourteenth day. If then such a retroflexion be discovered, its treatment is simple and effectual. All that is necessary is to replace the uterus with the fingers and to make the patient lie in the semi-prone position for the next few days instead of on her back. At the same time ergot and hot vaginal douches should be given to ensure efficient contraction of the uterus. It is most inadvisable to use a pessary in the early days of the puerperium, as this stretches the vagina and permanently interferes with its proper involution. If these points were sufficiently known and carried into practice, he considered that, on the theory that prevention was better than cure, very many fewer cases of retroflexion would be met with in practice. With regard to the treatment of this case at the present time, the first indication was to overcome the fixation and render the uterus mobile, and the second to replace it in its proper position and maintain it there. For the former, tampons soaked in a 10 per cent. solution of ichthyol and glycerine must be inserted high up in the posterior vaginal fornix every night before the patient goes to bed, and taken out again in the morning. Before inserting each tampon, and after removing it, a hot vaginal douche of lysol, ½ drm. to the pint, at a temperature as hot as can be borne, should be given. At the same time the bowels should be regulated by a saline purgative every morning. By these means adhesions, if not too extensive, will be absorbed, and in two or three weeks the uterus will probably be found mobile. Of course, in cases of retroflexion due to pelvic inflammatory disease, accompanied by disease of the tubes, and bound down by dense adhesions, these measures will have no effect in rendering the uterus movable again. It is only in such cases as the present, where adhesions are slight, as is usually the case in uncomplicated puerperal retroflexions, that these methods will be efficacious. When the uterus is again quite movable, it should be replaced bimanually, and kept in position by a well-fitting Hodge's pessary.

The second had been a similar case which had presented precisely the same history, and had been treated on the lines just laid down. She was first seen six months ago, and was now four and a-half months pregnant. At the time of the second and third expected menstrual periods during her present pregnancy, she had suffered from slight hæmorrhage, and had been instructed to remain in bed for three or four days at the time she expected her periods. There is no doubt that, especially in women who have had repeated abortions, the uterus is in a very irritable condition at the time of the menstrual epoch, and abortion is then apt to occur. Dr. Holland removed the pessary, as the uterus had now risen up out of the pelvis, and displacement, therefore, could not occur.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

OPERATION FOR ANKYLOSIS OF ELBOW.—MR. EDRED CORNER operated on a young man, æt. 17, who had been admitted for the relief of the condition of ankylosis of the elbow. The history was: Eight years previously he had fallen on his elbow, and though it was not much injured at the time, the joint became swollen some time afterwards. The arm never gave him sufficient pain to make him consult a medical man. The swelling gradually subsided, and the joint became stiff. Unfortunately for him, the ankylosis took place with the arm nearly in the fully-extended position. When the patient began to do some work, he found that it was impossible for him to do much with the arm fixed in this position. He therefore came to the hospital with a view to obtaining some relief. To obtain a good movable elbow, Mr. Corner said, is naturally the result which a surgeon would like to secure. This might be done in two ways—by means of an arthrotomy dividing the ankylosis, and following up the operation with active, passive movements and massage, or the elbow might be excised. The results which are seen from excision of the elbow are not such as should encourage surgeons to perform that operation more than is absolutely necessary; at best the arm is weak, and of little value. To meet this disadvantage, he had made it a rule to retain the olecranon where possible in all cases. By this means he had found that it was possible to eradicate all the disease, and to restore to the patient a strong, useful and serviceable limb. In one case even a skilled radiographer examined the joint and took a radiograph two years after the operation, and reported that there was nothing abnormal in the lower end of the humerus and the upper end of the radius, whilst, as a matter of fact, these had been removed in greater part at the operation. This, he thought, was the best testimonial which he has met with regard to Nature's restoration of the bony parts after operation. With regard to the present case, the elbow has been ankylosed for upwards of eight years, during which period the muscles of the upper arm have atrophied to such an extent that, even if he succeeded in obtaining a movable joint, there would not be sufficient muscular power to prevent the limb from becoming flail. Under these circumstances, it was undesirable that an attempt should be made to give the patient a movable joint, and he must merely content himself with freeing the joint sufficiently to allow ankylosis to take place again with the arm in such a position as to enable the patient to do some work. An incision was made in a longitudinal direction over the back of the arm on the outer side of the olecranon. The outer part of the tendon of the triceps was split, and the elbow-joint opened. It was then seen that the muscle remained as a yellowish-brown, soft mass. The ankylosis was found to be due to the adhesion of the under-surface of the tendon of the triceps to the lower part of the back of the humerus. When this had been freed with a knife and an elevator, it was possible, by stretching the triceps, to flex the elbow to an angle of about 30 degrees. The tendon of the triceps was then sutured with interrupted stitches of fine silk, and the skin wound closed with interrupted salmon gut. The arm was dressed with gauze, and maintained in the flexed position by a bandage arranged in a figure-of-eight round the fore and upper arms. The arm was tethered to the side by means of a bandage passed round the waist, enclosing it with two half-hitches. Mr. Corner said a splint was not used because it was desired that the arm should be maintained at less than a right angle, for which position there was no available splint, and the arm is much more comfortable when merely bandaged up.

The dressing will be taken down in two days' time to allow of a further examination of the power remaining in the muscles. If there should be any promise of its return, massage, movement, and electrical stimulation will be begun. If, on the other hand, it is decided that muscular power cannot be restored, then the elbow will be allowed to ankylose in a good position.

TRANSACTIONS OF SOCIETIES.

THE ROYAL SOCIETY OF MEDICINE.

CLINICAL SECTION.

MEETING HELD FRIDAY, MAY 8TH, 1908.

The President, Sir THOMAS BARLOW, Bart., in the Chair.

DR. STILL showed a girl, æt. 7, from whose stomach a mass of hair, welded together to form a complete cast of the organ, had been removed. She had been admitted to King's College Hospital for vomiting and an abdominal tumour, stretching from the left hypochondrium to the midline. An exploratory operation had revealed the nature of the tumour, and the removal of the hair had led to a successful issue. The hair had come from the patient's own head, by whom it had been pulled out and swallowed. Dr. Still referred to 14 similar cases on record, 13 of whom were girls.

Mr. C. A. BALLANCE stated that he had successfully treated a similar condition in a woman in whom the hair had traversed as far as the jejunum.

Mr. WATSON CHEYNE showed a patient illustrating spontaneous disappearance of recurrent carcinoma of the breast. The patient was a woman, æt. 51, whose breast had been amputated for scirrhus carcinoma on October 2nd, 1901. The nature of the growth had been proved microscopically. Early in 1903 several small subcutaneous nodules had developed over the chest and upper part of the abdomen, which were thought to be certainly cancerous. On October 1st, 1907, she wrote to say that three years before the lumps had disappeared concurrently with the menses, and in the absence of any medical treatment. This was found to be correct, and now there were no nodules or other evidence of recurrence.

The PRESIDENT and Mr. C. A. BALLANCE showed a boy, æt. 5, in whom a rupture of the upper cord of the brachial plexus had occurred during childbirth, and who had been treated by operation 10 months afterwards. Before the operation the muscular reactions, when examined under chloroform, showed that the deltoid, biceps, brachialis anticus, coraco-brachialis, and supinator longus were totally paralysed. It was found that the fifth cervical nerve was ruptured just where it joins the sixth, and reunion was effected by silk suture. After four years' absence the child returned to England, and it was found that the paralysed muscles had completely recovered. Complete supination, however, could not be effected, and shortening of the pectoralis major limited the movements of the arm.

Dr. POYNTON said that it was difficult to know when to operate in such cases, since in some many cords were partly affected, and many cases recovered very well without operation.

Dr. PURVES STEWART showed a man, æt. 50, who had been the subject of a gross lesion of the post-central gyrus associated with astereognosis. Symptoms referable to a lesion in the left cortex had started in 1894 or 1895, and had gradually increased until September, 1907, when there were weakness of the right lower face and clumsiness of the right arm, with tingling in the right index and middle fingers. Some aphasia was also present, and later astereognosis of the right upper limb. The right leg became affected, and the steadily progressive right hemiplegia, and intense headache, with the astereognosis of the right hand suggested a gross intracranial lesion in the region of the left post-central gyrus. Mr. Ballance operated on October 28th, 1907, and found a patch of thickened yellow pia-arachnoid occupying the middle third and adjacent part of the lower third of the post-central gyrus. The diseased area was removed. At the time of exhibition the aphasia had largely cleared up, but there still remained weakness of the right lower face and right arm, and astereognosis, as before. The reflexes in the right upper limb were increased.

Dr. J. BARNES BURT showed three cases of patients with gout showing destructive changes in bone. Case I.—A man, æt. 67, had suffered from gout for 25 years, and had not been able to walk for 11. A skiagram showed central necrosis of bone at the proximal end of the first phalanx of the index finger, and in the corresponding phalanx of the next finger, and also several punched out areas of necrosis in the distal end of the second phalanx of the index finger.

Case II.—A woman, æt. 36, who had suffered from gout for 5 years. The skiagram of the left hand showed a necrotic area, about the size of a pea, in the distal end of the second phalanx of the middle finger.

Case III.—A man, æt. 55, who had suffered from gout for 5 years. A skiagram showed a right area in the distal end of the first phalanx of the index finger. He pointed out that the areas of necrosis were not apposing tophi, and could not be produced by pressure from tophi, as is usually supposed.

Dr. POYNTON said that he thought Ebstein's view of the pathology of uratic deposit would prove to be correct, that there was a primary necrosis, and that by altered chemical reaction biurate of soda was produced locally.

Mr. C. H. FAGGE showed a woman, æt. 50, in whom parts of the femoral artery and vein were excised for recurrent sarcoma. A growth had been removed from the inner side of the right thigh in September, 1906, and proved to be a spindle-celled sarcoma, with many myeloid cells. A recurrent growth was removed in July, 1907, and a second in December, 1907. At this operation it was found necessary to ligature the femoral artery and vein above and below, and to remove them with the long saphena nerve. The circulation of the leg was quite restored on her discharge 18 days later.

Mr. C. H. FAGGE also showed a man, æt. 26, who had suffered from an aneurysm of the common femoral artery. The aneurysm and common femoral vein had been excised. The tumour had been noticed for eight months. At the operation the right external iliac artery was exposed and ligatured, and afterwards the deep epigastric and superficial femoral arteries. The aneurysm was then dissected out, and during its removal it was found necessary to remove the common femoral vein also. Sensation and power returned in the leg and foot after 48 hours, but the pulse in the tibial vessels could not be felt a month after the operation.

Dr. G. A. SUTHERLAND showed a case of "Scleroderma" in a boy, æt. 5½. For three weeks the skin of the face had been noticed to be tense and hard. The induration also affected the eyelids, scalp, neck and extremities, and to a less extent the trunk. The tongue was distinctly hard. The boy's general condition and development were good.

Mr. ALBERT CARLESS showed a man, æt. 37, with multiple symmetrical lipomata. The condition began as a small lump on the face in 1905. Subsequently many large fatty tumours, showing striking symmetry, had developed. Some had been removed by operation, which had shown that the growths were limited and localised, and that they tended to burrow and become adherent to surrounding parts.

Mr. P. MAYNARD HEATH showed a girl, æt. 6½, who suffered from caries of the spine associated with clubbing of the fingers and toes. The disease was of four years' duration, and associated with great thoracic deformity. There was no evidence of lung disease. Occasional attacks of cyanosis occurred.

Dr. F. PARKES WEBER showed a case of multiple idiopathic hæmorrhagic sarcoma of the skin in a man, æt. 52. The disease had started as a pedunculated growth from a wound in the sole of the right foot six years before, which was removed by a medical man. Afterwards small, hard, bluish or purple spots appeared, chiefly in the lower extremities, and from time to time sessile or pedunculated little tumours, which tended to ulcerate and drop off. It was a typical case of the condition described by Kaposi.

Mr. CHARLES A. BALLANCE read the notes of a case of "Arterio-Venous Anastomosis for Senile Gangrene." It was that of a woman, æt. 75, who was admitted to St. Thomas's Hospital, September 20th, 1907, with arterial gangrene of the first, second, and third toes of the right foot. The condition remained stationary for three weeks, but she suffered so much pain that sedatives were required. At the end of three weeks the gangrene began to extend, all the toes became affected, and the discolouration of the skin extended over the dorsum of the foot. On October 17th, 1907, an arterio-venous anastomosis was made in the upper half of Hunter's canal. The same evening an arterial pulse could be felt in the internal saphena vein, and in the veins on the dorsum of the foot. The foot became warm, and the pain was relieved. The discolouration of the skin of the fourth and fifth toes, and of the dorsum of the foot, disappeared. During the next few months the superficial gangrenous patches on the first, second and third toes began to separate. The patient died from gangrene of the large intestine on February 15th, 1908. In the paper comment was made on the case, and on clinical and experimental observations bearing on the subject.

Mr. FORBES ROSS suggested that more surgical use might be made of the fact that ligature of an artery is followed by vasomotor dilatation in the part supplied.

Dr. NORMAN DALTON read the notes of a case of "Leucoderma," the patient having died with symptoms of Addison's disease and cirrhosis of the suprarenals. The patient was an unmarried woman, æt. 35 at the time of death. She had had typical and widely distributed leucoderma (as shown by the photographs produced) for ten years, and her health had been quite good all this time. The only noteworthy point about the skin affection was that the white patches had the faintest shade of pink in them, so that she was brown and pale pink, rather than brown and white. After death, however, the patches were quite white. In July, 1907, epigastric pain and vomiting set in. She became very weak, and was admitted into King's College Hospital on October 4th, 1907. No indications of structural disease in any organ could be discovered. The vomiting continued, and she became weaker. On October 15 she became faint, and died in a few hours from cardiac failure. This final syncope, in conjunction with the vomiting, suggested that Addison's disease was present, although the skin was typically leucodermic, and at the post-mortem the suprarenals appeared to be simply atrophied. On microscopical examination, however, they proved to be cirrhotic. Dr. Dalton did not think that the association of the symptoms of Addison's disease with leucoderma was a mere coincidence, though he could offer no explanation as to why the innocent pigmentary changes, which are so unlike those of Addison's disease, should in any way be connected with the changes in the suprarenals and the gastric and cardiac symptom. He thought it important, however, to recognise that, if these symptoms supervene in a case of leucoderma, some lesion of the suprarenal is probably present, and that the prognosis is correspondingly grave. This case, though rare, is not unique, for McCall Anderson has recorded one of the same kind. Dr. Dalton did not discuss the pathology of leucoderma, but stated that this case might be heard of at a future time in that connection, for Mr. Lenthal Cheatle had found pathological changes in the Gasserian ganglion, corresponding to the white patches on the face.

Dr. **Parkes Weber** asked if there was any evidence, microscopical or otherwise, that the case was not one of pigmentation of the skin originally, with the retention of untouched normal areas, and not true leucoderma.

Dr. **Dalton**, in reply, said that he did not know about the condition at its onset, as he had only seen the patient a short time before death.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held Friday, May 1st, 1908.

The President, Mr. **Richard Lake**, F.R.C.S., in the Chair.

Dr. Herbert Spencer gave a short address on the examination of the

PELVIS AND ABDOMEN DURING PREGNANCY,

its advantages and, indeed, its necessity, if women were to have the full benefit of obstetric science at the time of labour. It was a practice he had personally adopted during the last 20 years. Lantern slides were exhibited illustrating the advantages of the examination and the dangers and fatalities resulting from its omission. He advocated external and internal examination at the end of the third month and external examination at the end of the seventh month. Vaginal examination should be gentle: he warned especially against forcible bimanual examination and the eliciting of Hegar's sign as liable to produce abortion. Attention was called to the value of abdominal *ballottement*, and methods of obtaining it were demonstrated on the screen. He stated that the height of the top of the pregnant uterus above the pubes was erroneously stated in English text-books. At the end of the third calendar month it was as high as the promontory (3¾ inches above the symphysis); at the end of the fifth calendar month it was on a level with the umbilicus. The height above the symphysis during the first six calendar months was obtained approximately, by adding half an inch to the number of the month. It could be felt at 2½ inches above the symphysis in all ordinary cases at the end of the second month.

The advantages to be derived from examination during pregnancy were that the fact and the period of gestation, the position of the uterus and the presentation and position of the child were ascertained, and treatment could be applied during the pregnancy. Presentation of the breech and shoulder would thus in many cases be prevented. Contraction of the pelvis could thus be discovered in time to decide on induction of labour or on Cæsarean section, which in such cases should always be successful at the present day. Fibro-myoma was a not uncommon complication of pregnancy, especially in elderly primiparæ, not often requiring interference, but sometimes needing Cæsarean section, as in three of his cases. He had operated on between thirty and forty ovarian tumours which had complicated pregnancy. Two required operation during labour when they were first discovered. The greater number of the cases were not examined during the pregnancy and many complications ensued. Those found and removed during pregnancy made simple recoveries. Even cancer complicating pregnancy was not hopeless: three of his cases with advanced pregnancy remained well after 11 years.

Dr. Seymour Taylor read a paper on

SOME NEGLECTED REMEDIES.

He deprecated the modern tendency to run after new drugs and remedies, and to discard the old methods. Fashion had much to do with modern prescribing, but it was not necessary that the profession should be told, and even mildly coerced, by interested drug vendors, to sell their special form of new remedy. Such an attitude presupposes that pharmacy is not nowadays taught in our medical schools. But, commencing with external applications, Dr. Taylor advocated the use of the seton in some forms of congestive headache, and even in epilepsy. He was convinced that in the latter disorder a judiciously applied seton deferred epileptic attacks, and even rendered them less severe. Venesection, again, is valuable treatment in those diseases where the circulation through the right heart is embarrassed. He quoted three cases, one of chronic bronchitis and marked cyanosis, one of acute œdema of the lung subsequent on mitral obstruction, who were fully bled and both of whom recovered when on the verge of death. The third case was one of suicidal hanging. In this instance the external jugular vein was opened, and life prolonged to the third day. Probably had this treatment been adopted earlier than it was the patient's life would have been spared. But bleeding should never be regarded as a routine practice, as it was formerly. Bleeding was useful in many cases of pneumonia, for example, but chiefly when cyanosis was a marked symptom. The indications for bleeding were afforded by the heart rather than the lung. The blister was also a somewhat neglected remedy, yet it afforded great relief to the acutely inflamed rheumatic joint, and the smart of a blister was more tolerable than the dull throbbing of a swollen joint. Blistering in pericarditis has been revived, and with advantage. Consistency also demands that if we blister a rheumatic knee we should also blister a rheumatic heart, and we do so in many instances with the utmost benefit.

Dr. Seymour Taylor then spoke of the use of many drugs. In the treatment of chlorosis, arsenic, if persevered with, was in numerous instances as efficacious as iron. It must be continued for a lengthened period, and if it acted as a slight aperient so much the better. Sarsaparilla, an old-fashioned remedy, but still retaining the confidence of the laity, as we see it dispensed by itinerant vendors in our country fairs and market places. It is undoubtedly a corrective remedy in some skin affections which are not syphilitic. But its chief efficacy lies as an adjunct to iodide of potassium in the treatment of cutaneous syphilides and of nodes. It should be prescribed in large doses. Other neglected remedies which were referred to were Plummer's pill, in primary syphilis. This remedy should be freshly made. Pulvis basilicus or royal powder, as a febrifuge in children suffering from fever due to gastrointestinal irritation; guaiacum, gum ammoniacum, and copaiba in chronic bronchitis with profuse or fœtid expectoration; galbanum and assafœtida for the relief of intestinal distension, so often a distressing symptom in failing heart; antimony in acute affections of the respiratory membranes; and lastly, musk, which, although a disgusting remedy, had apparently, in two instances, saved lives which, in typhoid fever, appeared to be on the brink of the grave. It was not contended that all, or any, of these remedies were entirely discarded; but it was contended that they might all be more frequently used with advantage, especially in carefully selected cases.

HARVEIAN SOCIETY OF LONDON.

Meeting held May 7th, 1908.

The President, Mr. **D'Arcy Power**, in the Chair.

The following clinical cases and specimens were shown and discussed:—

Dr. Leonard Guthrie showed:—(1) A case of cerebral diplegia in a child, æt. 4, the onset of which was after an attack of measles at 2.

(2) A case of cirrhosis of the liver in a child, æt. 10, with marked ascites There was no evidence of congenital syphilis.

(3) A case of obliterating endarteritis in a woman, æt. 42. The arteries of the right upper extremity were affected and no pulse could be felt. Pain and coldness of the affected limb were present, and there had been troublesome whitlows. There was symmetrical malformation of the clavicles.

Dr. Sutherland showed a case of scleroderma, which had followed a recent attack of measles.

Dr. Langmead showed (1) a series of congenital malformation of the nose, "fog nose," occurring in members of one family.

(2) Three cases of Mongolian imbecility.

(3) A case of tetany associated with dilatation of the large intestine.

Mr. Keogh Murphy showed:—(1) Cases of tuberculosis of the tarsus, with skiagrams by Mr. A. D. Reid.

(2) A case of ischæmic paralysis.

(3) A case of vesical calculus, with skiagram.

Mr. Arthur Edmunds showed:—(1) A case of spina bifida.

(2) A case of imperforate anus which had been successfully operated upon.

(3) A case of hypospadias.

(4) A case of exostoses of scapula and ribs.

(5) Pathological specimens.

Mr. Mayou showed a case of optic neuritis in one eye, due to retrobulbar inflammation.

Dr. Turtle showed three cases with marked Eustace Smith's murmurs. In one of the cases there were signs of enlarged tubercular gland in the superior mediastinum, with distension of veins over the upper part of the chest, and characteristic cough.

Mr. Laming Evans showed a case of "fragilitas ossium." There had been twelve fractures, involving the right humerus and both femora. There was great deformity of the limbs, and false joints had formed. Skiagrams were shown.

Dr. Willcox showed a case of congenital dislocation of the hip.

The cases were discussed by the President, Sir Wm. Broadbent, Mr. Edred Corner, Mr. Laming Evans, Dr. Guthrie, Dr. Sutherland, Dr. Langmead, Mr. Murphy, Mr. Crisp English, and Dr. Willcox.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, May 10th, 1908.

AT the Laryngological Society of Berlin, Hr. Finder reported on a case of

TUBERCULOSIS OF THE LARYNX AND PREGNANCY.

A woman, æt. 23, had suffered from hoarseness from October, 1905, caused by laryngeal tuberculosis, with ulcer on the posterior wall. Improvement took place under treatment with lactic acid. Pregnancy then supervened, the patient becoming rapidly worse. Artificially abortion was induced. With renewed treatment improvement set in. During the summer of 1906 pregnancy again took place. The improvement, however continued, the ulcer healed, with slight thickening of the posterior wall of the larynx and redness of the vocal cords. In a normal labour the patient gave birth to a healthy and strong child. In October, 1907, the patient became pregnant for the third time, and in January last spontaneous abortion occurred.

A similar case was reported by Hr. Davidson.

Hr. Lenhoff also reported the case of a woman who became pregnant whilst suffering from advanced tuberculosis of both larynx and lungs, and did well at her confinement. To his great surprise, about eight months afterwards the patient again presented herself in a condition of pregnancy, but very ill indeed. The labour passed off normally, but a few months later she had to have tracheotomy performed, her difficulty of breathing being so great. This led to an improvement that lasted several months, but the patient at last succumbed to gradual loss of the vital powers.

THE MORTALITY OF PRUSSIA.

Official statistics have just been published of the mortality in 1906, and, without going into any details, some interesting facts may be gathered. Tuberculosis, notwithstanding its diminishing tendency, caused a considerable proportion of the mortality. Of persons living on January 1st, 1906, 17.26 per 10,000 died of the disease, as against 19.13 in 1905. Inflammation of the lungs caused a mortality nearly as great—viz., 14.14, against 15.45 in 1905. Amongst the deaths from child-bed were included not only the cases immediately fatal, but also those dying from causes connected with it, including puerperal fever, and the death-rate was 1.97, against 2.13 in 1905, whilst the deaths from typhoid fever were only 0.62 and 0.73 in the two years respectively.

As compared with the year 1875, the returns show a very great improvement. The mortality for 1906 was 18 per 1,000, whilst in 1875 it was 26.3. As regards deaths from communicable diseases, the number was less by 16,436 than the previous year.

Twenty-six people died from diseases communicated by animals; there were 4 deaths from rabies, against 12 the previous year, the cause in all the cases being bites by rabid dogs. Anthrax caused 21 deaths—19 males and 2 females—against 18 in 1905. No deaths from trichinosis were announced during the period.

The *Deutsche Med. Zeit.*, No. 31, contains a *résumé* of a paper on the treatment of

INFLAMMATION OF THE MIDDLE EAR,

by Dr. J. F. Neumann. Middle-ear diseases, according to the author, occur *per contiguitatem* from the Eustachian tube; some few, however, are hæmatogenous. The secretion is at first usually sero-mucous. After spontaneous or artificial perforation it becomes purulent from immigration of pus germs either along the tube or through the external meatus; the exudation is purulent from the first only in cases connected with acute infective diseases. At the commencement of a case of acute otitis media, warm moist applications are to be prescribed, compresses soaked in a lotion of liq. plumbi; one should be passed into the ear, the others in front of and behind and over the ear, and all covered with some waterproof material. Cold applications are not so useful, as experiment has shown that inflammations are best combated by warmth. The dressing remains on for twelve hours, and should be continued until either recovery or perforation takes place. The writer has an abhorrence of the Politzer procedure, and also of cleansing the ear with the syringe. The auditory canal should be cleansed by dropping in a 1 to 8 per cent. of a H_2O_2 solution, and the removal of the softened discharge with pledgets of lint. After this a tampon is left in the canal. The tampon consists of absorbent cotton wrapped round a knitting-needle, and smeared over with red precipitate ointment. In place of the ointment-smeared tampon, one may be made use of that has been soaked for 15 minutes in a 1 to 10 per cent. solution of chloretone. Naturally other treatment demanded for other conditions will not be neglected.

AUSTRIA.

Vienna, May 10th, 1908.

NEPHRITIC TUBERCULOSIS.

LICHTENSTEIN presented a young woman, æt. 26, to the members of the Gesellschaft, on whom he had operated for tubercle of the kidney, and from whom he had removed the left. Three years ago she complained of great difficulty in urinating, and later suffered from severe colic, with pain across the whole abdomen. The diagnosis was a corroding destruction of the right kidney, with great enlargement of the left. In operating, both kidneys were exposed, and the left found to be a complete sac of pus, while the right, on the other hand, was normal. This mistake in the diagnosis was due to a crossing of the ureters, which is a very unusual condition.

CUTANEOUS GANGRENE IN HERPES ZOSTER.

Spiegler showed another interesting case of gangrene of the skin, resulting, as he said, from the Röntgen-ray treatment in leucæmia. The eruption on its first appearance was not gangrenous, which showed that the skin was in a healthy condition till the Röntgen rays altered the internal texture and produced an inflammatory process which altered the zoster to a gangrenous condition. Sternberg asked if the patient had been taking arsenic during the treatment. Spiegler replied in the affirmative, and thought that the relationship was between the zoster and the Röntgen rays. Sternberg differed from this opinion, and thought that the herpes zoster was due to the arsenic, which frequently occurs during the treatment of leucocythæmia with arsenic.

ORTHOSTATIC ALBUMINURIA.

Chvostek re-opened the discussion on Stejskal's paper on this subject, which was read last week. Chvostek is of opinion that the orthostatic albuminuria is simply a symptom of different phenomena, the most common of which are diseases in the kidney. He is therefore convinced that this form of albuminuria is nephritic in origin, and the orthostatic a simple type. It is true that orthostatic albuminuria does not always pass on to the severer changes and final destruction, but, like various hypotheses, these are insufficient for any other conclusion.

Loeb attributes orthostatic albuminuria to a particular loss of the coefficient in the cardiac impulse, which leads to a state of decompensation, and produces a functional disturbance in the veins that is fruitful of this form of albuminuria.

Jehle repeated his opinion of lordosis being the sole mechanical factor in the production of orthostatic albuminuria. Pelnack thought that the whole condition depended on the nerve system producing a congestion in the venous circulation of the kidney in the upright position, which may be due to an abnormal change in the motor supply, admitting an overflow into the splanchnic region, and thus producing a distension of the nephritic vessels. In this way oliguria is produced, and it is conceivable that the orthostatic position may also injure the filtering power of the kidney. We must either assume a physical temporary change or a permanent morbid one in the organ. In the upright position the albumin appears; when reclining it disappears. In the healthy individual no change is observed; therefore we must conclude that the filtering function of the kidney is damaged. It is also observed that nervous conditions produce albuminuria, and in certain conditions the nerve system may be disturbed in the recumbent posture or the normal reflex disorganised. It is also observed that this morbid state appears during the lengthening of the long bones, and disappears at puberty, frequently associated with chlorosis and morbid conditions of the genital glands. We have a similar disturbance in the climacteric period, which is only another disturbance of the vascular system. A congested state of the suprarenal bodies may be another source of trouble to the nervous supply of the kidneys.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

DEATH OF DR. TODD THROUGH MOTOR ACCIDENT.—We regret to record the death of Dr. Todd, of Callender, which took place on May 7th, as the result of injuries sustained in a motor accident on the previous day. Dr. Todd was returning from Strathlyn to Callender, when the car swerved and fell over an embankment on the shore of Loch Lubnaig. The other occupants of the motor escaped with trifling bruises, but the car fell on Dr. Todd and caused serious injuries. Deceased had an extensive practice, and was well-known and popular throughout Western Perthshire. He was a widower, and is survived by a grown-up family.

LARBERT ASYLUM SUPERINTENDENTSHIP.—The Stirling District Board of Lunacy met on May 7th, and appointed Dr. R. B. Campbell, M.B., C.M., as Medical Superintendent of Stirling District Asylum, in succession to Dr. G. M. Robertson, who has been elected Superintendent of Morningside. Dr. Campbell is 37 years of age, and held junior asylum appointments at Inverness, Montrose, and Dumfries Asylums, until his promotion about four years ago to the Medical Superintendentship of Inverness Asylum. The other names on the short list for Larbert were Dr. Sturrock and Dr. Rutherford.

DUTIES OF THE EDINBURGH POLICE SURGEONS.—A memorandum has been issued for the information of intending applicants stating that the duties attaching to these offices will be as follows:—To give medical and surgical attendance to members of the police force; to attend daily at the divisional headquarters to see sick and hurt constables; to certify fitness for duty and weekly pay bills as regards numbers of men off duty; to give medical attendance to prisoners in cells of district police stations, and to attend emergencies in the division. The salaries offered vary with the size of the division, from £15 to £80 per annum.

EDINBURGH ROYAL INFIRMARY.—At the last meeting of the managers, a letter was read from Dr. F. W. Haullain intimating his resignation of the post of Assistant Gynæcologist to the institution on the ground that his outside duties made such demands on his time as to render it impossible for him to continue to officiate. The letter was remitted to the medical managers. Though a comparatively young man, Dr. Haullain has for a number of years held one of the largest gynæcological practices in Scotland, and, under ordinary circumstances, the infirmary would have enjoyed the benefit of his services for fifteen years or more. His resignation would be a great loss to the infirmary, and the managers appear to have recognised this in deferring its acceptance meanwhile and remitting the subject to the medical committee. At the same meeting the resignation by Dr. Wade of his position as Assistant Pathologist, owing to his election to an assistant surgeonship at Leith Hospital, was intimated.

ROYAL COLLEGE OF SURGEONS, EDINBURGH.—An exensive reconstruction of the premises of the Royal College of Surgeons has been decided upon. The existing buildings will be connected directly with two tenement blocks in Hill Square, which are to be cleared out and rebuilt as laboratories, museum premises, and workshops. A large new hall will be formed on the first floor by building out on either side, the added structure being supported on stone piers. Among other internal structural changes will be the building of a new public staircase to the museum. The works are in the hands of Messrs. Rowand Anderson and Paul, architects, and are estimated to cost several thousand pounds.

BELFAST.

HOSPITAL ABUSE.—The question of hospital abuse in Belfast was raised in the Ulster Medical Society a few months ago by Mr. Fullerton, one of the assistant surgeons to the Royal Victoria Hospital, and, as the result of his efforts, a conjoint meeting of the Ulster Medical Society and the Ulster Branch of the British Medical Association was held, and a committee, consisting chiefly of general practitioners, was appointed to draw up a series of resolutions on the subject. These were printed and circulated, and a meeting of the Ulster Medical Society was summoned to consider them. At this meeting only five members turned up, and it was adjourned for a fortnight. At the adjourned meeting, held on Thursday evening, the 7th inst., the attendance had increased to eleven, including the President and Secretary of the Society. Attention was called to the fact that ten of those present held hospital appointments, while the eleventh was a senior member who had held one in the past. There was not a single representative of the ordinary general practitioner in whose interest the discussion was to take place, and a motion to adjourn the discussion for the present was passed *nem. con.* The resolutions, which have been drawn up with great care, certainly merit discussion, and no doubt they will be considered at the beginning of next session. Meantime, they will be brought up at the annual meeting of the Ulster Branch of the British Medical Association, to be held in Belfast in June. There is a strong feeling among the hospital men that the general practitioners have only themselves to thank for the way in which their patients go off to hospital. If only they would take the small amount of trouble necessary to write a note to the hospital man with each patient they send, it would be far easier to stop unsuitable cases. No doubt there is something to be said on the other side, and among the younger consultants specially there is a great temptation to treat any interesting case without too careful inquiry as to its suitability for hospital. It is abundantly evident to all who have studied the question that it is only by mutual goodwill and good faith between the general practitioner and the hospital man that hospital abuse can be checked.

THE IRISH UNIVERSITY BILL.—The papers continue to print columns of letters upon the University Bill, discussing endless side issues, but generally ignoring the main issue—how University education is to be extended and popularised in Ireland. The General Assembly of the Presbyterian Church in Ireland has met and discussed the Bill, the general result being to show that a large number of the younger clergy of that Church are in favour of it, and many more are convinced that it will become law, and though it does not please them in all particulars, they are prepared to accept it and make the best of it. The Royal University Graduates' Association is still strong in opposition, but this opposition is discounted by the fact that the Association is not a representative Association of Royal University graduates, as its name might seem to imply, but is really an Association got up by the late Dr. McKeown for the express purpose of opposing a local University. As such, the Association is true to its foundation principle in opposing the Bill to the bitter end.

LETTERS TO THE EDITOR.

THE DRINK QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad to see your admirable editorial notes to-day on this subject. The abuse of alcohol—drunkenness—as observable in the individual citizen or the nation, is merely a symptom or sign of deep-seated physical, mental and moral diseases, and cannot be effectually dealt with except by treatment of the true efficient causes. In some places where a small percentage of public-houses has been abolished during the past few years the convictions for drunkenness have been diminished, and these events have been placed by some temperance orators in the relation of cause and effect. Such an argument I listened to within the past few days, the speaker illustrating his remarks by the case of Liverpool. It would be impossible to produce a more fallacious argument. During the past thirty years every single measure possible for the social advancement of the people of Liverpool has been promoted on a vast scale. Formerly many thousands of the poor lived in cellars, and many more thousands in overcrowded slum dwellings of the worst description. There was virtually no provision for the isolation of infectious diseases, and none of the beneficial powers of latter-day sanitary legislation had been brought to bear. The speaker also omitted to mention that the tens of thousands of sailors landing in the port from week to week are now effectually protected against the army of male and female reprobates, by whom they were formerly captured, made drunk and plundered. Fine open spaces, magnificent parks, public libraries, art galleries, and every possible civilising influence have been provided within late years, and yet the fanatic can ignore all these factors and ascribe the improvement entirely to the shutting up of a few public-houses. There is no suggestion of abolishing alcohol, and it is evident that slight restriction will be met by provision of more places in another. For example, the mere threat of doing away with grocers' licences has already induced the great houses supplying grocers to open retail shops of their own in many provincial towns. The enormous success of fraudulent quack tonics, the chief ingredient of which is alcohol, suggests another line of supply to the inebriate. The drunkard, as a rule, has no "palate," he cares only for the intoxicating effect of his liquor, and if he can't get vile spirit under the name of gin or whisky he will be satisfied with a concoction of alcohol in one of the forms in which the nostrum-monger may purvey it. Large numbers of women are being insensibly converted into dipsomaniacs by the use of alcoholic mixtures labelled "tonics"; and a vast number of drunkards among women of the "respectable" and well-to-do classes are finding in these "tonics" a means of indulging their morbid appetite without the restraint which the difficulty of secretly obtaining alcohol from the usual sources formerly imposed upon them. Here is a fine field for Government inquiry and interference.

I am, Sir, yours truly,
MEDICAL TEMPERANCE REFORMER.
Liverpool, May 6th, 1908.

MARRIAGE OF THE UNFIT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The question of the morality of marriage on the part of persons likely to transmit disease to their offspring is clearly one of the utmost importance to the future of our race. In the case of consumption it would be unsafe, from a medical point of view, for either party to a marriage contract to complete the same while suffering from active tuberculosis. No responsible medical man would sanction such a step. Yet when we come to a no less deadly and disastrous microbial disease, syphilis, we find that marriages are contracted in all grades of society without the least inquiry as to the existence or otherwise of this loathsome malady. So far as the medical profession is concerned, marriage is forbidden in accordance with certain well-defined time limits after the disappearance of all symptoms. But I maintain, Sir, that we should not be content with this passive appeal to medical skill and knowledge. We should impress on the public the duty of parents and guardians to ascertain as far as possible, by careful medical examination, that both parties to a proposed marriage are free from obvious grave disease. In that way it would be possible to eliminate, not only tuberculosis and syphilis, without involving any great personal stigma, but also such conditions as grave organic affections, malaria, diabetes, cancer, and mental unsoundness. There is too much false shame about matters of this kind, and a firm, common-sense handling of them might prevent an immense amount of married misery.

I am, Sir, yours truly,
VERITAS.
Sydenham, S.W.

OBITUARY.

EDWARD HARFORD LLOYD, R.A.M.C.

WE regret to announce the death of Surgeon Lieutenant-Colonel Edward Harford Lloyd, who died on Sunday evening at the Royal Naval Hospital, Chatham. He was on a visit to Fleet Surgeon H. L. Penny at the hospital when he had a heart attack and expired suddenly. He was 72 years of age. He joined the Army as an assistant-surgeon in 1859, was promoted to the rank of surgeon in 1873, and to that of surgeon-major in 1875. He retired in 1885. He served with the Nile expedition in 1884, and was in charge of the field hospital at Kaibar, receiving the medal with clasp and the Khedive's bronze star.

ALEXANDER JOHN BALMANNO SQUIRE, M.B. LOND., M.R.C.S., F.L.S.

WE regret to announce that Mr. A. J. Balmanno Squire died on Thursday last at his residence, 24, Weymouth Street, at the age of 71. Professionally educated at University College Hospital, he became a member of the Royal College of Surgeons, England, and a licentiate of the Society of Apothecaries in 1858, and subsequently took the M.B. degree at London University (gold medallist). He had been house surgeon at University College Hospital, senior surgeon to the British Hospital for Diseases of the Skin, medical officer of St. Marylebone General Dispensary, and lecturer at St. Mary's Hospital Medical School. He was a Fellow of several learned societies, and was the author of several important works on diseases of the skin, amongst which may be mentioned "An Atlas of Coloured Photographs of Diseases of the Skin," "A Manual of Diseases of the Skin," "Treatment of Psoriasis," and "On Lupus." He was the writer of the article on "Skin Diseases in Reynold's System of Medicine."

FREDERICK HOWARD TINKER, J.P., M.R.C.S., L.R.C.P.ED.

WE regret to announce the death of Dr. F. H. Tinker, J.P., who had been for many years a prominent medical practitioner at Hyde, while he was an ex-President respectively of the Ashton and District Medical Association, the Hyde Mechanics' Institution, and the Hyde Division Conservative Association. He was appointed a Justice of the Peace on the formation of the borough bench at Hyde, and was some years ago placed on the Cheshire County Bench.

REVIEWS OF BOOKS.

THE CHEMICAL BASIS OF PHARMACOLOGY.

NO one more than the student of pharmacology deplores the fact that this country is behind in the matter of supplying new synthetic products. The cause of this lies in the fact that little or no atention is paid to chemistry, which, after all, underlies the study of pharmacology and its applications. The chemistry of the various synthetic products introduced into this country by foreign manufacturers is altogether unknown to the practitioner, who, unfortunately, takes little or no interest in the exact composition of the drugs he employs in his practice. Still, the scientific side of medicine can only be developed to its fullest extent when such a knowledge has been acquired. We believe that the volume before us will do much to further such a knowledge. Too long we have been without an English text-book on this all-important subject.

The modes of preparation of the hydro-carbons, together with their properties, form a suitable introductory chapter, in which the methods used in the synthesis of their derivatives are fully discussed. The physiological characteristics of the hydro-carbons are also very fairly considered and commented upon. Alcohols and their derivatives take up considerable space in this work. The aromatic antiseptics, such as creosote, guaiacol, and their derivatives, call for special remark. Substances containing iodine and sulphur include iodoform and ichthyol. Here we find the various substitutes for iodoform, such as europhen and aristol, referred to. The iodides have been largely replaced by such substances as iodalbin and iodipin. The latter is a preparation formed by the addition of iodine to sesame oil. The value of this substance when given subcutaneously has been recently referred to in this country by Burnet in a paper read before the Therapeutical Society. The chemistry of ichthyol has always formed a subject of great interest and speculation. It is an organic sulphur compound of great value medicinally.

The antipyretic series of hydro-carbons is of great interest and importance, and is fully discussed in a special chapter. Their antipyretic action is a function of the benzene nucleus. Recently urea derivatives have been introduced. Of these the best known, perhaps, is veronal. This belongs to the urethane group of hypnotics, which also includes hedonal. The purin derivatives also call for remark.

The chemistry of the alkaloids will be followed with interest by every reader of this work. Three chapters are devoted to their very full consideration. A chapter on local anæsthetics is one of great interest and importance, while the section on glucosids is of considerable value. A chapter on dyes and perfumes concludes the volume.

We have not attempted to criticise the subject-matter of this work, for to do so would have required more space than we have at our disposal. Of course, in a volume such as this, there must be room for criticism, favourable and otherwise; but, on the whole, we are bound to speak of it in terms of the highest praise. In no other English work have we ever found such a full and complete review of the chemistry of drugs. In Germany many such text-books exist, but these are not always available to the English reader; accordingly, the writers of this volume have done well in publishing it. Its need is all the more essential when we find that manufacturers are now disguising the real nature of remedies by adopting short and often meaningless names for them. Thus urotropine is known by at least half a dozen other terms, which only serve to confuse and to mislead the practitioner.

We sincerely trust that this work will serve to awaken an interest in the study of pharmacological chemistry in our medical schools, in many of which we fear that the subject of pharmacology is taught in a very crude fashion. The haphazard use of every new drug is, in these days, a thing to be regretted, and it is only by the careful study of such a work as this that the present-day evils of improper medication can be avoided.

THE OPERATIONS OF SURGERY. (a)

JACOBSON'S "Surgery" has been so long known, and its value has been so much appreciated by successive generations of surgeons and students, that a new edition is always greeted with interest, and one turns eagerly to find what alterations have been made. In the present edition the first feeling is almost one of alarm at the enormous increase in size of the work, the first volume containing over 900 pages and the second over 1,100; and yet, as one thinks of the increased activity in recent years in all departments of surgical work, one cannot be surprised. It will, however, add seriously to the work of those who read this book for the higher examinations. Mr. Jacobson has himself once again undertaken the greater part of the work, but has handed over to Mr. Rowlands the important section of the surgery of the abdomen, whilst Mr. Bellingham Smith has revised the chapters dealing with "Operations on the Ovaries and Uterus." Once again we note with regret the statement that this is the last edition that Mr. Jacobson himself will superintend, and we appreciate sympathetically the pathos of the note that tells us that this was merely undertaken "for the sake of occupation of mind."

Coming now to the work itself, and looking at it in a dispassionate manner, the critic is bound to ask, after a careful examination: Is it a complete and up-to-date representation of operative surgery? Is the increase in size justified? Is the information accurate? In the first place, one has always felt a definite want in the book in the absence of any expression of opinion as to operative *technique*. At one time surgical methods varied so greatly that the exclusion of such a subject was comprehensible; but varying opinions have now been crystallised into methods easily to be classified and only differing in the lesser details; and one would submit that a work which can discuss at length details of diagnosis and methods of examination as questionable as the methylene blue and chloridzin tests of renal efficiency, might well spare a chapter or two to help the beginner to attain a consistent asepsis which is the ultimate fundamental justification for all his surgical activities.

The actual changes in the work necessarily group themselves under the headings of additions and removals. As to the former, modern surgical literature has evidently been thoroughly ransacked, and a vast amount of new material added. Large sections, in places amounting to eight or ten pages, have been transcribed—*e.g.*, that dealing with the plastic surgery of tendons and muscles; single cases of new methods are here and there recorded *in extenso*, with borrowed illustrations; and one cannot but feel that in places the effort to be up-to-date has resulted in the recognition of procedures which will be demonstrated in time to be neither advisable nor harmless. In this connection one misses somewhat that which constituted one of the chief charms of this work in former editions—viz., the author's well-balanced criticism on the methods suggested as the outcome of his extensive personal experience. It is unnecessary to give a list of the various subjects that appear for the first time, but when one indicates, amongst others, that the surgery of the accessory sinuses of the nose, muscle, tendon and nerve grafting, the fixing of fractures by operation, new plans of excision of joints, and of amputations, references to the treatment of various affections by light and X-rays, paraffin injections, etc., it will be obvious that there cannot have been much in the shape of modern progress that has been overlooked.

(a) "The Chemical Basis of Pharmacology: An Introduction to Pharmacodynamics based on the Study of the Carbon Compound." By Francis Francis, D.Sc., Ph.D., Professor of Chemistry, University College, Bristol; and J. M. Fortescue Brickdale, M.A., M.D.Oxon. Physician, Bristol Royal Hospital for Sick Children, &c. London: Edward Arnold. 1908. Price 14s. net.

(a) "The Operations of Surgery." By W. H. A. Jacobson, M.Ch. Oxon., F.R.C.S., Consulting Surgeon to Guy's Hospital, and P. R. Rowlands, M.S.Lond., F.R.C.S., Assistant Surgeon, and Surgeon to the Orthopædic Department, Guy's Hospital, &c. Fifth edition, with 777 illustrations. Two volumes. J. and A. Churchill. Price 42s. net.

As regards elimination, a good deal of old material has been removed; but we cannot help feeling that a still more radical procedure was required here and there. For example, amputation at the hip-joint would never in the present day be undertaken by transfixion, and surely this method, together with Fergusson's old illustrations of it, might with advantage disappear. A similar criticism might well apply to not a few other amputation records; the new is present in most cases, but the old has been also retained. Then, too, there are here and there lists of cases which were of value and interest in days when such proceedings were not common, but which are now comparatively unimportant—*e.g.*, the list of twenty-one cases of nephrolithotomy on pages 188 and 189 of the second volume. The operation is now so common and so successful that these early successes are merely of interest historically. The retention of such things makes the work patchy, and adds much to its bulk.

A special notice must be given of the abdominal section, in that it is the work of Mr. Rowlands. It is a great improvement on the old, and is to a large extent an up-to-date record of modern methods, although here, too, there is an evident desire to retain so much of the old as to render it a little patchy at times. A useful chapter on abdominal aneurysms has been added, but we notice no reference to the method of treatment suggested by D'Arcy Power and Colt. The consideration of hernia is a great improvement. Taxis is merely referred to in the remark that it is important not to waste valuable time over it. In all cases of operation for strangulation one is advised to open the sac, and the old-fashioned method of operation without opening it is omitted for the first time. Gangrenous gut is always to be excised, and, if possible, at once, and the formation of an artificial anus thereby avoided. As to the radical cure of hernia, many of the former methods disappear, and reliance is placed in inguinal hernia on Halstead's, Bassini's and Macewen's methods. As to the intestinal work, one would have gladly seen reference to many of the plans of utilising buttons, bobbins, and artificial appliances of that type omitted, and the surgeon told to depend on the deftness of his own fingers alone. At the present time Murphy's button is merely of historical interest, and the six pages devoted to its consideration might have been saved. Gastric surgery is well represented, but again there are included methods which will probably disappear when further experience of them has been obtained.

Coming finally to the question of illustrations, one would urge the necessity of a much more thorough revision than has yet obtained. There are many excellent modern engravings and wash-drawings, but many of the line drawings are hopelessly antiquated and seriously defective. The whole work is enormously improved, and the amount of information is almost alarmingly extensive. The only fault really to be found is in the direction of imperfect elimination of old and effete material, and doubtless the necessity has merely to be pointed out in order to ensure its accomplishment in one of the many more editions which we heartily trust lie in front of this valuable text-book.

PRACTICAL ANATOMY. (*a*)

WE have great pleasure in welcoming a new edition of Professor Cunningham's Manual of Anatomy. This text-book is so well known and popular in the medical schools that it is not necessary to discuss its merits.

The third edition, published in 1903, possessed many marked improvements compared with the previous issues. The most noticeable feature in it was the many new and excellent illustrations which it contained. In the present, or fourth edition, there are numerous additional figures of the same useful and artistic type throughout the work. Perhaps in this connection those depicting the ligaments round joints may be particularly drawn attention to. The size of the volumes is not materially altered. We notice in Vol. I. that the anatomy of the stomach, especially of its pyloric portion, is dealt with in greater detail. Vol. II. contains a description of the auriculo-ventricular bundle, with an illustration of it, dissected in a calf's heart. The sections through the temporal bone have been omitted in the anatomy of the auditory apparatus, which is a matter for regret.

MANUAL OF SURGERY. (*b*)

THE second volume of this edition of Thomson and Miles' manual, which deals with Regional Surgery, has undergone more alteration and improvements than is to be found in Vol. I., previously reviewed. When first published, in 1904, this part of the work was not nearly so well illustrated as at present. There are 50 additional figures. Well-selected and artistic wood-engravings and diagrams, provided the text is good, as we find here, are an immense help and advantage in studying a subject such as surgery. The volume before us has been increased by one hundred pages. The arrangement of the articles has, in some cases, undergone considerable emendation. There are several new paragraphs, for instance, on lumbar puncture, the exercises for lateral curvature, and the treatment of pruritis ani.

We congratulate the authors for availing themselves so successfully of the opportunities afforded them by the publication of a new edition, to increase the efficiency of their work. The manual can be strongly recommended to the practitioner and student as a well-written and up-to-date text-book of surgery.

INJURIES OF NERVES. (*c*)

MR. SHERREN has been distinctly successful in the treatment of his subject. His book is marked throughout by clearness of thought, careful observation, and critical acumen. With regard to the vexed question of primary union of a divided nerve, *i.e.*, without the occurrence of degeneration in the peripheral end, the author states: "When every case of nerve division is tested carefully before as well as after suture, no more will be heard of primary union." This pronouncement, coming with the *ex cathedrâ* authority of Mr. Sherren, should settle the matter for good. The book merits an unqualified tribute of praise, and is, without doubt, a valuable addition to the somewhat scanty literature of the subject, and should be considered indispensable to every operating surgeon, as well as to the physician who is specially interested in neurology.

(*a*) "Manual of Practical Anatomy." By D. J. Cunningham. M.D. Edin. and Dub., D.Sc., LL.D. St. And. and Glasg., D.C.L.Oxon. F.R.S., Professor of Anatomy in the University of Edinburgh. Vol. I. Upper Limb, Lower Limb, Abdomen. Vol. II, Thorax, Head and Neck. Illustrated with 473 engravings, many in colours. Fourth Edition. Edinburgh and London: Young J. Pentland. 1907.

(*b*) "Manual of Surgery." By Alexis Thomson, F.R.C.S.Ed. Assistant Surgeon, Edinburgh Royal Infirmary; Surgeon to the Deaconess Hospital, Edinburgh; and Alexander Miles, F.R.C.S.Ed., Assistant Surgeon, Edinburgh Royal Infirmary; Surgeon to Leith Hospital. Vol. II, Regional Surgery. Second edition, revised and enlarged, with 203 illustrations, mostly wood engravings. Edinburgh and London: Young J. Pentland. 1907.

(*c*) "Injuries of Nerves and their Treatment." By James Sherren, F.R.C.S. Pp. 310. London: James Nisbet and Co.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT PATHOLOGICAL LITERATURE.

Excretion of Urotropin in the Bile and Pancreatic Juice.—Crowe reports the results (*Johns Hopkins Hosp. Bulletin*, April, 1908, p. 109) of an investigation into the paths of excretion of urotropin from the body. The investigation was undertaken as a result of a suggestion that a biliary antiseptic would prove of great value in the treatment of patients whose gall-bladders contained typhoid bacilli, and the drug hexamethylenamin was selected on account of the fact that it is at present largely used for bacilluria, and is, moreover, easily recognised by chemical tests. The experiments were carried out on dogs and a few observations were also made on patients presenting a biliary fistula. The principal results are summarised as follows:—(1) After its administration by the mouth, urotropin appears in the bile and pancreatic juice of dogs. It finds its way into the bile both through the liver and through the wall of the gall-bladder. (2) It has been demonstrated in the bile, cerebro-spinal fluid, synovial fluid, saliva, pleural effusion, and blood of man. (3) When given in doses of about 75 grains daily, it appears in the bile in quantities which suffice to exercise a decided bactericidal action. M.

Effect of Injected Leucocytes upon the Development of a Tuberculous Lesion.—Opie has succeeded in obtaining large quantities of washed neutrophile cells from the dog by the repeated injection of turpentine into the pleural cavity, and has experimented with them to see if their injection can arrest the progress of a tubercular lesion (*Johns Hopkins Hosp. Bulletin*, April, 1908). An emulsion of tubercle bacilli is first injected into the pleural cavity of a dog, and then an injection of the leucocytes is given. In control animals death occurs in five to six weeks, with marked tuberculosis of the pleural surfaces and of the intrathoracic lymph glands. Injection of approximately 10 c.c's of leucocytes alters materially the clinical course of the disease, as far as dulness on percussion is concerned, but the disappearance may not be permanent. In several instances, however, tuberculous animals which have repeatedly received leucocytes have been found at autopsy to present almost entirely normal pleura and mediastinum, while the control animals showed numerous tubercular nodules and caseous masses.

Hæmatogenesis in Fœtal Sheep.—Goodall has studied the development of the hæmopoietic organs, and hæmatogenesis generally in a series of fœtal sheep, and has arrived at the following interesting conclusions (*Journal of Pathology*, Jan., 1908, p. 191):—(1) In fœtal sheep, measuring from 6 to 1 c.m., hæmatogenesis consists in a proliferation of hæmoglobin—containing megaloblasts in the vessels and connective tissues. (2) The liver is the most important hæmogenetic organ (erythroblastic and leucoblastic) in fœtal life, and no diminution in the activity of its hæmogenetic functions occurs till near the end of intra-uterine life. (3) The thymus lymphocytes are derived from the primitive leucocytes, and not from hypoblastic epithelium. Leucocytes are numerous in the liver and elsewhere before they appear round the thymus epithelium. M.

Epidemic Pneumonia.—Antonine reports the occurrence of acute lobar pneumonia, in an epidemic form, in an infantry regiment, which he had under observation (*Zentralblatt, für Inn. Med.*, No. 15, 1908, p. 368). Out of a total of 600 men 56 were within a short period affected by the disease. During the epidemic certain cases of pneumonic infection of parts other than the lungs occurred, and the author refers especially to one case of acute pneumococcic polyarthritis, and to another of acute middle ear disease complicated with perineal abscess and meningitis. The predisposing cause of the pneumonia appeared to be in most of the cases exposure to cold. The general type of the disease was mild, as all the cases terminated in recovery. M.

Opsonins and Agglutinins.—Sleeswijk (*Annales de l'Institut Pasteur*, December 25th, 1907) publishes a contribution to the study of opsonins more sympathetic with Wright's work than the previous studies emanating from the Pasteur Institute. Up to the present, the workers in the metropolis of bacteriology have been somewhat sceptical of the existence of opsonins as distinct bodies. Sleeswijk, however, by experiments on frogs with the anthrax bacillus, has satisfied himself that opsonins are, at any rate, distinct from agglutinins. On the other hand, he hints that he is in agreement with Levaditi in the view that the normal opsonin is identical with the complement. He states the following as the results of his experiments:—(1) There are in the serum of the frog two bodies (*a*) a substance which prepares the anthrax bacillus for phagocytosis by the phagocytes of the frog; (*b*) a substance which causes agglutination of the anthrax bacillus. (2) Substance (*c*) the opsonin is destroyed by heating at 56° C., while the agglutinin (*b*) is only destroyed at 70° C. (3) The opsonin acts on the bacteria, fixing itself equally on virulent and dead organisms, but not on an indifferent substance such as carmine powder. (4) Lymph and peritoneal exudate have an opsonic power like serum. (5) The phagocytes of frogs may be deprived of their phagocytic power by washing them twice for five minutes in normal salt solution. They may have their power restored by the fresh serum of the frog, while they are left unaffected by warmed serum. R.

The Spirochæte of Yaws.—Castellani describes in detail (*British Medical Journal*, December 23rd, 1907), under the title, *spirochæta pertenuis*, the organism first noted by him in a case of yaws, in 1905. It is an extremely delicate, motile, spiral-shaped organism, varying from a few microns to 20 microns in length. It is stained with difficulty, but good preparations can be obtained either by Leishman's or Giemsa's stain. The number of waves in the body varies, and sometimes part of it is quite straight. Sometimes two spirochætes seem to be twisted together. Castellani thinks he has observed the presence of a flagellum at one end, but requires further investigation to establish the fact. In proof of the spirochæte being the specific cause of yaws, he advances the following facts:—(1) In the non-ulcerated papules, in the spleen, and in the lymphatic glands of yaws patients, as well as of inoculated apes, the *spirochæta pertenuis* is the only organism present, no other being demonstrated either by microscope or culture. (2) The extract of yaws material, containing the spirochæte, but no other organism, is infective to monkeys. (3) The extract of yaws material from which the *spirochæta pertenuis* has been removed by filtration becomes inert. R.

Opsonins and Vaccine Therapy.—The May number of the *Practitioner* is devoted to this subject, and contains articles by Wright and a dozen or more of his disciples. Passing over all question of the utility of vaccine therapy as a settled matter, Wright devotes himself to two practical points—(1) The question whether it is possible to achieve and maintain the desired improvement in the patient's blood apart from periodic blood. (2) The question as to what is the best method of directing such protective agencies as a patient may be possessed of, or acquire by immunisation, to the destruction of the microbes in the focus of infection. In reply to the first question, Wright argues strongly in favour of the advantage gained by regular periodic estimations of the opsonic contents of the blood. Vaccine treatment guided merely by clinical signs is a crude affair, and cannot give the best results. In certain mild or strictly localised infections, however, good results can be got by the use of doses which have been originally determined under opsonic control. On the other hand, in many cases where the course of the disease is difficult to determine, as in most tubercular affections, and in all cases of general septicæmia, clinical symptoms are not to be trusted to furnish the necessary guidance. In the latter class of cases the use of vaccines without opsonic control would appear to be highly risky. On the second point Wright has a very interesting discussion. He holds that in the circulating blood the organism has at its immediate disposal practically the whole of its defensive forces, the phagocytes, and the bacteriotrophic substances existing in the plasma. The object of our treatment, therefore, in all cases of localised infection should be to level up the conditions of the infected tissue to the conditions in the blood. This effect can be best produced by aiding the lymphatic circulation. This can be done in various ways, the old-fashioned remedy of poultices or fomentations being efficacious. In another manner the lymph circulation may be increased by diminishing the coagulability of the blood. This is easily done by the administration of decalcifying agents such as citric acid. Wright recommends 4 grammes three times a day by the mouth, while as a lotion for sinuses and discharging abscesses he suggests 4 parts of common salt and one of citrate of soda in 120 parts of water. Wright's paper is intentionally practical and popular rather than scientific. Fleming contributes a conscientious paper on the accuracy of Wright's method of opsonic determination, and on some of the sources of error. The paper is based on the fullest series of tables which has yet come from St. Mary's Laboratory. He quotes Bullock's observation of the tuberculo-opsonic index in 84 presumably healthy people, where he found that 75 came out with indices between 0.90 and 1.10. In St. Mary's, of 635 estimations in normal sera, 0.8 per cent. were under 0.90, 10.1 per cent. between 0.90 and 0.95, 76 per cent. between 0.95 and 1.05, 10.7 per cent. between 1.05 and 1.10, and 1.7 per cent. over 1.10. Fleming proceeds to point out various sources of error:—(1) With a diminution in the number of washed corpuscles in the opsonic mixture there is an increase in the amount of phagocytosis. (2) Agglutination of the washed red corpuscles increases the amount of phagocytosis. (3) If red corpuscles are taken up with serum the amount of phagocytosis is reduced. (4) Serum sealed in a capsule at room temperature retains its full power, in the case of healthy blood, for at least a week, and, in the case of pathological blood, for a day or two less. (5) Blood capsules left widely open for several hours give very untrustworthy readings. Other conclusions arrived at are:—(1) The tuberculo-opsonic index is the same, whether the washed corpuscles are from a healthy or tuberculous individual. (2) Two practised observers, counting the same slide, obtain results almost always within 10 per cent. (3) Duplicate estimations of the tuberculo-opsonic index of tuberculous patients can be performed, the results differing from each other by less than 20 per cent., except in rare instances.

Wells records certain opsonic estimations on infants under one year old, in relation to various bacteria. He concludes:—(1) A low opsonic index is not diagnostic in children under one year old. (2) In infants a low opsonic index is not inconsistent with health, and a child may be thriving well with a declining index. (3) A low opsonic index rises in response to the stimulus of an inoculation with a bacterial vaccine. (4) The healthy, breast-fed infant possesses no advantage over the healthy artificially-fed child. (5) The anti-bacterial defence in children cannot depend upon the opsonic content of the serum. White contributes a short note in reply to criticisms of the accuracy of the method of opsonic estimation. He shows that in 1906, when his methods were cruder than at present, the experimental error in normal bloods never exceeded 13 per cent. Greenwood, jun., has a very important note on statistical considerations relative to the opsonic index. The discussion is purely statistical. He found, in going over a number of counts of slides, a remarkable unevenness of distribution of the bacilli in the cells, or, in statistical jargon, an excessive "skewness." This, of course, does away, to a great extent, with the value of the average. He concludes:—(1) There is no valid evidence that the limits of error do not exceed 20 per cent. of the mean value. (2) In the case of low emulsions errors in excess are more frequent than errors in defect. (3) There is reason to hope that with high emulsions the variation may become symmetrical. Harris relates some of his experiences in treatment by vaccines. Most interesting are those relating to *B. coli* infections. The conditions treated were infections of the bladder and kidneys, infections of the uterus, colitis. He recommends 5 to 15 millions of bacilli given every two, five or ten days. Inman writes on the value of the opsonic index in the treatment of pulmonary consumption. He believes inoculation, either auto-inoculation or artificial inoculation, an important element in the cure of phthisis. In cases of phthisis not at rest, auto-inoculation is taking place, while in febrile cases rest is essential, and injections of tuberculin under the control of the opsonic estimation are useful. Briscoe and Williams discuss the same subject, with a record of the cases treated. The cases which have done best were those which presented the following conditions: Good physical state, as shown by relation of weight and height; absence of temperature after the first 14 days; pulse below 100; moderately low blood pressure; regular menstruation; a colour index 0.8 or over; red blood corpuscles not less than 4.5 millions per c.m.m.; leucocytes less than 15,000; and an opsonic index tending to remain below normal, and to react sharply to inoculations. The interval between injections was generally 14 days, but in some cases 17. Collier, in a sympathetic note on the relations of surgery to the opsonic methods, closes with a not unnecessary rebuke to the opsonists. "Upon those," he says, "who may intend to follow this specialty, I would urge the importance of wide clinical study, which will enormously add to their usefulness and enable them to escape from the danger of bigotry and the tendency to belittle the efforts of those in other branches of practice." Whitfield, in regard to the treatment of skin affections by vaccines, says that in generalised furunculosis the opsonic method surpasses all others; in early cases of sycosis cure is immediate; in acne the results are variable; in lupus the method is not in competition with the light treatment or ordinary surgical measures. The collection of papers, as a whole, forms a valuable exposition of the results of Wright's methods as practised by enthusiastic disciples. There is an entire absence of hostile criticism. The collection may, therefore, be regarded as an indirect answer to the Johns Hopkins criticisms which we abstracted some months ago. R.

MEDICAL NEWS IN BRIEF

The Irish University Bill.

The past week has brought forward a considerable expression of opinion regarding the Irish University Bill, and most of it can be reduced to the statement that the Bill is not good, but that it is better than none. However, good or bad, it will have received its second reading or else have disappeared before these lines are printed. The preliminary drafts of the charters of the new Colleges were published during the week. The names of the Governing Body of the Cork Colleges have been published, and the names of the Governing Bodies of the Dublin and Galway Colleges have been published as we go to press. We find in the case of the Dublin College the following medical men:—Drs. Denis J.

Coffey (President), M. F. Cox, J. S. McArdle, Alexander Dempsey, George Sigerson, and Sir Christopher Nixon. In the case of the Galway Colleges the following medical men are named:—Drs. Colohan, J. P. Henry, R. J. Kinkead, and J. P. Pye.

A correspondent has already called attention in our columns to the difference between the position of existing professors in the Queen's Colleges, as laid down by Mr. Birrell in his speech introducing the Bill, and as defined in the Bill itself. The question of their position has been raised in Parliament by Mr. Rawlinson, who asked the Secretary of the Treasury what were the maximum terms of superannuation which could be given to professors of Queen's College, Cork, and Queen's College, Galway, under the Irish University Bill; what were the terms of superannuation granted to the professors and officers of the Queen's University in Ireland who were not transferred to equivalent posts in the Royal University of Ireland.

Mr. Hobhouse replied:—"The maximum terms of superannuation—that is to say, pension granted on retirement through age or infirmity—which can be given to the professors under the Irish University Bill are the same as can be given to them now—viz., two-thirds of salary and emoluments, according to the scale laid down by Section 2 of the Superannuation Act of 1859. The maximum terms of compensation, as distinguished from superannuation, are to be determined in each case by the Commissioners appointed under the Bill, subject to an appeal to the Lord Lieutenant in Council. Professors and officers of the Queen's University in Ireland, who were not transferred to equivalent posts in the Royal University of Ireland, were declared entitled to receive by way of retiring pension the full amount of their salaries as officers of the Queen's University, under Section 14 of the University (Ireland) Education Act, 1879."

An important meeting has been held in London of past students of the Queen's College, Cork, for the purpose of considering what action could be taken to secure better treatment for the Queen's College than that foreshadowed in the Bill. The chair was taken by Sir T. J. Galway, K.C.M.G., C.B., who called on Dr. MacNaughton-Jones to make a statement. Dr. MacNaughton-Jones, after referring to the position of the Queen's College in the past, said that Munster was as much entitled to receive a new University as Ulster, and that there was no reason why it should only receive £18,000 while Ulster received £60,000. He considered that the example of Germany showed that population had nothing to do with the matter, as many of its most celebrated Universities were in towns not a third the size of Cork. The two points which they might submit to the Chief Secretary were, first, the utter inadequacy of the proposed grant, and, secondly, the need for greater independence with regard to the internal management.

After some further general discussion, it was decided to ask the Chief Secretary to receive a deputation of graduates and old students of the College.

A Rural Council and Medical Examination of School Children

The following resolution was passed at a meeting of the Rural District Council of Glendale:—"The members of this Council view with extreme disfavour the proposal of the County Education Committee with regard to the medical examination of school children. They consider such a system would entail a large and useless expenditure of ratepayers' money; they think it would be distasteful to very many of the parents; and they are, moreover, of opinion that if Parliament makes such an order, the funds to pay for the working of it should be provided out of the Imperial Exchequer and not out of local rates. They hope that the County Council will not adopt the proposal, and suggest that a strong protest should be sent to Parliament against such a method of legislating."

Dust in Factories.

Mr. Gladstone, M.P., the Home Secretary, received at the Home Office, on May 5th, a deputation, introduced by Mr. Shackleton, M.P., of the executive of the United Textile Factory Workers' Association, who drew his attention to the necessity for an improved exhaust fan for removing dust in the card-rooms, and to the long spell of five hours in bleaching which employers are endeavouring to introduce under a certain provision of the Factory Act of 1878. Mr. Gladstone, in reply, promised to make a close examination as to the hours of work, and to put the matter before the manufacturers. In regard to the dust-removing, he would continue the inquiries. He understood that the fibrous dust was actually dangerous, and had been the cause of permanent injury to health, and discontinuance, consequently, of active work. He asked if the deputation had any figures. Mr. Crinion said he would obtain some. Many young men under 30 years of age had been obliged to give up work through chest troubles. He knew of two cases recently where young operatives had been compelled to go into the workhouse.

Medical Defence Union.

The annual general meeting of the Medical Defence Union will be held on May 21st, at the Medical Institution, Hope Street, Mount Pleasant, Liverpool, at 4.30 p.m. The annual report of the Council, together with the balance-sheet and accounts as certified by the auditors, will be presented to the members, and the usual statutory business as required by the Articles of Association carried out.

Tragic Death of Dr. Gramshaw, of York.

Dr. F. S. Gramshaw, of Bootham, York, was found unconscious in his bedroom on May 5th, and died the next day. The patient's condition up to a late hour on Wednesday, May 6th, gave cause for satisfaction, as during the afternoon Dr. Gramshaw was semi-conscious. Between 11 and 12 o'clock at night, however, pulmonary complications supervened, and from that time Dr. Gramshaw gradually sank. Death is ascribed to exhaustion and collapse, following the effects of the injection of morphia, presumably to induce sleep. The City Coroner had been informed of the occurrence, and an inquest was held on the 8th, when the jury found a verdict of "Suicide during temporary insanity." Dr. Gramshaw, who had practised in York for the past few years, was about 54 years of age. He received his early education at Woodbridge School, Suffolk, and commenced his medical studies at the University College, London, and pursued them later at St. Andrew's University, Dublin and Paris. The deceased gentleman was an extremely able practitioner, and held the following degrees:—M.D., St. Andrew's, 1896; M.D., Pennsylvania, 1871, F.R.C.S. (exam.), 1903; L. and L.M., 1878, L.R.C.P.I., 1885, L.A.H., Dublin, 1873.

Explosion at King's College Medical School.

An explosion occurred on May 8th at King's College Medical School in the Strand, whilst a number of the students were conducting experiments. An experiment was being made with sulphuric acid, when a cylinder burst and injured at least half a dozen of the young men. John Ricketts, who was burnt about the face and eyes, was admitted to the hospital as an in-patient. The others injured were:—Percival Newton, burnt hands and face; Herbert Buxton, burnt hands and face; Walter Harley, burnt hands and face. All are students.

Notes on Books.

We have received from the Editor of the *Chemist and Druggist* a booklet entitled "Dose Tables for Students of Pharmacy." It consists of tables showing the adult doses in ordinary cases of the principal medicinal agents, of the metric equivalents for dispensing, and of atomic weights, comprising the B.P. figures and the International Committee's latest pronouncements ($O = 16$ and $H = 1$). The little book is handy in form and likely to be very useful to those for whom it is intended.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

The following candidates have passed the Third Professional Examination, May, 1908:—W. Coffey, F. J. Colgan, C. H. Christal, W. Crymble, J. Donoghue, T. Duncan, J. Healy, D. J. Harty, F. J. O'Donoghue, P. O'Farrell, E. Ryan, T. Sheedy, P. T. Warren, R. S. White.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

SUBSCRIPTIONS.

Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

Pur.—The treatment of wounds by heat has been tried two or three times. Verneuille's method consisted in placing the part, thickly wrapped in cotton wool, in a kind of brick oven, and the plan has been somewhat revived by M. Asbeck, another Frenchman, who uses iodoform gauze to wrap the limb in, and a kitchen fire as the means of conveying heat.

Madeira.—The question is more a commercial than a medical one, and we are not clear as to the obligations of the parties. Besides there are points of foreign politics involved, with which we should be very sorry to interfere.

OYSTERS AND INFLUENZA.

The opening sentence of an advertisement in *The Ladies' Field*:—Oysters avoid influenza when eaten regularly.
But they must find it monotonous after the first few times.—*Daily News.*

Anxious.—You will see such a post as you are anxious for in our to-day's advertisement columns. The vacancy is at the Hospital for Sick Children, Great Ormond Street, London, the most important children's hospital in the United Kingdom. The house surgeon receives, in addition to board and residence, a small salary (£20 for six months), but the practice at a hospital of such reputation should be the higher consideration.

Paddington.—We think it would be considered somewhat ungenerous were we to insert your letter in our columns, and manifestly no one could answer your query as to comparative costs. Your second communication will appear in our next.

Besar (India).—Many thanks for your kind letter of appreciation. We can hardly deal with "Dental Surgery" as such without encroaching on the province of the dental journals, but you will frequently find reference to dentisty as affecting the general health and development.

Meetings of the Societies, Lectures, &c.

Wednesday, May 13th.

Society of Tropical Medicine and Hygiene (20, Hanover Square, W.).—8.30 p.m.: Dr. J. P. Maxwell (Amoy): The Use of Quinine during Pregnancy, Labour, and the Puerperium.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. P. Daniel: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. W. H. Clayton-Greene: Abdominal Injuries.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipman); Skin (Dr. Meachen); Eye (Mr. Brooks).

Thursday, May 14th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20, Hanover Square, W.).—7.45 p.m.: Paper:—Dr. R. H. Paramore: The Supports of the Female Pelvic Viscera. (N.B.—This paper will not be read, but an abstract will be given, and a discussion will take place, in which leading anatomists and gynæcologists have already promised to take part. Copies of this paper are now ready, and can be obtained from the Secretaries, 20, Hanover Square.) Specimens: Dr. Nepean Longridge: Visceral Hæmorrhages in New-born Infants. Dr. Herbert Williamson: Womb-stone (sent by Dr. Preston Maxwell, China). Mr. J. Bland-Sutton: (1) Two Examples of the Encapsulation of Sterile Fluid in connection with the Fallopian Tubes and the Ovary; (2) Sarcoma of the Uterus. Mr. J. D. Malcolm: A Malignant Ovarian Tumour and Part of a Malignant Sigmoid Flexure removed by Operation.

United Services Medical Society (Royal Army Medical College, Millbank, S.W.).—8.30 p.m.: Lieut.-Colonel A. Duncan, I.M.S. (retired): On the Effects of Heat in the Tropics and their Treatment.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. C. O. Hawthorne: The Diagnosis of Functional Nervous Disease.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical (Mr. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. Chappel).

Friday, May 15th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. W. J. Horne: Clinique. (Throat.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Cliniques: Surgical Out-patient (Mr. J. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

Appointments.

Carstairs, J. Lindley, M.B., C.M.Glasg., Assistant Obstetric Physician to the Maternity and Women's Hospital, Glasgow.

Chapman, J. S., M.B., B.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Turriff District of the county of Aberdeen.

Johnston, D. J. G., M.B., B.S.Aberd., Assistant Medical Officer of Health of Ipswich.

Mathieson, D. Morley, M.B., Ch.B.Edin., D.P.H., School Medical Officer and Assistant Medical Officer of Health of the City and County of Norwich.

Scott, James, M.B., Ch.B.Edin., Senior House Surgeon at the Bolton Infirmary and Dispensary.

Stamp, William Daniel, M.R.C.S., L.R.C.P., L.M.Edin., Deputy Medical Officer to the Workhouse and Northern District by the Plympton St. Mary (Devon) Board of Guardians.

Stirk, Percy Herbert, L.R.C.P.Lond., M.R.C.S., Medical Inspector of Schools by the Exeter Education Committee.

Wilmot, E. Darwin, M.B., Ch.B.Edin., Junior House Surgeon at the Bolton Infirmary and Dispensary.

Vacancies.

County Borough of Croydon.—Croydon Borough Hospital.—Senior Resident Medical Officer and Bacteriologist. Salary, £160 per annum, with board, lodging, and washing Applications to F. C. Lloyd, Town Clerk, Town Hall, Croydon.

King Edward VII. Sanatorium, Midhurst, Sussex.—Senior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19, Devonshire Street, Portland Place, London, W.

Cardiff Infirmary.—Senior Resident Medical Officer. Salary, £120 per annum, with board, washing, and apartments. Applications to Leonard D. Rea, Secretary and General Superintendent.

County Borough of Huddersfield.—Local Education Authority.—School Medical Officer. Salary, £300 per annum. Applications to Dr. S. G. Moore, Medical Officer of Health, Public Health Office, Huddersfield.

The North Riding of Yorkshire Education Committee.—Medical Inspector. Salary, £250 per annum. Applications to J. C. Wrigley, Secretary, Education Offices, County Hall, Northallerton.

City of Edinburgh.—Medical Officer of Health. Salary, £800 per annum. Applications to Thomas Hunter, W.S., Town Clerk, City Chambers, Edinburgh.

West Wales Sanatorium, Alltymynydd, Carmarthenshire.—Medical Superintendent. Salary, £200 per annum, with board and residence. Applications to the Hon. Sec., Dr. Bowen-Jones, Carmarthen.

Nottingham City Asylum.—Second Assistant Medical Officer. Salary, £150 per annum, with board, apartments, etc. Applications to the Medical Superintendent.

The Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon for six months. Salary, £20, washing allowance £2 10s., with board and residence in the Hospital. Applications to Stewart Johnson, Secretary. (See Advt.)

Fermanagh County Hospital.—House Surgeon. Salary, £63 per annum. Immediate application to C. Wilson, Secretary. (See Advt.)

Births.

Fraser.—On May 6th, at Trevenna, Slough, the wife of Herbert Fraser, M.R.C.S., L.R.C.P., of a daughter—Joan Mary.

Matthew.—On May 5th, at St. Ives, Cornwall, the wife of F. Crichton Matthew, M.D., F.R.C.S.Edin., of a son

Muriel.—On May 9th, at 109, Scotch Street, Whitehaven, the wife of G. Bertram Muriel, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P.Lond., of a daughter.

Osborn.—On May 5th, at Ennismore Lodge, Park Avenue, Dover, the wife of Francis Arthur Osborn, L.R.C.P.Lond., M.R.C.S. Eng., of a daughter.

Thompson.—On May 8th, at Royal Naval Hospital, Great Yarmouth, the wife of Surgeon J. A. Thompson, R.N., of a daughter.

Marriages.

James—Rankin.—On May 5th, at St. Anselm's, Hatch End, Philip William James, M.D., eldest son of the late Canon James, of Bermuda, to Muriel Lindley, youngest daughter of the late A. M. Rankin, of Broomhills, Rochford, Essex.

Vining—Colman.—On May 9th, at St. Matthew's, Ealing Common, Charles Wilfrid Vining, M.B., B.S. (Lond.), third son of R. Willoughby Vining, of 17, Florence Road, Ealing, to Marjorie Gladys, eldest daughter of the late Charles Colman.

Deaths.

Cullingworth.—On May 11th, at 14, Manchester Square, Charles James Cullingworth, M.D., F.R.C.P., Consulting Obstetric Physician, St. Thomas's Hospital, in his 67th year.

Duka.—On May 5th, at Bournemouth, Theodore Duka, M.D., F.R.C.S., Knight of the Iron Crown, Lieut.-Colonel I.M.S., retired, in his 83rd year.

Gramshaw.—On May 7, at 78, Bootham, York, Farbrace Sidney Gramshaw, M.D., F.R.C.S.E., aged 54.

Hoets.—On May 7th, at Sydney, N.S.W., Alton Kingsley Hoets, M.R.C.S.Eng., L.S.A., elder son of the late Rev. I. W. Van Rees Hoets, of 150, Adelaide Road, London, aged 51, of pneumonia. (By cable.)

Knox.—On May 9th, at Church House, Bakewell, Derbyshire, Eliza, wife of John Knox, M.D.

Nutt.—On May 5th, at 5, Northwick Terrace, St. John's Wood, London, Fanny Anne Nutt, widow of William Clarke Nutt, M.R.C.S., late of Plymstock, Devon, aged 86.

Todd.—On May 6th, at Tulipan Lodge, Callendar, Perthshire, N.B., Dr. James Todd, M.D., J.P., in his 70th year

By Appointment to H.M. the King.

Cyllin Inhalant

as given off by the Cyllin Inhalator is most beneficial in all diseases of bacterial origin in the mucous lining of the throat, nose, and ears.

In Influenza

its germicidal action on the specific bacillus situated in the superficial layers of the mucous membrane of the respiratory tract, renders valuable assistance.

Cyllin is also put up as a Syrup, and in Capsule form (Palatinoids) for stomachic and intestinal antisepsis.

See pamphlet entitled "Standard Chemical Disinfectan's." Copies, together with working samples, sent gratis and post free on applying to

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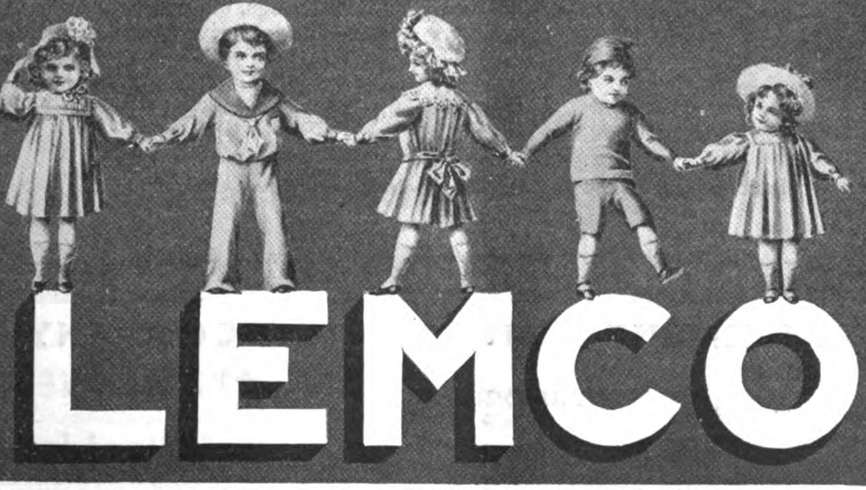
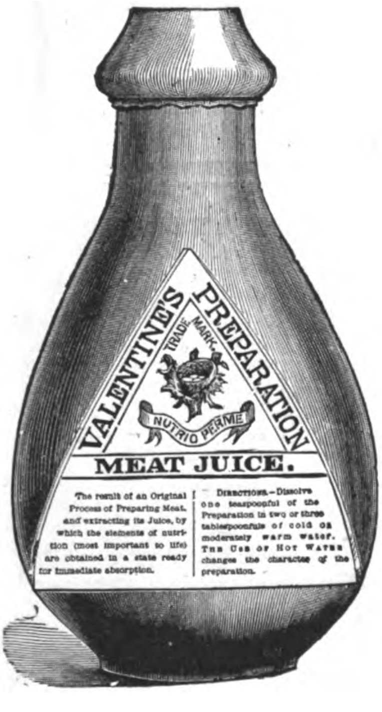
If in doubt-

as to the best food to prescribe to delicate or rickety children, try an eighth or quarter of a teaspoonful of "Lemco" in half a pint of warm milk. Children who cannot digest milk often experience no difficulty with it when combined with "Lemco".



Valentine's Meat-Juice

In **Wasting, Acute** or **Febrile Diseases** of **Children, Marasmus, Rickets, Anaemia, Measles, Cholera Infantum, Diarrhoea,** or **Debility** due to the Immaturity of the Newly-Born, where an Energetic, Concentrated, Easily-Assimilated Nutrient is demanded to Nourish and Sustain, **when milk and other forms of food fail, Valentine's Meat-Juice** is recommended by eminent medical authorities who have thoroughly tested its value in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TRADE MARK
NUTRIO PERME
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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MAY 20, 1908. No. 21.

NOTES AND COMMENTS.

Breakfast Foods.

ONE of the features of latter-day enterprise has been the advertising of breakfast-foods of various kinds, said to be capable of imparting to the eaters all the qualities of Samson and Solomon rolled into one. We confess to having been puzzled as to the necessity for some of these concoctions, both as regards their composition and as to public demand. The Ontario Department of Agriculture has lately issued a bulletin on the subject, prepared by teachers in the Ontario Agricultural College. This document shows that the most nutritious and economical foods are those derived from oats, wheat and other cereals, with a preponderance in favour of oatmeal. As to prepared breakfast foods, says the report, they "are more expensive because of the way they are prepared, the manner they are put on the market, and the cost of advertising. A curious name or appearance, or a mysterious process of preparation does not give them the extraordinary food value sometimes claimed. They may have a place in a hurry-up breakfast; but where economy is considered, there is nothing in the composition, digestibility, or palatability of these high-priced, pre-digested foods to justify the extravagant price asked for some of them." This is good sense and good economics. We only wish our Local Government Board would do similarly good work for us in this benighted country. At present it is sufficient for some speculative advertiser to roll up stale breadcrumbs into pellets, and advertise them as good for the brain, liver, or kidneys, for fond and foolish parents to buy them at exorbitant prices for their children and household.

Damages for Typhoid.

IN March last a case was tried before Mr. Justice Grantham and a special jury, in which the widow of a farm bailiff, engaged at the Three Counties Asylum, in Bedfordshire, sued the Asylums Committee for loss of her husband, alleging that their negligence in supplying impure water for consumption had caused him to contract typhoid fever, which proved fatal. She also complained that he had been provided with improper medical attendance, but happily, this part of the case was abandoned, there being no basis whatever for the charge. After a long trial, the jury, in reply to the judge's questions, found that the husband died of typhoid fever due to the bad state of the water, which was through the defendants' negligence, allowed to be contaminated with sewage. They also assessed the damages at the substantial sum of £650, and expressly exonerated the medical officer from all blame. An appeal against this verdict was made, but on what grounds it is not clear, the allegations that the verdict was against the weight of the evidence, and that the judge misdirected the jury, being exiguous in the extreme. The verdict was upheld by the Court of Appeal, and the case is now closed. This is an exceedingly satisfactory result from the point of view of the water consumer, as there is nothing so likely to rouse water authorities to their responsibilities as the knowledge that these claims can be brought home to them. The academic censure of a Local Government Board Inspector they bear with dignified equanimity, but the fact that their negligence may entail enormous sums in compensation in case of an epidemic is likely to be a potent factor in bringing them to an appreciation of their duties.

Overlying Infants.

THE Children's Bill is making good progress in Committee, and we are glad to see that the Government intend to pass it into law this session. The Under-Secretary for Home Affairs is conducting the Bill in a conciliatory spirit, and there is every reason to hope that a good, workmanlike Act will result; an Act, that is, which will really deal with the evils affecting child-life, and yet not impose impossible conditions on poor parents. A long discussion took place over the clause dealing with the overlying of infants. With regard to the word "overlying" there has been controversy not only in Committee, but in the columns of the *Times*. Mr. Samuel made the interesting announcement that he had referred to Dr. Murray the question of the correct word for the offence, and that that distinguished scholar had, on the whole, pronounced in favour of "overlaying." The letter containing this decision is too long to reproduce, but we are by no means convinced by the arguments adduced by that authority. It is so obvious that the offence is a passive one that the use of the active verb grates both on the ear and on the intellect. However, apart from grammatical considerations, the proposal to make overlying a criminal offence was too strongly opposed for the clause to be pressed, and the question is to be considered anew at a later date. It is certainly beset with difficulties, not the least of which is, that the danger of incurring a penalty may induce mothers to depute the management of the infant at night to others than themselves. Certainly it is desirable that a woman who smothers her baby by overlying when she is drunk should be amenable to severe punishment, and the bulk of the cases would certainly be covered by that provision, but the difficulty would be in getting evidence to prove the drunkenness.

Age and Accident.

AN interesting communication has been made by Sir John Brunner on the relationship of age to liability to accident in industrial pursuits. It is frequently argued that employers hesitate to take on elderly workmen because of the increased risk of accident. The calculations made in the communication referred to deal with the workmen of Messrs. Brunner, Mond, and Co., who have had in employment during the last fifteen years an average of 3,848 workmen. Their experience shows a continuous fall in liability at each age period, the percentage at ages 18 to 25 being 8.5 and that at 56 and over 2.4, the intervening periods showing a uniform decrease from the higher to the lower figure. Unfortunately, the value of these figures is greatly discounted by the fact that all accidents, even the most trivial, are included, and that the numbers actually employed at the various ages is not clearly set out. It may well be that the older men are less liable to minor accidents, but more liable to serious ones; or again that the older men are employed on less risky work; or that the total numbers of old men employed have been comparatively small. Still, the result is significant, as it tends to show that there is not much ground for the *prima facie* assumption usually made that workmen are liable to accident in proportion to their age, and Sir John Brunner is to be thanked for bringing forward the negative evidence so far as he has it to hand.

Natural Method of Healing.

THE methods of the book-tout, though legitimate enough in themselves, lend themselves to much abuse, especially when the operator has to deal with people unaccustomed to his wiles. At Belfast a case has just been tried in the Recorder's Court, which shows the need for caution on the part of nurses who are beset with these gentlemen trying to sell them professional works. It seems that the tout in question invaded a hospital and induced a nurse to promise, or half promise, to buy a book called "Natural Method of Healing," at £1 5s. This volume appears to have been a work by some German quack, and to have been illustrated in a way which his Honour described as "very realistic." The nurse thought it was a text-book of nursing, and signed a paper, on which the Recorder was satisfied the vendor subsequently inserted 3s. as the sum payable per month. When the character of the book was discovered, she sent it back to the publishers, who then sued her for its full price. Happily, the case was dismissed, and the victim did not have to pay the price of her folly. Since our premier newspaper disposed of an enormous number of out-of-date encyclopædias on the instalment system, worthless books have been palmed off on all sorts of unsuspecting people, and the book-lover of to-day cannot take a better motto than *Caveat emptor.*

The Royal Medical Benevolent Fund Society of Ireland.

THE annual general meeting of the Society will be held on Wednesday, June 10th, at the Royal College of Surgeons, at 4.30 p.m.

LEADING ARTICLES.

COSMOPOLITANISM IN MEDICINE.

THE gradual evolution of medical science is in some ways one of the most gratifying results of human endeavour. Year by year medicine is attaining slowly but steadily the firm ground of an exact science. The closest approach to that ideal position has, so far, been made by its subsidiary branch of ophthalmology, but signs are not wanting that in process of time all, or nearly all of the remote recesses of pathology will be effectually explored. So astonishing, indeed, have been the advances already made in the science and art of medicine, that it places no undue tax upon the imagination to conjecture that the secret of life itself may one day be fathomed. Meanwhile, however, there are many gaps in medical knowledge that can be filled only by the patient labour of investigators in all parts of the civilised globe. There is no more striking and interesting fact in this latter connection than the intensity of the modern scientific spirit that fills with enthusiasm the worker in the great fields of medical research. Whatever the accidents of race, language, or geographical position, it is open to the humblest individual at any moment to present a solid and lasting contribution to the sum of the world's knowledge, no matter whether his observation be conducted in a well-equipped European laboratory, in the deserts of Africa, in the swamps of Central America, or in any other likely or unlikely quarter of the world. In a word, medical research is essentially cosmopolitan in its nature, and every addition to its store of achievement represents so much gain to the world's commonwealth. But the greater diffusion of scientific labour has necessitated a better machinery for the interchange of observations. A good example of this extension of international interest is afforded by the vast number of English medical books which are sent every year to American readers, and *vice versâ.* To a less extent a demand exists for medical books between all civilised countries. There are a few international medical journals, but these are limited, almost of necessity, to nations speaking a common language. Of late years the circulation of medical journals in colonies and in English speaking countries has undergone a great expansion. In the case of British colonies and dependencies, there has been a large and steady increase of the demand for home journals. In our own case, we have been able to register a gratifying increase of circulation in America, Canada, South Africa, India, and Australia, not to mention such places as Japan and the West Indies. We have no doubt that the experience of THE MEDICAL PRESS AND CIRCULAR has been shared by other leading medical journals in the United Kingdom. One marked feature in the journalistic literature of to-day is the prominence of abstracts and short notes. Some of the most valuable parts of a medical practitioner's education is picked up from chance suggestions of that kind. Moreover, there is often a freshness and attractiveness of form about information that hails from another country which is not altogether easy to explain. Some day a scientific Volapuk may be introduced as the medium for interchange of the world's opinions. We have already arrived at the stage of international medical congresses of various kinds. On the whole, this cosmopolitanism of medical work is a thing to be carefully fostered. Should mankind ever be blessed with the Millennium, its advent will probably be in no small degree rendered possible by the influence of cosmopolitan and humanising medical science.

HOUSING LAW AND THE BIRTH RATE.

For some years the outstanding feature of the Annual Report of the Registrar-General on Births, Marriages and Deaths has been the steady decline in the birth-rate. It is hardly possible to overrate the significance of this fact, whether it be viewed from the social, the economic, or the Imperial standpoint. History has shown that one of the first signs of decadence is a fall in the ratio of increase of population. In France, at the present moment, so great has been the diminution in that respect that the question has been seriously mooted as to whence the next generation will draw its soldiers. Since the days of Malthus the problem of the relation of the population to the status of the nation has been ever before the thinking reformer and politician. In the United Kingdom, imbued as it is with an underlying spirit of puritan morality, the matter has given rise to the keenest controversy. In spite of all protest, however, the fact remains that our national birth-rate has fallen to a point well-nigh unprecedented. The decrease, moreover, has been due to the limitation of families amongst the upper and middle classes. In the process of time the movement according to the usual social experience, will spread to the poorer classes, and thus sooner or later the crux of the question will be forced upon the attention of the legislature. In discussing the matter broadly, one of the first things to be noted is the way in which the State has for generations past successfully increased the average duration of life by the adoption of many wise sanitary laws. In this way the diminished rate of production is appreciably counteracted by the longer life-value of the product. Another phase of a kindred nature is the movement now on foot to reduce the excessive infantile mortality. It needs no formal argument to show that the diminished output of children will be counterbalanced if a proportionately greater number can attain healthy adult life. From that point of view all enlightened schemes of national health advancement acquire a significance deeper than that which has hitherto invested the labours of the sanitarian. The most recent advance of the kind is embodied in the new Housing Bill now being brought forward in the House of Commons by Mr. John Burns. Its main object, to put the matter in a nutshell, is to do away with slums in town and country. The housing problem has been strained to the uttermost in the towns by the steady exodus which has decreased the rural population of England by fifty per cent. or more. But the need for stringent legislation with regard to housing is hardly less urgent in the country. Mr. Burns proposes to bestow compulsory powers of acquiring property upon local authorities. It compels the owner of small properties to keep his houses in a condition fit for human habitation. It confers upon the Local Government Board the right to take action should the local authorities evade their responsibility. Beyond a doubt, this measure registers a reform in national sanitation of first importance to the future of the race. It is to be hoped that all British Colonies and independencies will follow the example set by the Mother country. In younger communities it is often easier to adopt new principles than is the case where more complex and old-standing interests are involved. In any case, an honest endeavour to improve the housing of a number may be hailed as a step in the right direction towards the attainment of the ideal in the Commonwealth of mankind.

CURRENT TOPICS.

The Society of Members and the Council of the Royal College of Surgeons.

At a meeting of the Council of the Royal College of Surgeons of England held on Thursday last, the President reported the steps which he had taken with regard to the proceedings of certain members of the College in connection with the poll of Fellows and Members on the admission of women to the examination for the diplomas of the College. The proceedings of the President were approved and confirmed. In his report the President stated that in deciding to take notice of the unofficial circular, which had been issued by the Society of Members, he was desirous of securing the object aimed at by the Council, of obtaining simple and direct answers to the questions in the ballot paper. He also stated that he was further influenced by the following considerations:—

"While, apart from the question of propriety, it may be open to any member or group of members to take an unofficial poll in such form as they may think fit, it was, in my opinion, improper that the members in question, not content with taking a poll, introduced an issue which intentionally had not been placed before the members by the Council. The Council would remember that in May, 1907, it was resolved 'that in the event of women being admitted to examination, all diplomas granted to them would be granted by virtue of, and subject to the Act of 1876, in order to make it clear that women acquire no right to take any part in the government, management, or proceedings of the College,' and the terms of the official circular make it clear that the questions put by the Council relate to the admission of women under existing powers conferred by the Act of 1876. The suggestion in the unofficial circular, that affirmative answers to the Council's questions should be in the form of 'Yes, with full Collegiate rights,' is a suggestion that women should be admitted not under existing powers, but under powers which the Council might or might not be able to obtain in the form of a new Charter, and this seeks to introduce an issue which the Council have not placed before the members."

"It is, moreover, obvious that difficulty must arise with regard to the meaning of answers in the form suggested by the unofficial circular. Some members so answering may mean that they are in favour of the admission of women under any conditions, but preferably with full Collegiate rights, whilst others may mean that they are not in favour of women being admitted unless full Collegiate rights be granted to them. In taking the result of the poll the question will therefore arise as to whether such answers can be regarded as valid." To us it seems a pity that the Society of Members, which has done so much good work for general practitioners, should have suggested the action they did, as it has merely irritated the Council of the College and apparently made them more hostile to members' claims, and has not advanced the cause they had at heart.

Medical Inspection of Children in Canada and America.

Among the many functions which the school doctor should perform, and which under the present proposals of the Education Board he will be unable to carry out efficiently, is that of recognising and taking early action with regard to infectious diseases. We note with interest that Dr. Laberge, Chief of the Staff of Medical Inspectors of Montreal, reports that there has been a fall of no less than 50 per cent. in the notification of infectious diseases in that city since the introduction of school inspection by medical men. This result he attributes to the increased cleanliness of children, to better ventilation, and to the prompt checking of outbreaks as the result of frequent inspection; a condition of things that the rare appearances of inspectors as at present proposed in this country, would not be calculated to effect. Medical inspection has not only been adopted in Montreal and Toronto, but even in some of the small Western townships; the first district in Canada which instituted the system being Pincher Creek, Alberta. In the United States inspection, which was adopted by Chicago some time ago, but discontinued, had been revived to the general satisfaction of parents, who were frightened by a series of scarlet fever outbreaks last year. Here too the doctor goes to the schools under his charge every morning, and examines any children who are suspected of infectious disease or have been absent for more than four days from any cause. As a matter of fact each doctor is assigned only three or four schools, containing altogether three or four thousand children, but he is expected thoroughly to do his work, seeing the absent children, if need be, in their homes. Whatever the difficulties of such a plan may be, it is obvious that it is far more likely to be effectual than the three or four "inspections" during school life that our own Education Board favours.

Tuberculosis in Ireland.

The opening of the Tuberculosis Exhibition, organised under the auspices of her Excellency the Countess of Aberdeen, marks a departure that may well prove an example to the rest of the world. The chief speaker on that occasion was General Sir William Butler, who gave a stirring address. His arguments were based upon the "one awful fact" that within one year 12,000 of their fellow-countrymen had died from tuberculosis, a disease that was preventible under proper conditions as to air, food, and general environment. The general feeling of the movement was registered in the following resolutions, which were carried unanimously:—(1) "That special registration should be introduced without delay with the object of making it compulsory that all cases of pulmonary tuberculosis should be notified, taking care at the same time to protect consumptive patients from any undue interference with their liberty." (2) "That the adoption of more stringent and uniform measures for the regulation of milk and food supplies is urgently required." (3) "That County Councils in Ireland should be enabled to erect and maintain such hospitals, sanatoria, and dispensaries for the treatment of consumption as they think fit." (4) "That there is urgent necessity for a system of medical inspection of schools and school-children."

An Official Directory of Nurses.

We do not know that anyone will regret the fate of the ill-judged Bill introduced by Lord Balfour last week to the House of Lords. It was properly pointed out in criticism of the measure that the proposer had not been able to adduce a single medical corporation supporting the Bill. The working of the Midwives Act has not been such as to encourage us to take any step toward giving nursing a quasi-official status as a profession; but, whatever might be said in favour of State registration, we know nothing to justify an official directory. For admission to a State register presumably certain requirements of education and training would be necessary, whereas a directory—official or otherwise—would be merely an untrustworthy list of those engaged in the occupation of nursing. Registration might be compulsory—enrolment in a directory would be optional. A directory would, therefore, fulfil no useful purpose. Incomplete, and at the same time also indecisive, it would be useless even as a work of reference, whereas admission to its pages would doubtless be claimed by nurses as proof of official status.

Medical Men and Academic Management.

A considerable amount of hostile criticism has been roused by the prominent position accorded to medical men in the governing bodies of the new University and College to be founded in Ireland under Mr. Birrell's scheme. It is claimed that the medical profession has a considerable over-representation as compared with other professions; there are, for instance, some dozen medical men on the proposed Senate, whereas there are but two lawyers. The comparison, however, is hardly a fair one. The medical men are to be regarded as representative, not merely of medicine, but of science, and many of them are engaged in purely scientific work. Lawyers do not in any analogous fashion represent any special sphere of academic study. Moreover, if judged merely as professions, there is no doubt that, for the present, at any rate, it is more important to have medical men than members of other professions in positions of influence in the new University, for among the professional schools the medical school will be the most frequented. It is possible that in the future, schools of commerce, or industry, or agriculture will predominate, but under present conditions it is certain that medical students will be more numerous. Mr. Birrell was right, therefore, in the interests of both science and medicine, in finding place for a considerable number of medical men on the Senate. It is a point of interest that when the new scheme is carried out, the heads of three of the five Colleges of University rank in Ireland will be medical men, viz., Dr. Traill, of Trinity College; Dr. Winder, of Cork; and Dr. Coffey, of the new College in Dublin; while the head of the Galway College, though not a medical man, is a teacher of science.

The Position of the Royal College of Surgeons in Ireland.

A very strong case was made on behalf of the Royal College of Surgeons in Ireland during the second reading debate on the Irish Universities Bill, both directly and indirectly. Mr. Campbell, the late Attorney-General for Ireland, speaking as the representative of what "might be considered a rival of the College School, declared that the worst blot upon the Bill was the gross injustice it tried to perpetrate upon the College School. It would be a great injustice on the part of the State, which he thought that House would never tolerate when they realised it, to crush a School such as this, which had been in existence for over a century and a half, for the benefit of its rival." Again, Mr. Kettle, expressing the Nationalist view, declared that "nobody wanted to inflict any injury on the College of Surgeons—it obviously had a case." Lastly, Mr. Haldane said, although his words did not refer to the College School, that, in his view, "it was a mistake to meddle with existing institutions in Ireland. You want to add to them, not to destroy them." The Council of the Royal College of Surgeons asks for a grant of money for the purpose of endowing certain of its chairs, of establishing prizes and bursaries for poor students, and of maintaining the School in the highest state of efficiency, so that it may be in a similar position to its new rival. Mr. Birrell, in his reply, did not mention the College School, and we trust that his silence indicates that he is preparing to re-consider his attitude towards the College. It would be strange if one who by nature is so strong an opponent of denominationalism in education should be even indirectly responsible for the destruction of what, if everyone is to be believed, will be the only undenominational medical school in Ireland.

PERSONAL.

Principal Donald MacAlister will preside at the 87th Session of the General Medical Council on May 26th, at 2 o'clock.

Dr. J. S. Mather has been made the recipient of a clock by the Bristol Branch of the Midland Railway Corps of the St. John's Ambulance Association.

Dr. S. G. Scott, on retiring from the Demonstratorship of Physiology at Leeds University, has been entertained at a complimentary banquet by the Leeds Pathological Club.

Dr. Henry, who has been Medical Officer of Rochdale for nearly 29 years, has been offered the position of whole time Medical Officer for the borough at a salary of £600 per annum.

Inspector-General of Hospitals and Fleets, Sir Herbert M. Ellis, K.C.B., Director-General of the Naval Medical Department, has been placed on the retired list at his own request.

Sir William Smyly, M.D., has been nominated as President of the Irish Medical Association for the coming year.

Dr. J. Walton Browne, M.D., and Dr. R. W. Leslie, M.D., have been elected representatives of Convocation on the Senate of the Royal University of Ireland.

Sir William Allchin will open the Summer Post-Graduate Session of the Mount Vernon Hospital for Consumption with a lecture on "Some Inter-Relations of Thoracic and Abdominal Disease."

Sir William B. Berry, M.D., has been granted the Royal permission to retain the title of "Honourable" on retiring from the Speakership of the House of Assembly of the Cape of Good Hope.

Dr. Alexander Granville has received the King's licence and authority to wear the Insignia of the Fourth-Class Order of Medjidieh conferred on him by the Khedive in recognition of distinguished service.

We regret to learn that Drs. Raikes and Wray, Government medical officers, have died of plague, which they contracted while performing a post-mortem examination on a patient who died while in quarantine.

The members of the "Loyal Hall of Justice" Lodge of Oddfellows, Steyning, have presented Dr. Charnock Smith with a handsome illuminated address, appropriately voicing their genuine regret at his coming departure.

The Murchison Scholarship, awarded alternately by the Royal College of Physicians of London and the University of Edinburgh, has been won by Mr. E. L. M. Lobb, of Guy's Hospital. This scholarship was founded in 1880 to commemorate the work of Dr. Charles Murchison.

Dr. L. F. Barker, Professor of Medicine in Johns Hopkins University, Baltimore, and formerly of the University of Toronto, was honoured by Queen's University, Kingston, on April 29th, by having conferred on him the honorary degree of Doctor of Laws.

Mr. Charles J. Heath, F.R.C.S., one of the surgeons of the Hospital for Diseases of the Throat, Golden Square, London, has generously given a donation of £250 to the hospital for the purpose of increasing the number of beds and thus reducing the existing delays in the performance of operations.

A memoir of Dr. Edmund Symes-Thompson, Gresham Professor of Medicine, whose death was recently reported in these columns, has been prepared by his widow, and will be shortly published by Mr. Elliot Stock. Lord Balfour of Burleigh is a contributor to the volume, which will also contain a portrait of Dr. Symes-Thompson.

As a testimonial of the great work of Dr. Walter B. Geikie, formerly Dean of Trinity Medical College, in advancing medical education in Toronto, and in founding and building up Trinity Medical College, his life-size portrait in oil was unveiled before the Academy of Medicine, on Tuesday evening, April 7th, in the presence of a large number of Fellows of the Academy and friends. The picture was accepted by Dr. Geikie and presented by him to the Academy of Medicine.

A CLINICAL LECTURE
ON
THE AFTER-RESULTS OF THE SURGICAL TREATMENT OF UTERINE DISPLACEMENTS. (*a*)

By ARTHUR E. GILES, M.D., B.Sc., F.R.C.S.,

Surgeon to the Chelsea Hospital for Women, and Gynæcologist to the Prince of Wales's General Hospital, Tottenham.

THE surgical treatment of uterine displacements depends upon results for its justification. Other conditions, such as tumours, are in themselves sufficient indication for operation, whatever the remote results may be; but with displacements, if operations for their relief do not relieve, or if they create more serious troubles than they cure, they must give place to other methods of treatment.

I have, therefore, inquired into the after-results of my operations for displacements. These operations can be classed in three groups. In the first, the uterus was suspended to the abdominal wall, with or without the addition of plastic procedures on the vaginal walls. In the second group, the uterus was suspended, and the appendages of one side were removed on account of a tumour, inflammatory disease, or tubal pregnancy. In the third group, the uterus was suspended, and one or more fibroids removed from its walls.

Some of the cases operated upon are too recent for records of after-results to be of much value—those, namely, in which the operation was less than a year ago. Of the remainder, some could not be traced owing to removals. The material at my disposal is as follows:—

Group.	Operation.	Total Cases.	Cases operated on a year or more.	After-results investigated.
1	Hysteropexy	160	130	93
2	Hysteropexy and unilateral Salpingo-oöphorectomy	48	37	32
3	Hysteropexy and Myomectomy	19	13	11
		227	180	136

In a paper read at the British Medical Association meeting at Toronto in 1906 (*b*) I dealt with the subject of Hysteropexy or Ventrofixation from the point of view of indications for the operation, technique, and after-results. In this communication I do not propose to touch on either indications or technique, otherwise than incidentally; but I wish to amplify what I then said on the subject of after-results. At the present date I have performed 80 more operations than I had then, and the cases in which after-results have been traced have been increased from 73 to 136.

Just a word may be said on the subject of nomenclature. In this country the term "ventrofixation" has been applied generally to all cases in which the uterus is attached to the abdominal wall; the term "ventrosuspension" has been employed almost interchangeably. But in the United States and the Colonies a sharp distinction is drawn between the two terms. By ventrofixation is understood an operation in which the uterus is made to assume a position of extreme anteflexion, and the sutures are passed through its posterior wall and firmly fixed to the fascia. A normal pregnancy after such an operation is practically out of the question. By ventrosuspension, on the other hand, is meant an operation in which the sutures are passed through the anterior wall of the uterus or the fundus, and tied to the peritoneum, and not to the fascia. By this means any subsequent pregnancy can develop undisturbed, but there is a definite tendency to return of the displacement owing to the ease with which the peritoneum stretches. The operation that I have almost invariably adopted differs from both of these, in that the sutures are passed through the anterior wall of the uterus, low down, leaving the fundus free in the event of subsequent pregnancy; and these sutures are passed on each side of the incision through the fascia as well as the peritoneum, so as to guard against a return of the displacement. Therefore, to avoid confusion, I have decided to abandon both the above terms, and use the word "hysteropexy," which merely implies that the uterus is stitched up to the anterior abdominal wall.

In order that we may claim to have cured displacements by surgical means, it must be shown that certain requirements have been fulfilled. These are:—

(1) The patient's general health subsequent to operation must be satisfactory, in so far as the operative results are concerned.

(2) The displaced organs must remain in good position.

(3) The necessity for pessaries must be done away with.

(4) There must be no interference with the bladder.

(5) It must be possible for normal pregnancy and labour to occur, and for the good position of the organs to continue undisturbed.

(6) There must be no trouble resulting from the abdominal scar.

In a review of a book by Dr. Casalis, of Wynberg, in the *British Medical Journal* of March 7th, 1908, the reviewer says:—"There are manifest objections to all kinds of fixation operations, and at the best it is not easy to define what can conscientiously be registered as a 'cure.'" I think that any case that fulfils the above requirements comes within the definition of a cure, and can be conscientiously registered as such. I shall now present my report of after-results under the six headings just enumerated, and we shall then be able to decide how far we are justified in saying that these patients have been cured.

(1) *General Health.*—It is obvious that we cannot expect to cure such conditions as chronic indigestion, anæmia, epilepsy, lung troubles, etc., by operations on the pelvic organs, and the fact that patients who have suffered from such conditions continue to do so cannot be regarded as invalidating the operations. Conditions of general health for which the operation may be considered responsible are general debility and neuroses, coming on subsequent to the operation, and pain referred to the pelvic organs.

Of the 136 cases, 5 felt better until pregnancy or confinement occurred, and had felt weaker or not so well since; 3 had felt much better until within the last month or two; 4 had suffered from various troubles—namely, gastric ulcer, hæmorrhage after miscarriage, curetting and fistulæ in ano; 1 had had a subsequent hysterectomy for uterine fibrosis; 1 was reported by her doctor to be a "hopeless neurasthenic"; 9 stated that they were about the same as before the operation, and in 2 of these this fact was accounted for by a return of the displacement; and 9 stated that they felt weaker or otherwise worse.

The remaining 104 felt better than before the operation, although some of them had not very good health on various accounts. Many of them described their improvement in such terms as "perfectly well in every way since the operation"; "much better than before"; "better than for years"; "a world better—I was no good only to lie on my back and suffer"; "better than ever I have been"; "decidedly better in every way"; "I was very glad to do away with pessaries";

(*a*) An Address delivered before the Tottenham Division of the British Medical Association.

(*b*) A study of 146 consecutive cases of Ventrofixation of the Uterus, *Brit. Med. Journ.*, Nov. 3rd, 1906.

"a lot better—not like the same person"; "a different woman altogether"; "I'm twice the woman I was"; "very different to what I have ever been for years before the operation"; "better—no comparison." I have given the patients' own words, because they convey a much better idea than any statistics. Properly, we must include in the cases of improvement those who were better until some extraneous condition supervened, and we may therefore say that, of the 136 patients, 116, or 85 per cent., were decidedly improved in their general health; 10, or 7½ per cent., remained about the same; and 10, or 7½ per cent., were worse.

(2) *The Position of the Pelvic Organs.*—One case requires to be excluded, as a hysterectomy was done subsequently. Two patients were not seen, as one is in Jamaica and the other in South Africa. In 4 cases the uterus was in good position when last examined, but the patients have since been confined, and I have no report of the position of the organs after the confinement. In 6 cases the uterus was mobile, or presented a slight degree of retroversion, apparently owing to lengthening of the "attachment band" which sometimes forms; one of these patients had been confined. In 14 cases there was some relaxation of the vaginal walls or deficiency of the perinæum; two of these had been confined. In 4 cases the operation was a failure, as the uterus became detached from the abdominal wall, leading to a return of retroversion in 2 of them, to prolapse in 1, and total procidentia in the fourth. I hope to operate again shortly on the last case. The other three were re-fixed, and the result remained good. The four unsuccessful cases were operated upon in May, July, and September, 1904, and in November, 1905. The first three were due to insufficiently secure fixation; the last case was a very stout woman with lax tissues. After 1904 I generally employed three sutures to secure the uterus, instead of two, as I often used before, and there have been no failures in the later cases.

As far as the results of the hysteropexy were concerned, we find that, excluding the first 7 cases mentioned, there were in all 129 cases, in 119 of which (92 per cent.) the uterus remained firmly fixed to the abdominal wall; in 6 (5 per cent.) the uterus was suspended by a band; whilst in 4 (3 per cent.) the operation failed.

It has been said that, while hysteropexy gives good results when done for retroversion, it is unsatisfactory in cases of prolapse and procidentia. This has not been my experience. Of the 119 cases examined, 97 were done for retroversion, 2 of which were failures, as above-mentioned; 21 were done for prolapse, and these were all successful; 10 were done for procidentia, in 1 of which the procidentia returned completely, whilst in the other there was a partial return—viz., to the stage of prolapse. In a certain number of cases a plastic operation was done on the vaginal walls; referring only to the 119 cases examined, a perinorrhaphy was done in 29 cases; in 21 of these the perinæum remained quite sound; in 8 the perinæum was found stretched, a confinement having occurred in 2 of them; and in 1 case, where confinement had also taken place, the perinæum had torn again. An anterior colporrhaphy was done in 7 cases; in 4 of these the anterior vaginal wall remained good and taut; in 2 there was a partial, and in 1 there was a complete return of cystocele. More or less prolapse of the vaginal walls was present in a certain number of cases where no plastic operation had been done. My criticism of these cases is that results would have been better if I had done more at the time of operation. Of later years I have done more combined operations.

(3) *The Necessity for Pessaries.*—I have not precise records on this point. In only 3 cases is there any note that a pessary was required after the operation, and I think that I shall be well within the mark if I say that not more than half-a-dozen patients have had occasion to wear one. We are, therefore, I think, justified in saying that surgical treatment for displacements obviates the necessity for pessaries.

(4) *Interference with the Bladder.*—It might be supposed that trouble would generally arise from the fact that the attachment of the uterus to the anterior abdominal wall prevents the ordinary expansion upwards of the bladder as it becomes fuller. I therefore made special inquiry as to bladder disturbance after the operation, and my reports give particulars of 125 cases. In 85 of these the patient had no trouble at all with the bladder; in 2 there was frequency of micturition, but it was less troublesome than before operation; in 5 there was frequency, about the same as before the operation; 1 had frequent micturition for six months, and 1 for a year after operation; 6 had frequent micturition sometimes; 2 complained of it during or after menstruation; and 12 complained of habitual frequency; 1 patient had frequent and painful micturition; 5 had pain during or after micturition; 2 had pain when they held the water too long; and 3 had difficulty in passing water at times. Summing up, we find that 92 either had no trouble or had no more than before; while 21 complained of frequency, and 12 of pain or difficulty. In percentages, 74 per cent. had no trouble, or none more than they had before; 17 per cent. had frequency, and 9 per cent. had pain or difficulty. If we investigated the matter in relation to patients who had not had a hysteropexy done, I think that we should still find as large a percentage of women who had either frequency or pain; and therefore the operation cannot be regarded as presenting any serious drawback from this point of view.

(5) *Pregnancy and Labour after Hysteropexy.*—I have not infrequently been asked by medical men who have seen me doing these operations: "But what happens if the patient should become pregnant?" And I have replied: "Well, it would be all right, because the attachment is done in such a way as to leave the fundus free to expand." It now remains for me to justify this statement.

Thirty-four patients became pregnant after the operation; 1 of them had 3 pregnancies, and 4 others had 2 each, making in all 40 pregnancies. Of these, 4 were pregnant when last seen, whilst 36 had terminated. Of the completed pregnancies, 10 ended in miscarriages at periods varying from 2 to 5½ months, and 26 went to full time.

With regard to the miscarriages, it may be noted that no fewer than 6 took place within a few months of the operation, and I think that it may fairly be urged that pregnancy was allowed too soon. Two of these patients had a normal confinement afterwards; 1 patient had had 4 or 5 miscarriages at 2 to 3 months before the operation; afterwards she became pregnant, and indulged excessively in dancing, with the result that she miscarried at 4 months; 1 patient miscarried at 5½ months, by which time the uterus had probably enlarged beyond the stage of being affected by the operation; and 1 patient miscarried after she had had two full-time pregnancies, so that it was independent of the operation. When we take into further consideration the fact that among women who have not had the operation of hysteropexy the proportion of miscarriages is about 1 in 4, we can justly conclude that the operation can be held responsible for miscarriages in only a small percentage of cases.

Turning to the cases of confinement of living children, 19 were reported as quite normal, some of them being also described as easy and rapid. One of these I had the opportunity of attending myself, in a primipara, æt. 37; the labour was absolutely normal, and the second stage was completed in about an hour. One patient was confined twice at 7 months, the presentation being in each case a cross-birth. She stated that precisely the same thing happened in a confinement which took place before the operation. In two cases forceps were required for occipito-posterior presentations; in two others forceps were required for "delay," and in one there was said to be a "rigid cervix," for which forceps were used. These results compare very favourably with confinements in patients who have not been operated upon, as I venture to think that most medical men would be well content if normal cases, in which even forceps were not required, formed 73 per cent. of their confinements.

We come now to the second part of this question of pregnancy. The first was, Does the operator affect the work of the obstetrician? The second is, Does the confinement undo the work of the operator? The 26 confinements were distributed among 21 patients; 3 of these were not seen afterwards; one was seen after the first, but not after the second, confinement, and in this case and in 16 others the uterus had remained well fixed up in good position. In the remaining case the uterus had a certain degree of mobility so that it could be partially retroverted, but it gave rise to no symptoms. We may, therefore, conclude that subsequent pregnancy does not interfere with the operative results.

(6) *The Abdominal Scar.*—Three patients had to be operated upon later on account of yielding scar; one of these was the stout, flabby person previously alluded to, and another had the wound weakened by suppurating stitches. Thirteen patients, including this last one, had stitch abscesses after operation. With better operative *technique*, and especially with the use of sterilised gloves during operation, the tendency to this trouble has greatly diminished in the later cases, only one case operated upon within the last 2 years having had a stitch abscess. These drawbacks are not inseparable from the operation, except in so far as patients with flabby abdominal muscles and fasciæ will probably show a tendency to yielding scar; and we may, therefore, confidently say that in the future we are not likely to have troubles arising from the scar in more than 2 or 3 per cent. of the cases.

If we sum up our sixfold test from the coldly statistical point of view, we find:—

(1) The general condition was improved or unaltered in 92½ per cent. of cases, the percentage of actual improvements being 85.

(2) The uterus remained firmly attached in 92 per cent., and had certain mobility in 5 per cent., giving 97 per cent. of successful results, with 3 per cent. failures.

(3) Not less than 95 per cent. of patients were permanently relieved of the need for pessaries.

(4) In 74 per cent. of cases the operation was followed by no bladder trouble; on the contrary, some were relieved.

(5) Of 40 pregnancies following operation, 4 had not terminated, 10 patients had miscarried, and 26 had borne living children. Of the 26 confinements, 19 had been quite normal, making 73 per cent. In only 1 case out of 21 was the uterus at all disturbed in its position, and then only partially, by pregnancy and confinement.

(6) The abdominal scar gave no trouble at all in 89 per cent. of cases; herniæ occurred in 2 per cent.

On statistical grounds it may be fairly claimed that the surgical treatment of displacements fulfils the requirements imposed in a sufficient proportion of cases (averaging 88 per cent. for all the tests) to justify its existence. But there is another aspect of the matter which is, if possible, more convincing, namely, the untabulated and unrecorded statements of patients as to their satisfaction at the doing away with pessaries and periodic examinations, their greater fitness for work and ability to get about, their loss of those bearing-down pains and that general discomfort and lack of energy which combine to reduce a woman to the condition of being "not ill, and yet never well." I must confess that I, at least, have been not a little influenced by these considerations; and I claim to be myself the most exacting critic of my results, because my interests and my satisfaction alike depend, not upon the making of many operations, but upon the securing of cured and grateful patients.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor R. de Bovis, M.D., Professor of Obstetrics at the Rheims Medical School. Subject: "How to Set to Work in Ordinary Obstetrical Practice."*

Session of the General Medical Council.

WE are officially informed that the Eighty-seventh Session of the General Medical Council will commence on Tuesday next, May 26th, at 2 o'clock p.m., under the presidency of Dr. Donald MacAlister.

ORIGINAL PAPERS.

SOME POINTS IN
SYMPTOMATIC ALOPECIA. (a)

BY DAVID WALSH, M.D.ED.,
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THE subject of alopecia, or baldness, interesting as it is, from many points of view, has hardly yet had its proper share of attention. In various ways its study is of value to the medical practitioner, whose advice is constantly asked for on account of impending or of complete baldness. From the standpoint of scientific investigation a great deal remains to be learned with regard to the pathology and ætiology of baldness. Take as an illustration the ætiology of so common an affection as *alopecia areata*, which is simply in a chaotic condition—one set of authorities vigorously maintains its parasitic origin, another set is no less dogmatic in claiming it as a tropho-neurosis—while a third, with more reason, adopt the theory of multiple origin. The authenticated history of outbreaks of alopecia areata in schools renders it impossible to doubt the infection theory—on the other hand, it is clear that bald patches may follow a blow on the head, and that they are definitely connected with myxœdema. As will be shown later, there are phenomena concerned in one form of "band" alopecias which appear to be of an extremely complex origin and relationship to pathological processes in other parts of the body.

Alopecia may be partial or complete: it may be circumscribed (*areata*) or generalised: and it may be congenital or acquired.

A convenient classification is into congenital and acquired alopecia, the latter being subdivided into—

(1) Symptomatic.
(2) Senile.
(3) Premature or so-called idiopathic.
(4) Alopecia areata.

The congenital forms will not be discussed here. In dealing with the subject systematically it is convenient to divide the acquired alopecias into well-defined groups like the foregoing. As a matter of fact, they may all be ultimately allotted to the symptomatic group, whether their origin be due to invasion by fungus or bacterium, to nervous or to nutritional changes dependent on local or general conditions.

Space does not permit us to deal exhaustively with this interesting subject, but it is proposed to discuss a few of the many forms of symptomatic alopecia in the hope that some light may be thrown on the points of causation, diagnosis, prognosis and treatment.

A familiar diffuse thinning of hair in general practice is the acute toxic form met with after scarlet fever and other specific affections. As a rule, recovery is rapid and complete, provided the scalp has been previously free, or fairly free, from seborrhœa, and that the patient has a good constitution and attends to local cleanliness.

It sometimes happens, however, that complete recovery does not take place after acute maladies. Many cases of premature baldness in patients, say, from 20 to 40 years of age, may be traced to some such attack. For some reason or other measles is often the starting point of a chronic seborrhœa which ends in partial or complete baldness. The fall of hair during or after measles is probably due to damaged nutrition of the hair bulb by toxic products of the malady. According to the writer's view of the general law of the exanthematous rashes, there is an attempt of the skin, along with other excretory organs, to throw off the toxic factor or product from the body, with corresponding excretory irritation of all the parts concerned in the elimination. (b)

When the measles rash has subsided the hair should rapidly regain its normal condition of growth. When regrowth does not take place it is probably due to the development of seborrhœa, which may be regarded as a bacterial infection that is either a multiple invasion or due to a single micro-organism, the identity of which has not been yet completely established.

(a) Abstract of Lecture delivered at the Western Skin Hospital, May 14th, 1908.

(b) See MEDICAL PRESS AND CIRCULAR, October 22nd, 1890, and "Excretory Irritation." By David Walsh, M.D. London: Bailliere, Tindall and Cox. 1897.

The extent to which the hair falls after measles varies from simple thinning to complete baldness. As a rule regrowth takes place. It is interesting to compare with the above picture the facts of syphilitic alopecia. One of the earliest lessons of the student in the out-patient room is the almost invariable loss of hair that accompanies constitutional syphilis. In this case we can observe the whole process at our leisure. In the alopecia associated with early forms of eruption the hairs lose their natural glossiness, become dry, brittle, and come away freely in the brush. Not only the hair of the scalp, but that of the eyebrows, eyelashes, and all other hairy parts of the body, including the pubis, may be shed. As a rule, the hair falls uniformly from the scalp, but syphilitic alopecia areata is not uncommon. The patchy form is more usually associated with later syphilides of the papulo-pustular variety. In congenital syphilis there are various forms. In one case in a baby under the writer's care, there was a perfectly smooth area sharply confined to the frontal bones. Under anti-syphilitic remedies the bare part became covered with hair. In another form of hereditary syphilitic alopecia the scalp is covered with numerous roundish patches, the size of a sixpence or a shilling, over which the hair is partially denuded, giving the head a characteristically "moth-eaten" look. In adults the syphilitic alopecia may be inferred from its somewhat angular outline as against the rounded or oval patches of the ordinary form; it is often symmetrical, more or less covered with hair, and accompanied by frontal headache and other signs and symptoms of syphilis.

The course of syphilitic alopecia is curiously like that following an ordinary exanthem. As a rule, the hair grows again freely, but the hair may never regain its original luxuriance of growth; while, if complicated by seborrhœa, partial or complete baldness may result. It seems not unlikely, in the light of modern bacteriology, that the early alopecia of syphilis may be of toxic origin, while that of the later rashes is caused by the local presence of the *spirochæte pallida*. In either case, the undoubtedly beneficial action of mercury applied to the scalp may be explained on different grounds. Thus, in the early toxæmic condition it would be due to a general effect after absorption into the system, and in the germ-infected syphilide mainly to local germicide action.

A further consideration of these symptomatic alopecias from the point of view of treatment will furnish us with an illustration of the general principles that should guide the practitioner.

In an ordinary alopecia following, say, enteric fever, it is a familiar experience that a complete cure may be effected by natural processes. Satisfactory regrowth, however, may not follow on account of unfavourable conditions of the patient, which may be general or local. For instance, should convalescence be attended by anæmia, or chronic nephritis, or any debilitating condition of health, the hair may not grow again. If the general health cannot be restored by appropriate measures the chances of successful treatment of the alopecia are proportionately diminished. From this point of view it is just as necessary to give iron and cod-liver oil to a debilitated patient in order to encourage growth of hair as it is to apply local stimulant and antiseptic applications to his scalp. So far, we have no drug that we can say acts specifically as an internal stimulant to the growth of hair. We know that in some way the thyroid gland exerts a powerful influence upon the nutrition of hair. Its administration, however, in cases of baldness, is disappointing. As our knowledge of the physiological effects of the internal secretions is extended we may reasonably look forward to the discovery of a drug which, administered internally, will definitely promote the growth of hair. It is a familiar observation that in consumptives there is often a strong growth of hair, but a similar effect does not follow the use of tuberculin. Pilocarpin appears to be occasionally successful. Arsenic is credited by some authorities with the power of stimulating the growth of hair. If it be so the results are certainly capricious, and, in the author's opinion, do not warrant the internal administration of a drug that has been shown experimentally to damage all the channels of excretory outlet from the body. Who shall say what lasting harm is done to the kidneys, say, by a course of arsenic extended over one or two years, as often happens in hospital practice? After a prolonged trial the writer can state with confidence that he has obtained equally good results without arsenic, which he has ceased to prescribe except on the rarest occasions for many years past.

On the other hand, we have seen that certain toxic products of disease processes have the power of so disturbing the nutrition of the hair of the scalp as to cause it to be shed. There is a precise analogy to that in the case of thallium acetate, which has been found to cause alopecia when administered to check the sweating of phthisis. The alopecia has ceased with the discontinuance of the drug.

While it is desirable, and sometimes absolutely essential, to attend to any constitutional error in a patient suffering from alopecia, it must nevertheless be admitted that by far the more important part of treatment is, in the majority of cases, purely local.

External Treatment.—The first great principle of treatment is stimulation. This is readily applied by lotions containing such stimulant drugs as lysol, resorcin, salicylic acid, strong ammonia, or cantharides.

Systematic washing, it need hardly be said, is absolutely necessary under all circumstances. Any good antiseptic soap may be used for the purpose. Should there be much dandruff, it is well to use soft soap, or a shampoo of equal parts of soft soap and spirit for a few weeks; but this should not be continued indefinitely. The frequency of the washing should be regulated by the amount of dandruff, but, as a general rule, once a week should suffice. Where there is much seborrhœa, the main indication is to apply as far as possible the principles of antisepsis and asepsis to the scalp. This point was originally insisted upon by the present writer in 1902. (*a*)

Increasing experience has proved the value of antiseptic methods, so far as they can be applied, in dealing with all cases of alopecia at all ages. Without entering into detail, systematic cleanliness of brushes and combs is essential, together with aseptic hair-cutting.

Amongst other symptomatic alopecia, that which is connected with myxœdema is specially interesting. It is a well-known fact that when a monkey or rabbit is deprived of its thyroid, patches of alopecia areata develop in various parts of the body. In the human subject the hair changes in myxœdema are characteristic. One of the early signs is that the hair grows coarse and grey, especially along the anterior margin. It then becomes dry and brittle, and falls out, sometimes in patches, but more generally diffusely, until the whole scalp may be entirely bald. The process may extend to the eyebrows and rest of the hairy parts of the body. An interesting point is that under treatment by thyroid gland the growth of hair may usually be restored, and, what is more remarkable, the new hair may be as fine as the original texture, and of natural colour.

When these changes come on in the course of exophthalmic goître, it may be suspected that myxœdema has become superadded. In the writer's experience it is extremely common for exophthalmic goître to be followed, or even accompanied, by myxœdema. In these particular instances the condition of the hair is of positive diagnostic value, and there seems little doubt that as knowledge increases we may reasonably expect that the hair will become more and more a delicate index to the state of the general health.

The writer has noted the occurrence of a form of frontal band alopecia in connection with exophthalmic goître. It is congenital, and has been noted as a constant accompaniment of a fairly extensive series of cases of that malady. This congenital high forehead has been investigated in a large number of cases,

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(*a*) "The Hair and its Diseases." By David Walsh, M.D. First Edition. London: Baillière, Tindall and Cox. 1902.

and in the majority is found to be connected with abnormality of the thyroid gland, tachycardia, nervousness, headache, and a group of vasomotor symptoms, such as epistaxis and chilblains or Raynaud's disease. This temperament the writer has called potential exophthalmic goître. In several instances the disease has developed in patients while under observation, after shock, or fright, or other depressing influence. The occurrence of a sharply-defined band of alopecia across the forehead is not capable of any ordinary anatomical explanation. Should this congenital sign be definitely connected with so obscure a symptom-complex as that of exophthalmic goître, the problem will be still more complicated.

So far as the hair changes in exophthalmic goître and myxœdema are concerned, the constant current, which has been recognised as an excellent treatment since Cardew introduced its use in 1891 for exophthalmic goître, has a potent effect also in restoring the normal growth of hair.

In cases of exophthalmic goître with or without myxœdema, the writer has seen excellent results from the application of a continuous current. The routine treatment of stimulant antiseptics to the scalp, of thyroid feeding and of electrical treatment, will often work wonders, not only in the restoration of the hair, but also as regards the tachycardia, nervousness, depression and the various vasomotor disturbances which accompany the condition.

In this combination of external and internal therapeutics we probably find the germ of the future scientific treatment of alopecia symptomatica due to more or less obscure constitutional changes.

For syphilitic diseases mercurial applications should be used—an ointment of red oxide or of the oleate, preferably. White precipitate is useful in connection with tar preparations and antiseptics such as salicylic acid.

One of the most valuable forms of stimulation is by means of the electrical current. Faradisation is useful, but far better results, as a rule, can be obtained by the constant current. A powerful battery and some skill are required in its use. The high frequency current sometimes produces brilliant results. In the near future there is a strong probability that more enlightened use will be made of electrical methods in the treatment of alopecia of all kinds. It is only by the development of a scheme of treatment based on scientific observation that one may hope to bring symptomatic alopecia under the control of the medical practitioner.

Finally, the treatment of alopecia, of all maladies, demands the most unwearied patience on the part of all concerned.

THE “EMPTY BRONCHUS” TREATMENT BY POSTURE IN THE BRONCHIECTASIS OF CHILDREN. (a)

By WILLIAM EWART, M.D.Cantab., F.R.C.P.,

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I do not propose on this occasion to go over the entire ground which was recently covered by my paper on “The Principles of Treatment of Bronchiectasis,” read before the East Sussex Medico-Chirurgical Society at Hastings, but rather to confine myself to the special points in the mechanical part of the treatment in children. This intractable disease, if it is to be cured at all, is more likely to be cured in childhood than at any other age. And the responsibility is great of not missing that better chance by delay.

A sad instance in point is the lamented death a few days ago of the little patient, W. C., æt. 5, who had suffered from the affection since an attack of pneumonia nearly three years ago. Her systematic treatment in July, 1907, by the inclined bed and by the prone posture on the All-Fours Exerciser was of very short duration owing to the temporary closure of the ward. When at last her mother brought her again a month ago, she had developed lardaceous disease and albuminuria. Although after a few days of postural treatment the expectoration was greatly reduced, so that even partial inversion did not lead to much being coughed up, the fœtor showed no improvement; and the probability that ulcerative and necrotic changes had occurred in the dilatations was borne out by the patient's rapid failure and final exhaustion; but an autopsy could not, unfortunately, be obtained. I believe that, had she been under continuous treatment during the last twelve months, she would have been, not only alive to-day, but probably vastly improved under the treatment which I have to describe to you as “The Empty Bronchus Method.” For there is reason to believe that a well-drained bronchus is also one that practically ceases to secrete.

The Principles of Treatment.—This brings me to say a word of introduction on the general question. There are two fundamental principles which must be carried out if any line of treatment which may be adopted is to be successful. One of them is to *empty the bronchus; and to keep it empty.* The other principle is to *fill the lung with air; and to keep it actively expanding.* These two objects were conveyed in the title of the paper published in the *Lancet* for July 13th, 1901, which marks the difference between the practice of this century and that of previous ones—“The Treatment of Bronchiectasis by Posture and by Respiratory Exercises.”

The Various Modes of Treatment.—On that basis various therapeutic measures may be founded with good hope of success. It is not my object to deal with them to-day, but it is right to enumerate them. (1) The latest, and that which is claimed by its author, Dr. Colin Campbell, of Southport, to be the most rational, and also the most successful in curing the affection, is the direct medicinal treatment of the bronchus by *intra-tracheal injections.* Unfortunately, it is not one easy of application in very young children. (2) Of great importance is also Arnold Chaplin's well-known method of *creosote inhalation.* It is applicable even in young children, and it is recognised to be the most effectual means of overcoming by medicinal agencies the fœtor of the expectoration and of the breath. (3) In the third place, we have a variety of internal remedies which I need not enumerate. And, lastly, (4) a large assortment of inhalations made available by methods to which I may presently refer.

The mechanical methods which I have to urge as essential adjuncts to these various plans combine two objects, *the bronchial and the pulmonary,* which are distinct, but possess one great feature in common—they are both intended for *continuous application,* in the strict sense.

The Intermittent Postural Treatment.

The bronchial treatment is mainly postural. It is strange that the obviousness of this indication should have so long escaped notice. My own earliest employment of the *ultra-prone position, or inversion,* dates back many years in connection with the emptying of basic cavities in phthisis. It was not a novel device, at any rate in this country, and had been advocated and practised before. It is the type of what I shall term the *intermittent postural method,* which should rightly be connected with the name of H. Quincke (a), of Kiel. In 1898 he published his short but weighty “Contribution to the Treatment of Bronchitis,” in which he suggested the inclined prone position for adoption for comparatively short periods once or twice daily, for the sake of bronchial drainage in cases where this was wanted. In October, 1900, Jacobson (b) published a further account of the method, with cases in which the inclined posture had been used for periods of one hour once or twice in the course of 24 hours with favourable results. These papers were not known to me until I consulted the literature in connection with the publication of my own paper mentioned above. In the latter I advocated the *continuous postural*

(a) **Read before the Society for the Study of Disease in Children, May 8th, 1908.**

(a) *Berlin Klin. Woch.*, 1898, p. 525.
(b) *Ibid*, 1900, p. 904.

method by keeping the patient in bed, and by raising the foot of the bed considerably so as to keep up a strong downward slant from the bronchi to the larynx, whatever the positions might be into which the patient might turn during sleep.

The intermittent "ultra-prone" posture or "inversion" is the most rapid and effectual for the evacuation of accumulations in the cavities of phthisis or of bronchiectasis. The patient leans over the side of the bed or of a table, placing the hands on the ground, so that the long axis of the thorax approaches to the vertical. A few coughs will rapidly clear away the greater part of the collection. The method is fortunately available in children in a degree not to be attained in the adult, for even up to adolescence they are not alarmed at the thought of "standing on their head." Infants will bear to be held vertically head downwards, and in small children something approaching to actual inversion may be safely resorted to. These extreme positions, in which patients are encouraged to cough and to expectorate, are exceedingly useful for dislodging remote accumulations, and it may be possible to improve the opportunity by the judicious application of bi-manual pressure at the base of the thorax judiciously performed and limited to the period of expiration. As a fact, *absolute* inversion is not necessary. The child may be either held in the ultra-prone position by the nurse, or laid across a low chair or a stool, head and hands downwards, in imitation of the procedure in the adult.

The intermittent prone postural method of Quincke is likely to come into extensive use in various affections, and I have devised with that view, and had constructed, a set of appliances or machines enabling me to apply the prone method with graduated inclinations and lateral positions, according to the requirements of the case and of the affection under treatment.

THE CONTINUOUS POSTURAL TREATMENT.

The Continuous Treatment has three practical instalments: *The Nocturnal postural treatment; the Diurnal postural treatment;* and the *Respiratory treatment by means of the Elastic Belt and of the "Exerciser."*

(1) *The Costo-Abdominal Elastic Belt* should be worn during the night as well as the day, for its virtue is active for good during each breath that is drawn. If this were neglected, the loss of advantage to a child during the 10 hours' night sleep might be easily reckoned up in figures to an important total. The belt itself, made of waterproof material, easily washed and dried, has its buckles in front, and at one or both sides an insertion of a lacing of indiarubber cord or tubing. It is mainly *abdominal*, extending some way below the umbilicus, and upwards not quite as far as the costal arch. But I have found it useful to attach to it in the back a *lower thoracic elastic band*, one or two inches wide, also buckled in front, which, being quite separate except over the spine where it is continuous with the belt, can be carried obliquely over the costal arch, and its buckle fastened to the night-gown by a safety pin at any level desired. Its pressure can thus be regulated nicely so as to be just sufficient to stimulate the costo-abdominal breathing. I have explained elsewhere the probable mechanism of the advantage accruing to the upper costal breathing from wearing the abdominal belt. The recurring stimulation of the diaphragm with each expiration by the artificial elastic recoil of the abdominal contents calls reflexly into action some of the apparatus for extraordinary respiration, and in particular the upper costal muscles, whilst it directly amplifies in a marked degree the inspiratory excursions of the diaphragm. It goes without saying that judgment is requisite in dealing with so active a therapeutic agent.

(2) *The Nocturnal Treatment.*—This should be made as effectual as possible. Everything depends upon the declivity of the inclined plane being effective, not, as might happen, illusory. In the first place, as the distance from the diaphragm to the larynx is so short in a little child, *the angle* of the inclined plane must be relatively greater. In the "Bronchiectasis Cot," which I have to describe, the foot end of the "fracture-bottom" bottom must therefore be secured to its graduated support at a higher level.

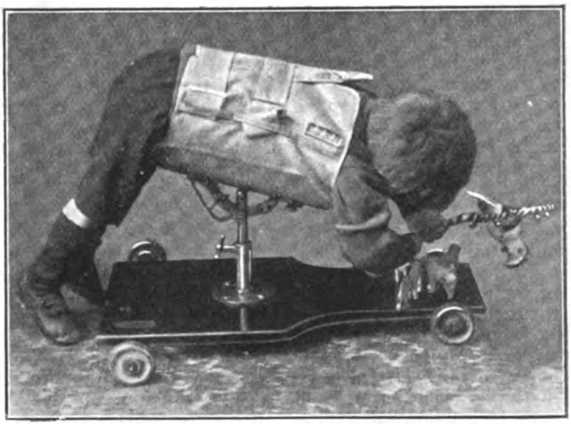
The "Bronchiectasis Cot" is easily prepared in the case of the ordinary bed-shaped cot with high end rails, as well as side rails. A fracture-bottom is placed under the mattress, and its foot end must be raised to the desired height by means of the *graduated support;* the other end extending as far as the head rail.

The graduated support is simply a firm board of sufficient width, from which project two thick movable wooden pins to bear the weight of the foot end of the fracture-bottom. The board is perforated with two parallel vertical rows of holes to receive the pins. A strap passed through two of the holes not in use and round the upright rails will ensure its stability. This or some similar contrivance will be found convenient for hospitals, as it occupies little space for storage and offers the choice of several positions to suit various cases. For private patients it is easy to obtain the same result by slinging the end of the fracture-bottom on a rope fastened to the foot posts, and passing underneath through eyes or holes to prevent any slipping.

The mattress having thus been duly slanted, it is necessary, in the second place, that the slant of the thorax itself be made a genuine one by posture. It is clear that, let the degree of inclination be what it may, if the child were to lie transversely to the cot the long axis of the chest would be horizontal, in spite of the inclination; and as this almost invariably happens it will be often found necessary to let the child lie between two sandbags, which will also afford assistance against the tendency to slide down the slant "into a heap." In the groove thus formed the child can lie in any decubitus; the more this is varied so much the better.

Another practical point is *the bolster.* The bolster must be *small and firm*, for the support of *the head only;* and to this effect it should be secured to the head rails so as not to be displaced. The ordinary square pillow and squash bolster are quite unsuitable, as they extend under the shoulders and thus modify the inclination in the direction of the horizontal. With these practical precautions the nocturnal instalment of treatment becomes one of the most important.

(3) *The Diurnal treatment* is, as previously stated, the agent *par excellence* of pulmonary regeneration, whilst it also affords the most effectual means, next to inversion, for drainage. The prone posture which is to be kept up, is anatomically the most direct for that purpose (the greater bulk of the lung being posterior) and brings to bear the active force of the respiratory pump for emptying the sacculations by lateral compression. The All-Fours' Exerciser, upon which the prone treatment is conducted, is a small edition of one of the arrangements which are provided for in my "Convalescent Machine" for the adult. The supporting body trough, upon which the child is secured by a broad belt is provided with three sets of movements regulating its height and its inclinations from end-to-end and from side-to-side. The lateral inclination is usually not called into play here. It is



specially used for the lateralisation of the chest in empyema, pleurisy, and other conditions requiring special unilateral measures of rest or of re-expansion.

The end-to-end declivity required is that which will bring the shoulders appreciably lower than the hips, and at that angle the child is made to recline in the prone position.

Prone Exercising.—The height of the body trough is to be so adjusted as to allow free use of the four limbs—the feet for propelling the machine (the front wheels of which might be made also workable by the hands), the arms and hands for any appropriate work or amusement. In this way, quite independently of any of the dumb-bell and *respiratory exercises* for practice at stated intervals, a good deal of activity is thrown upon the limbs and the neck, and this brings fully into requisition the posterior and basic pulmonary districts. A table can be improvised in front of convenient height for drawing or writing, and to hold the book for reading, or cushions to rest the head. *Prone Exercising* need not, therefore, imply idleness or complete interruption of the lessons.

"*The All-Fours Exerciser*" for Children (*a*), and the "*Convalescent Machine*" for Adults (*b*), illustrations of which are included in my paper, "On Convalescence and Its Stages" (*c*), are purposely adapted for most varied medical and surgical affections. They are therefore specially suitable for hospitals and institutions, where they can be in constant use, thanks to their adjustability. But for a makeshift, and as only one position is required, any individual case of bronchiectasis in a child is easily extemporised by padding a high stool, cutting down its legs to the extent desired, and finally mounting it upon wheels. Or we may adapt for our purpose, with slight modifications, Dr. Tucker Wise's "Inclined Plane for Phthisis," a description of which he has kindly communicated to me in advance of its impending publication in the *Lancet.*

The Rationale of the "Empty Bronchus Method" has probably been made clear by the foregoing practical description. It aims at stopping the bronchial irritation and hyper-secretion by bronchial drainage and by pulmonary ventilation, and at reclaiming for active pulmonary expansion the thoracic space usurped by the dilatations and by the fibrous tissue. This vicarious pulmonary development is eminently attainable in childhood, and therefore within our own gift; let it not be withheld. As even one day of this treatment is a gain, every succeeding day will be a further step towards a cure.

Is any further treatment necessary? Advanced and neglected cases may need a good deal more of it than could be discussed here. Early cases will certainly need very little. But for both sets of cases *inhalation* is of value. The simplest form is the *Respiratory Bib,* a twofold piece of flannel soaked in terebene or other inhalant, and enclosed in an open bag of jaconnette to be secured between the night-shirt and under-vest, just below the collar, so that the impregnated air is constantly being inhaled.

The dry Bottle Inhaler, filled with horsehair and with small pieces of blotting-paper steeped in the inhalant, is a variation on the same theme, acceptable to children for variety's sake, and because of the tube and its mouthpiece. Whether they blow or whether they suck through it, none of the strong fluid can come into their mouths.

These devices will generally render unnecessary the more searching treatment by the creosote chamber, even in cases of fœtor. But, in conclusion, they also may be superfluous if the rational treatment be conducted, instead of in a crowded town, in the pure air of the mountain or in the strong air of the sea. *Atmosphere and climate* are the most potent and sometimes the most indispensable of our adjuncts, and in children they are likely to produce results not to be equalled in the treatment of adults.

(*a*) Constructed for me by Mr. G. P. Turner, of 16 Eccleston Street, S.W.

(*b*) Constructed for me by Mr. John Ward, of 246 Tottenham Court Road, W.

(*c*) Medical Press and Circular, Feb. 19th, 1908.

ON THE DIAGNOSIS OF HÆMATURIA.

By ANDREW FULLERTON, M.D., F.R.C.S.I.,

Hon. Assistant Surgeon to the Royal Victoria Hospital and the Belfast Hospital for Sick Children.

The diagnosis of the cause and source in a case of hæmaturia is not always easy, especially when the apparatus for directly illuminating the parts is not available. Certain definite rules have been laid down by writers on this subject for the guidance of the practitioner, but it must be freely admitted that, if these alone are relied upon, frequent mistakes will be made. Indeed, the cystoscope, and, I might add, the urethroscope must be used for the purpose of correcting or verifying the diagnosis.

With regard to the *colour* of the urine, we are taught that when the fluid is bright and arterial looking, the source of bleeding is near the outlet—bladder, prostate, or urethra. While this rule is of value, too much dependence must not be placed upon it, as a good deal depends on the quantity of blood present and the length of time it has lain in the bladder. Quite frequently we see bright red blood in the urine when severe hæmorrhage has taken place from the kidney. In cases of kidney tumour, for instance, the hæmorrhage may be very free, and be passed *per urethram* almost as it comes from the kidney. This occurred in a case of congenital cystic kidney which I saw last year with one of my colleagues. The patient lost enormous quantities of blood, and was reduced to a condition of the most extreme anæmia. I found on cystoscopic examination that the blood issued from the right ureteral orifice. The diagnosis was confirmed by subsequent inspection of the kidney, which was removed. Unfortunately, the other kidney, which was also cystic, did not prove adequate to the demands made upon it, and the patient died from uræmia.

I have also seen bright arterial blood passed in a case of injury to the kidney by a buffer accident. Cystoscopic examination in these cases is most difficult if the ordinary instrument is used. It is much better to use a washing-out cystoscope like that described by Dr. Newman, of Glasgow. In this instrument the telescopic portion of the apparatus can be removed, and the bladder washed out, without removing the cystoscope, from the urethra. A similar instrument is the newest form of Casper's catheterising cystoscope, sold by Schall, of London. This instrument is the most efficient and convenient I have yet seen.

When the colour of the urine is dark, and the blood intimately mixed with it, we are taught that the blood probably comes from the kidneys. This rule is also useful, but frequently leads the practitioner into grave error. I was asked the other day to cystoscope a patient who was passing without pain dark, port-coloured urine, with a view to ascertain which *kidney* was affected. The patient was a man, aged about 60. I found the ureteral efflux normal from both sides, but at the base of the bladder there was a large carcinomatous ulcer with numerous dark points from which hæmorrhage was taking place sufficiently slowly to allow the blood to mix intimately with and be acted upon by the urine. So much for the colour of the urine.

Now, with regard to the *time* at which the blood appears in the stream. If it appears at the end of micturition, the source of the hæmorrhage is probably prostate or bladder. The bleeding is caused by the contraction of the bladder producing engorgement of the vessels of the mucous membrane, with the result that if inflammation or ulceration is present, the thin-walled vessels rupture, and blood is forced out with the last drops of urine. This is quite frequently seen in cases of stone, in cystitis, and in Bilharzia hæmatobia. It is also sometimes seen in cases of enlarged prostate.

If the blood comes just before the stream, it must have lain in the prostatic urethra or at the neck of the bladder, shut in temporarily by the compressor urethræ muscle. In cases of enlarged prostate one occasionally finds this sequence of events.

Lastly, if the hæmorrhage occurs quite independently of micturition, dripping or flowing from the meatus, it must be due to trouble in the urethra. I need not here do more than refer to the cases of urethral hæmorrhage due to rupture, instrumentation, etc., so common in hospital practice. I have recently seen a case of very severe hæmorrhage due to papillomata of the urethra. In this case the diagnosis could only have been made by actual inspection of the canal. After removal of the growths the bleeding entirely ceased.

The *size and shape of the clots* will help one to form some idea of the source of the hæmorrhage. Large clots are much more frequent in cases of hæmorrhage from the bladder. Here again, however, much depends on the quantity of blood poured out. Large clots may form in the bladder in cases of severe hæmorrhage from the kidney. Small, worm-shaped clots moulded in the ureter will often suggest the origin of the hæmorrhage. These must not, of course be confounded with the larger clots formed in the urethra and forced out at the beginning of micturition.

Cases of hæmaturia may be divided into two great classes: those associated with pain, and those in which this symptom is entirely absent. I propose briefly to discuss the vesical group of the latter class of cases.

In addition to the renal group of painless hæmaturias, discussed in a recent article, (*a*) we have the vesical cases, due, as a rule, to tumours, innocent and malignant. A typical case is the following: A man, æt. 30, was sent by his medical adviser with the history that for the past two months he had been passing blood in his urine. He had no frequency, but complained sometimes of pain across his loins. The blood-stained urine was arterial in colour, and, according to the patient's statement, blood sometimes preceded micturition, and sometimes occurred at the end of the act. The introduction of the cystoscope caused considerable hæmorrhage, which was with difficulty controlled by adrenalin. On obtaining a clear medium a large villous tumour was seen to the left of the internal meatus. This was removed by supra-pubic cystotomy, and is an excellent example of this form of growth. The tumour was single and sessile. A portion of the mucous membrane at its point of attachment was excised with the tumour to prevent recurrence. The edges of the cut mucous membrane were brought together by fine catgut sutures. I have already mentioned an example of malignant tumour of the bladder where the blood, instead of being as one might expect, bright red in colour, was dark and intimately mixed with the urine. No operation was undertaken in this case. I might also refer to a case of carcinoma which occurred in an old man, æt. 80, who lost large quantities of blood. He was thought at first to have enlarged prostate, but on cystoscopic examination a rounded projecting tumour was found, ulcerated on its free surface, growing from the anterior wall of the bladder. A supra-pubic cystotomy was subsequently performed by another surgeon for the relief of retention. The growth was then found to have invaded the internal meatus. Bilharzia hæmatobia may give rise to a painless form of hæmaturia, as seen in the following case. A man, æt. 26, was sent to me on account of the presence of a small quantity of blood in the last few drops of urine. He had been a soldier in South Africa during the recent war, and had contracted the disease there. He passed blood also in his motions. The characteristic ova were found in his urine, and on cystoscopic examination collections of ova, white in colour, and resembling miliary tubercles, with patches of hæmorrhage and ulceration, were found on the posterior wall of his bladder.

Lastly, one occasionally sees cases of painless hæmorrhage due to rupture of varices of the bladder. After washing out with adrenalin, a small clot may be found in the vessel at the seat of rupture.

It will be seen from the cases I have described, that without great care and the intelligent use of the cystoscope and urethroscope it will be impossible for anyone to diagnose accurately the many causes of hæmaturia, especially those very puzzling cases of painless hæmaturia which, in my experience at any rate, are tolerably frequent.

SOME CONSIDERATIONS REGARDING

PNEUMONIA IN CHILDREN,

DRAWN FROM AN ANALYSIS OF 500 CASES. (*a*)

By G. H. MELVILLE DUNLOP, M.D.Ed., F.R.C.P.,

Lecturer on Diseases of Children in the University of Edinburgh; Physician to the Royal Hospital for Sick Children, Edinburgh.

The author remarked on the difficulties which beset any attempt at classifying a series of cases of this disease. Clinically, it was sometimes impossible to say whether a pneumonia should be looked on as a lobar or a broncho-pneumonia, while pathologically broncho-pneumonia was often found to have a lobar distribution. He had adopted the ordinary grouping into lobar, and broncho-pneumonia, (*a*) primary, (*b*) secondary, and when the record of the case left the precise nature of the malady in doubt it had been reckoned among the broncho-pneumonias. It was well known that irregular types were met with which it was difficult, or even impossible, to allocate definitely. Of the 500 cases, 147 were lobar-pneumonia, 85 being boys and 62 girls, a ratio of about 3.2, which was in agreement with the statistics of other observers. Analysing the cases with reference to age, it appeared that 12 had occurred under one year and 45 during the first two years. The majority of the patients were admitted during the winter and spring months. In 88 of the 147 cases the base of the lungs was affected. The order of frequency in which involvement of the lobes occurred was—left base in nearly half of all cases, then right base, and least frequently the left apex. The cases of lobar-pneumonia fell into three groups according to the time of onset of the physical signs. In 7 cases, which nevertheless were apparently genuine instances of pneumonia, no physical signs were detected. In another series the signs were delayed until the crisis approached, and in a third, largest group, the signs developed early in the usual way. Among the earliest signs of pneumonia he laid stress on a tympanitic percussion note with muffled breathing. Crepitant râles,

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(*a*) "Painless Hæmaturia," Medical Press and Circular, May 6th, 1908.

(*a*) Read before the Edinburgh Medico-Chirurgical Society, May 6th, 1908.

which were so characteristic of the disease in the adult, was usually absent in children. Of the initial symptoms, vomiting, which was present in two-thirds of the cases, was the most common. Convulsions were rare. Rigors were not very frequent; diarrhœa occurred in a good many cases. In several instances an acute onset with vomiting, fever, and abdominal pain had led to the patient being admitted to hospital with the erroneous diagnosis of appendicitis. The most common cerebral symptom was delirium, which occurred in 25 cases, the majority of them being children over five years. Herpes was present in 119 cases; it does not appear to occur in infants. The temperature seldom rose much over 105°; temperatures above this were ominous. One case of temperature of 107.5° occurred in the series. Crisis usually took place on the eighth day, but might be postponed until the twelfth or even twentieth day. For cases in which the disease terminated early, after 24 to 48 hours, he thought it was a pity that the term acute congestion of the lungs had to such a large extent fallen into disuse. It seemed to describe these very accurately. Empyæma was the most common complication, and sometimes, although it was strongly suspected, pus could not be detected by the needle. He instanced one such in which despite repeated failure to withdraw pus, a rib had been resected. A large piece of leathery fibrin was extracted, followed by a gush of pus. The temperature fell by lysis in 29 cases. Post-critical rise of temperature was common. Slowing of the pulse, at times down to 50 or even 40, and irregularity of the heart's action were met with in a number of patients, but there had been no instance of sudden collapse after the fever subsided. The mortality was 10 per cent.; the disease was most fatal during the first two years. The cases of broncho-pneumonia numbered 353, of which 120 were primary, and 233 secondary, to such diseases as measles, whooping-cough, bronchitis, rickets, diarrhœa, etc. The symptoms of primary broncho-pneumonia differed from those of the lobar form, in that the cough and dyspnœa were greater, and the temperature was more remittent. There was generally a morning fall of one or two degrees, though some times the type of temperature was reversed and the morning temperature higher than that of the evening. Fits occurred in 30 of the cases. The duration was from 2 to 35 days—longer, on the whole than in secondary broncho-pneumonia. Of the 233 cases of secondary broncho-pneumonia, 92 occurred in children over two years. It was impossible, clinically, to distinguish capillary bronchitis from broncho-pneumonia, and the diagnosis must often rest on the rising temperature, increased respiration, and cyanosis. Owing to the small size of the patches in many cases no physical signs of consolidation could be detected. Not infrequently the temperature rose rapidly shortly before death, and sudden death from heart failure, or from convulsions was common. The mortality was higher than in croupous pneumonia, being 25 per cent. Factors which unfavourably influenced the prognosis were pre-existing diseases, such as rickets and diarrhœa, and malnutrition. Among the points which aided in the diagnosis between broncho- and croupous-pneumonia were the distribution of the patches of consolidation, the temperature curve, and the fact that cough and cyanosis were more prominent symptoms in the former than in the latter. Statistics from various sources gave differing rates of mortality; this was to some extent attributable to the ages of the patients. In hospitals from which infants were excluded the mortality was naturally much lower than in foundling hospitals. The figures he gave—10 per cent. for croupous and 25 per cent. for broncho-pneumonic, were based on cases occurring at all ages up to 12 years. With regard to treatment the following measures were referred to as those on which he relied. In croupous-pneumonia nursing was the principal thing, and drugs were not always required. In all cases the food should be light, and care should be taken not to distend the abdomen and so further embarrass the respiration. Plenty of ventilation was essential, but he had not ventured to try open-air treatment in acute pneumonia. He often employed light poultices consisting of one part of mustard to four parts of linseed, applied for a few moments at a time every few hours. Instead of steam, he hung round the cot, on a screen placed at its head, towels soaked in hot water and sprinkled with eucalyptus. For reducing the temperature cold sponging was best. Cough mixtures he seldom employed. If the heart failed he gave strophanthus and strychnine; inhalations of oxygen were serviceable in cases of cyanosis. In secondary broncho-pneumonia alcohol was given as a routine.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Radical Cure of Inguinal Hernia in Adults.—Mr. Willmott Evans operated on a man, æt. 47, who had suffered from inguinal hernia for fifteen years. It was difficult to keep back the hernia with a truss, and as in his work as a railway porter the patient had to do heavy lifting he was advised to have a radical cure done. The hernia was reducible, and at the operation the contents were returned into the abdomen. The patient was anæsthetised and an incision three inches in length was made parallel to and three-quarters of an inch above the inguinal ligament; the inner end of the incision was placed a little external to the pubic spine. A few touches with the knife deepened the incision until the sac was reached; this was then completely separated from all surrounding structures and the inguinal canal was examined. It was found that the canal was decidedly shortened, the internal ring being almost opposite the external ring. It was decided to remake the inguinal canal. By means of scissors the aponeurosis of the external oblique was slit up from the external ring for a distance of two inches. The hernial sac was ligatured opposite the internal ring after it had been opened to see it contained nothing, removed on the distal side of the ligature and the stump was returned to the abdomen. Sutures of silk were then inserted so as to draw together the lower border of the arching fibres of the internal oblique and transversalis; these stitches were of the mattress form, and care was taken that they were not tied too tight; thus a new posterior wall of the canal was formed. The spermatic cord was replaced so as to rest on the new posterior wall, and the severed edges of the aponeurosis of the external oblique were also drawn together by mattress sutures, an external ring only sufficient for the cord being left. Two small superficial vessels required ligature, and the superficial wound was united by Michel's suture clips. Mr. Evans said that in considering the advisability of operation for the radical cure of inguinal hernia in adults the surgeon has to bear in mind several points: in the first place he has to consider the age of the patient; it is rarely advisable to do a radical cure on a patient over 55 or 60 years of age, though, if his general health is good and he is young for his years, if especially his arteries are not hardened, it may be done. On the other hand, even if a patient is below fifty, an operation for radical cure may not be advisable if the general health is bad or marked disease of any important organ is present. The occupation also of the patient is a factor in the matter; if it is arduous, requiring great physical exertion, a truss is not, on the whole, so satisfactory a method of treatment as is a radical cure. Further, if the patient is to remain in England a truss will be more satisfactory than if he has to go to some uncivilised country where a broken truss probably could not be repaired and where a strangulated hernia could not be treated. The question then arises, if it has been decided to operate, what operation should be performed: the answer depends entirely on the degree of hernia present; if the case is slight and the inguinal canal is not at all diminished in length then, in his opinion, all that is necessary is to ligature the hernial sac opposite the internal ring and cut it away on the distal side of the ligature. If this removal of the sac is thorough, the ligature being applied sufficiently high, no return of the hernia need be feared; in fact, the operation done is exactly that which he always performs for inguinal hernia in children. If, however, the hernia is of a more marked degree, the inguinal canal will have become shortened, the internal ring approaching the external. In these cases the canal has lost its protective power, for the natural mode in which a hernia is prevented in a healthy person does not depend on the smallness of the inguinal ring, but on the obliquity of the inguinal canal, owing to which increased abdominal pressure presses the posterior against the anterior wall of the canal, so that the greater the abdominal pressure, the greater the difficulty of the production of a hernia. In those cases of hernia in which the inguinal canal has become materially shortened, mere ligature and removal of the hernial sac will not suffice to prevent a return of the hernia; it is necessary to remake the posterior wall of the canal so that the canal is lengthened. With regard to the deep sutures employed, he sees no objection to silk; silk sutures will never cause suppuration, leading to extrusion, if care be taken with regard to asepsis, and also with regard to avoidance of excessive tightness when the suture is tied; a tight suture leads to strangulation and necrosis of the tissue included within the suture, this need not occur if the excessive tightness is avoided. The mattress form of suture was certainly the best for uniting aponeurotic structures, for by it flat surfaces are brought into contact, and not mere edges. With regard to the dangers of the operation, if perfect asepsis be employed there is only one danger of any importance, and that is injury to the bladder; the bladder is no rare constituent of an inguinal hernia; it does not lie within the serous sac, but is generally attached to the outside of the sac wall, and if the surgeon is not alive to the importance to the occurrence of such a complication the bladder may be wounded during the dissection, or may even be included within the ligature if the sac has not been thoroughly cleared from surrounding structures. The surgeon must always bear in mind the possibility of the presence of the bladder, and should any doubt arise in his mind whether or not some structure present is the bladder, the introduction of a metal catheter *per urethram* will speedily settle the point. Michel's sutures form a very convenient and simple method of uniting skin wounds. They can only be employed where there is no tension. The only harmful result that follows their use is a little local inflammation which may occur if too much pressure is employed in introducing them.

The wound healed by first intention, the Michel's clips were removed on the eighth day, and the patient left the hospital eighteen days after the operation. When allowed to sit up he was fitted with a Day's truss, not from any suspicion of the thoroughness of the operation, but because Mr. Evans considered that the support afforded by a suitable truss was useful until the abdominal wall recovered fully from the effects of the operation. The truss was to be left off some four months after leaving the hospital.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, APRIL 24TH, 1908.

The President, A. F. DIXON, M.B., in the Chair.

COLOUR FATIGUE.

PROFESSOR T. H. MILROY, in making a communication on the above subject, said that experiments had been frequently carried out in order to study the effects produced by partial or complete fatigue to various colours. Such effects as we term negative coloured after-images may be regarded as partial fatigue effects, whether the view of Young-Helmholtz or that of Hering be regarded as correct. According to the former theory, the after-image effect is due to the white light stimulating the nerve endings not fatigued by the original light—that is to say, it is a partial fatigue phenomenon. According to the latter theory, the after-image effects are due to an opposite change occurring in the visual substance to that produced by the original stimulus. In order to obtain more complete colour fatigue, different methods have been employed. Burch produced fatigue by condensing sunlight upon the eye, passing the light through transparent coloured screens, and studied the after-effects on colour vision. In this way he was able to produce conditions somewhat similar to those existing in the colour-blind. The method of excitation in this case is of such a severe character that some doubt has been expressed as to the validity of the results. Nagel, of Berlin, produced fatigue for red by wearing spectacles with orange-coloured gelatine films. Fatigue of a definite character was produced after wearing the glasses for one or two hours. This observer found that after this time he was red colour-blind for one or two minutes, having all the sensations of the dichromatic. I have employed this method for producing fatigue, and also another one depending upon the excitation by discontinuous retinal stimulation with spectral light. This flicker method, if the spectral light be intense, is very satisfactory in so far as fatigue phenomena are soon apparent. Discontinuity in stimulation may be easily brought about by rotating in front of the collimator slit of the spectroscope a disc with variable open sectors. On fixing with the eye the red part of the spectrum, fatigue is produced for that colour, and usually, if accurate fixation be adopted, within a very short time The study of the fatigue phenomena, however the condition may have been produced, is difficult, unless the fatigue be very pronounced, because the condition so rapidly disappears and the visual sensations alter with bewildering rapidity. One may study the fatigue phenomena by comparing the spectrum before and after the stimulation, or by testing with Holmgren's wools or similar tests, or by examination of successive or simultaneous contrast phenomena. After prolonged fatigue for green, the changes in the spectrum are seen in the green, yellow and orange mainly, the yellow encroaching on the red of the spectrum, while on the other side there is a gradually increasing admixture of white until the green tint disappears. In matching colours there is always a difficulty, even in slight fatigue for green, to distinguish between pure greens and bluish greens. Some of the most interesting fatigue phenomena are to be seen in testing successive and simultaneous contrast in the fatigued eye. For a fairly long period after fatigue for green there are changes in the simultaneous induction phenomena which are met with in the normal person when he observes a grey disc on a red field, either as carried out with Meyer's papers, or with a rotating red disc having a narrow circular grey band midway between the centre and the periphery of the coloured field. Under normal conditions the grey field appears of a green colour. This does not occur in the case of the person fatigued for green. In fact, the grey field shows no green tint until long after the slight red-coloured after-image has disappeared. It is advisable not to examine for these induction effects until time is given to allow the slight negative after-image effects to disappear. The advantage of these contrast effects as tests for colour fatigue and colour-blindness lies in the fact that they arise under conditions which, if we believe Hering's theory, necessitate a definite change in a visual substance due not to a stimulus from without solely, but also to an autonomous change. These colour sensations due to autonomous changes may be of special value as tests in cases of colour fatigue and blindness, for the reason that there is not the same opportunity for recognition of qualities in the stimulating body, other than the colour quality, as may occur in retinal stimulation resulting from coloured light from a definite object in the visual field. A colour-blind person may be able to match certain coloured wools by certain differences in the intensity of the saturation, illumination, texture, etc., although the colour sense necessary to the normal person in making the matches be actually absent, or at least deficient, in the case of the former.

Professor THOMPSON said that the explanation which he had always in his mind in the case of a grey patch on a coloured ground was that the judgment in the case of a given colour depended in a large measure on the prevailing colour of the field. Thus, in the example before them of a grey patch in a green field, one judged that the green field overspread the whole area, and so one subtracted green from the central white disc, which appeared, therefore, of a pink tint. He thought that these contrast effects, referred to in connection with fatigue phenomena, supported to some extent the theory of Hering, in which he had not hitherto believed very strongly.

Sir HENRY SWANZY said the communication and demonstration were exceedingly interesting, and dealt with a subject concerning the physiology of vision which was of extreme difficulty.

Professor MILROY replied.

A METHOD FOR THE EXAMINATION OF THE FISSURE OF ROLANDO.

Dr. C. R. CRYMBLE said that Professor Symington and he had examined the central fissure of the brain, and had studied specially its surface form, its walls, and its floor. Their first difficulty was to obtain records of a number of central fissures. They found that, as the fissure crossed the convex surface of the hemisphere, a photograph only gave a true picture of about one-third of the fissure. However, they were able to examine about forty brains by means of tracings taken on a sheet of xylonite moulded to the brain. After this a block of brain substance containing the central fissure was cut out, the fissure opened, and its floor cut through, so as to separate the anterior and posterior walls. Photographs of the walls, and of the different varieties of central fissure and floor were exhibited, the anterior wall showing convexities and the posterior showing concavities. It had been stated that as a rule the floor was shallowed by a deep annectant gyrus in the region of the superior genu, and this had been taken as showing that the central fissure had developed in two parts, but they had found only one specimen in twenty-four brains showing that condition, and it was only slightly marked. Slides were shown summarising the work of the observers. Authorities agreed that the superior genu was produced by a buttress on the anterior wall. There was a difficulty about the inferior genu. It was stated to be a curve of the fissure about the junction of the middle and lower thirds, opposite a transverse branch of the post-central fissure, but they frequently found two such branches. They had taken as a guide to it a buttress on the posterior wall fitting into two well-marked buttresses on the anterior wall. They found some difficulty in coming to a definite conclusion about the buttresses on the anterior wall, but were inclined to recognise two main buttresses, both exhibiting a tendency to sub-divide. They only found one specimen showing two single buttresses on the anterior wall, while ten out of twenty-four showed two main buttresses which partially sub-divided, making four buttresses; many showed one sub-divided and one single. The upper buttress produced the superior genu, and in it was said to be located the trunk centre. They believed that the concavities on the posterior wall were produced by the buttresses on the anterior wall.

Professor SYMINGTON said he thought the results obtained by Dr. Crymble and himself showed that, although a large amount of attention had been devoted to the anatomy of the central fissure, the methods pursued had been by no means satisfactory. Physiologists had, as a rule, depended on diagrams for their illustrations of the areas they stimulated, and it seemed to him that our knowledge of the exact position of a number of the motor centres had not been so accurate as they might have been if they had had some method of taking tracings of the fissure with an indication of the exact points where the stimulation was applied. Some surgeons attached great importance to the inferior genu, and yet they had great difficulty in determining from the text-books its exact position.

Dr. MOORHEAD stated that some years ago he had been asked by Professor Cunningham to investigate the fissure of Rolando, and it was possible that from a study of these specimens he came to the conclusion that there was a bridge in the fissure. He had had a brain from a person whose arm was greatly diminished in size, and no change had been noticed in the brain as regards the size of the arm area, but there was a distinct gap behind the arm area in the fissure of Rolando.

Professor THOMPSON said he regarded the bulgings seen on the anterior face as the strongest confirmation, apart from the actual physiological evidence that had been produced, that the grey matter had been developed in particular places in association with movements of limbs which were well supplied with skilled movements.

Professor FRASER also spoke.

The CHAIRMAN thought there was no description of the fissure of Rolando which fitted a majority of the cases which were studied. He believed that Professor Cunningham had himself become somewhat doubtful as to his former descriptions.

Dr. CRYMBLE replied.

Professor Symington and Dr. Crymble exhibited two specimens, one showing unilateral interruption of the fissure of Rolando, the other almost complete absence of the corpus callosum.

Professor Symington and Dr. J. C. Rankin showed a series of radiographs illustrating the development of the teeth. These beautiful and interesting exhibits were much admired.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, MAY 7TH, 1908.

The President, Mr. MARCUS GUNN, F.R.C.S., in the Chair.

EXHIBITS.

MR. E. E. HENDERSON showed microscopical sections from the case of orbital growth which was shown at the previous meeting.

Dr. EDRIDGE GREEN exhibited and demonstrated a lantern, of an economical design, for testing colour perception.

Mr. DEVEREUX MARSHALL highly approved of the lantern, which he understood would cost only 25s., as against about 6 guineas for the more elaborate lantern of Dr. Edridge Green.

Mr. **Nettleship** said he had used Priestley Smith's lamp, and found it very useful, patients making very few mistakes.

The **President** said he had had a lamp in use for 15 years, with ordinary red and green glasses, and an opaque ground glass, with a diaphragm.

Dr. **Clement Hailes** showed a portable illuminative attachment for the ophthalmoscope, which could also be used as a focal light. It was attached to a small accumulator, which could be carried in the pocket, leaving the hands free.

Mr. J. H. **Tomlinson** showed a Nernst lamp-projecting lantern for the consulting-room, also a small Nernst lamp in which the resistance was in the handle.

Mr. **Jessop** showed a case of aniridia of both eyes. Mr. **George Mackay**, Mr **Treacher Collins**, and Mr. **Devereux Marshall** described similar cases. Mr. **Jessop** showed a boy, æt. 9½, with glioma.

Mr. **Freeland Fergus** read a paper entitled

PTOSIS OPERATIONS.

The author first referred to the operations by sutures and ligatures, as illustrated by the operations of Mules, Harman and Worth. Attempts had also been made at advancement, as in his own method of advancement of the occipito-frontalis, and to attach a portion of the superior rectus muscle to the upper eyelid. Others had tried to advance the levator palpebræ superioris. Finally, there was the plastic operation, as in the well-known operation of Panas. The suture operations seemed in their essence bad; a thread which was absolutely sterile would not cause cicatricial contraction. Moreover, threads left projecting on the skin surface were apt to be channels of septic invasion. Ligature operations left the lid without much mobility, and success depended on the permanency of the metallic or tendinous suture. Of the advancement operations, he was satisfied with that of the occipito-frontalis. Recently, however, he had used a much larger incision than formerly. He now made an incision right along the eyebrow, and then continued it for 1½ to 2 inches upwards and outwards, so that he could reflect the skin very thoroughly. Where asepsis was secured, the patient was not disfigured with a scar in after-life. In many cases of ptosis, the levator palpebræ superioris did not seem to be developed at all. The eyeball was protected either by a Knapp's lid clamp, or by an ordinary metal spatula. A skin incision was made parallel with the edge of the eyelid and across its entire extent. It was situated a few m.m. above the free border of the lid. Another incision began at one end of the primary incision, curved upwards over the eyelid, and downwards, so as to terminate at the other end of the incision. The portion of skin thus isolated was then dissected up, and the tissue down to the conjunctiva removed. One set of sutures was placed deeply, consisting of one point in the middle, and one at either side. Superficial skin sutures were also inserted. For the deep sutures he used Van Hoorn's .00 gut. That operation lifted the eyelid easily to the required amount, and put it completely under the control of the occipito-frontalis muscle. Dr. Fergus showed a number of photographs of cases so treated, with excellent results.

Mr. **Priestley Smith** thought the question of most importance was what happened during sleep in cases which had been operated on; there might be considerable gaping of the lids.

Mr. **Roll** thought quite as good results were obtained from Hess's operation as Mr. Fergus got by his method.

Mr. **Marshall** thought that during sleep the eyeball rolled upwards, and that therefore the cornea would then be covered in any case.

Mr. **Fergus** replied. He said he did the first operation 12 years ago, and he had not yet seen corneal trouble. He believed that closure of the eyelid during sleep was involuntary. If he should encounter a case of ulceration of the cornea following the operation, he would consider it his duty to report it to the Society.

Messrs. E. **Clarke** and S. **Mayou** read a paper on

TUBERCLE OF THE IRIS TREATED BY TUBERCULIN.

In the case there was a large area of detached retina, forming a whitish prominence on the nasal side of the disc, 3 D, at the highest point, and crossing below the large inferior retinal vein. The retina in the upper part was covered with an exudate. There was no history of tubercle or syphilis in the case. The vision was 6/18, the vitreous full of opacities, and there was a mass of k.p. spots in the lower part of Descemet's membrane. A tumour was very distinctly seen, and as a result of a consultation with one or two colleagues, it was decided to ask Sir Almroth Wright to treat the case by tuberculin. That was done, and six months after commencing the treatment improvement set in, vision increased, and the k.p. spots disappeared, and the growth became flatter. The treatment was continued for a year, during which 21 inoculations were given, and the result was to drive the tubercle out of the system. The eye was now practically normal. Mr. Clarke next read a paper on "Confluent or Conglomerate Tubercle of the Iris Treated by Tuberculin." Except for hyd. cum. cretæ every night for a week on admission, and cod-liver oil, no other treatment was given. After needling, which he proposed to do later, the case was a complete success.

The cases were discussed by the President, Mr. Jessop, Mr. Herbert Fisher, Mr. Sydney Stephenson, Mr. Bishop Harman, Mr. Fergus, Mr. Johnson Taylor, and Mr. Cruise.

Mr. **Clarke**, in his reply, said the mercury was given, as he wanted to have a second string to his bow and avoid wasting precious time. He did not use Calmette's reaction, as he knew of a case in which inflammation of the eye had persisted for some weeks after its use.

Dr. **George Mackay** (Edinburgh) read a paper on a case of

ARTERIO-VENOUS ANEURYSM

treated by ligature of the common carotid artery. The author reported the result of a case shown by him at the Edinburgh meeting of the Society last year. The exophthalmos had now entirely disappeared, the bruit was no longer heard, and the vision now practically 6/18 in each eye. A month after the carotid had been tied, and while the patient was still in hospital, he developed thrombosis of the left leg and thigh, but he made a good recovery from that, and was discharged on August 2nd, and had since resumed his work as a coachman. Early last month he came to see whether anything could be done to remedy the convergent strabismus which remained as a result of the paralysis of the right external rectus. The power of that muscle also had improved considerably, and Dr. Paterson tenotomised the internal rectus, leaving only 5 degrees of convergence. He also read a paper on a case of phlyctenular keratitis and pustular episcleritis treated by antistaphylococcic injections. The patient at the age of 14 had keratitis in the left eye, with considerable impairment of vision, and five years later the other eye was affected, and she was under the care of Dr. Dufour, of Lausanne. His treatment was by hot fomentations, and anti-rheumatic powders internally. Shortly afterwards she consulted Dr. Mackay, and he found a small pustule on the right conjunctiva, which had discharged its contents and appeared as a raised ulcer. There was a haze in the cornea and a thinning in the ciliary region, but no pain. Hypermetropic astigmatism was present in both eyes, but she had not worn glasses. He ordered weak yellow oxide of mercury ointment, with atropine, and grey powder and bicarbonate of soda internally, followed by an arsenic and iron tonic. Under this she gradually improved, and correcting glasses were ordered. Three years later she returned with a small patch of injection in the edge of the right cornea, and there was a fringe of older opacity in the position of the arcus senilis. The same treatment again produced improvement. Subsequently there were several recurrences, and in August, 1906, he suspected the cause was tubercle, especially as her parents had been related before marriage, and she had some phthisical relations. Dr. Ian Stewart, at his request, took the opsonic index, and it was found to be for tubercle 0·74, and for staphylococcus aureus, 1.24. Films from the conjunctival sac showed large numbers of polymorphonuclear leucocytes, and a few staphylococci, but no tubercle bacilli. Dr. Stewart thought the condition was not tubercular. After a week antistaphylococcic treatment was started, 1/55 mg. of dried staphylococcus aureus being given, dissolved in 1 c.c. of distilled water. The following day there was a decided negative phase, the index falling to 0.92, but 24 hours later it had risen to 1.86. Steady improvement set in, and in January this year she said she was very well, and had kept so. The general aspect of her eye was much improved. He proceeded to discuss the ætiology of the episcleritis, and to bear testimony to the great value of the opsonic index, particularly in distinguishing tubercular from staphylococcic infection. He laid stress on studying the positive or negative phase 24 hours after an injection. He believed the first suggestion of diagnosis by giving small doses of dead bacilli was made by Drs. Lawson, of Banchory, and Ian Stewart, of Edinburgh, in the "Edinburgh Medico-Chirurgical Transactions, 1905."

Mr. **Jessop** discussed the case, and Dr. **Mackay** replied.

ROYAL SOCIETY OF MEDICINE.

Therapeutical Section.

Meeting held Tuesday, April 28th, 1908.

The President, Dr. **Burton Brown**, C.I.E., in the Chair.

Dr. **Leonard Guthrie** read a paper upon

RHEUMATISM AND CHOREA IN CHILDREN.

He maintained that salicylate of soda and allied drugs were palliatives, but not cures, for rheumatism. Carditis and nodules appeared in patients fully under the influence of chorea. The use of large doses of salicylates was not devoid of danger. It was contended that sodium bicarbonate was an antidote to the poison of salicylates, but to give poison and then antidote at the same time was a questionable therapeutic measure. The treatment of the acute stage of chorea was by rest in bed, quiet, isolation, protection from injury, nourishing food. In severe cases hypnotics were necessary—chloral and bromide, chloralamide or chloretone. Arsenic, given on the intensive method, was not recommended. Ill results in the shape of gastro-enteritis and peripheral neuritis were too frequent. Salicylates, including aspirin, could not be regarded as curative. The average duration of chorea, under the mode of treatment recommended, did not exceed four or five weeks, and cases which did not recover under three months could not be considered testimonials to any form of treatment adopted.

Dr. **Cecil Wall** said that with almost all that Dr. Guthrie had said he felt himself in complete accord. Referring to statistics, published in the "Transactions of the Therapeutical Society for 1905," which he had compiled in an attempt to estimate the effect of different drugs in chorea, Dr. Wall stated that he then found that, of cases treated by arsenic, 38 per cent. were cured in less than two months. Similar figures were given for treatment with salicylate of soda, and with other drugs. It was only when they came to the treatment with aceto-salicylic acid that they found a very marked difference. Of these 92 per cent. were discharged from hospital in less than two months, the majority in four weeks from admission. After two more years' experience of this treatment, he still felt very strongly in favour of it. With regard to the dangers of the use of aspirin—the vomiting to which Dr. Guthrie had alluded—he found that it was possible to avoid that altogether if aspirin was only given when there was food in the stomach. Moreover, aspirin should never be given in tabloid form, but invariably as a powder. Very large doses—doses such as he himself would not prescribe—he had seen give rise to hæmaturia. In violent cases he thought it wise to make use of sedatives, and he would select chloral and chloralamide. He thought the use of bromides very harmful. In certain cases the result of giving bromides had been to produce mania. Any depressing drug like bromide was liable to exaggerate rather than ameliorate the condition. He looked upon chorea as being due to a paralysis of the cortical centres allowing the lower parts of the nervous system to act spontaneously.

Dr. D. B. **Lees** maintained that the neurotic element in chorea was probably the effect of the rheumatic toxin on the brain. He laid emphasis on the alteration in temper and disposition which was often manifested in children with early chorea. At times, too, there was very distinct aphasia, more than could be accounted for by simple weakness of muscular movement. Lastly, hallucinations of vision were not infrequently met with. In the treatment of rheumatism and chorea, he advocated the use of very large doses of salicylate of soda. He believed very strongly that salicylates were more readily tolerated if a double dose of sodium bicarbonate was given at the same time. When unpleasant symptoms occurred, the dose should be decreased, not omitted. Given in this way, it was usually possible to educate the patient to tolerate without difficulty three or four times the dose which at first caused unpleasant symptoms. He had found such extraordinary benefit result from the local use of ice in pericarditis, that he was surprised to hear Dr. Guthrie say that he gave opium in pericarditis because he did not know what else to do.

Dr. **Gordon Sharp** said that he had never found that depression resulted from the use of salicylates, and he agreed with Dr. Lees that large doses did great good. He was much astonished that opinion in London was against the use of arsenic in chorea. His own experience in the North of England was that it was a most valuable drug. He thought that there must be something peculiar in the London constitution that could not stand that important drug. He believed very strongly that there was an intimate connection between rheumatism and chorea.

Dr. J. **Gray Duncanson** spoke of the success which attended the use of arsenic in chorea in Scotland. He thought that it was all a matter of environment.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held May 6th. 1908.

The President, Dr. **James Ritchie**, in the Chair.

Dr. T. D. **Luke** demonstrated a new dropper for ethyl chloride, made by Messrs. Bransom and Co., Leeds, and an open ether mask, by which it was possible to anæsthetise a patient as easily, and with as little ether, as with a Clover's inhaler. For robust or alcoholic patients, however, a closed inhaler was preferable, unless an injection of morphia was given prior to the administration of the anæsthetic.

Professor **Chiene** described a simple method of preparing catgut, and showed several appliances for conveniently demonstrating auto-chrome transparencies without a lantern. They consisted of carriers for lantern slides, some with magnifying arrangements, suitable for handing round to a class of students.

Dr. **Melville Dunlop** read a paper on "Some Considerations regarding Pneumonia in Children drawn from an analysis of 500 cases." (A full abstract of this paper will be found on page 555.

The paper was discussed by Dr. **James Carmichael**, who urged the value of atropine in pneumonia; by Dr. **Russell**, who dilated on the pathology of the disease, and pointed out that histologically and bacteriologically there was little or no distinction between lobar and broncho-pneumonia; and by Dr. **Playfair**, who said that he thought that cough mixtures were frequently of service, and that he did not hesitate to give small doses of antipyretics if he was anxious about the temperature. Dr. **Thomson** referred to the recurrence of pneumonia in the same patient, and to its occurrence in families. He spoke of the usefulness of Dover's powder as a sedative, and of the efficacy of treatment in the open-air in some cases.

The paper was also discussed by Drs. Fowler, W. B. Drummond, Geo. Hunter, Cowan Guthrie, and the President.

Dr. Douglas Argyll Robertson and Dr. J. Hughlings Jackson were elected honorary members of the Society, and the following gentlemen were elected corresponding members:—Ivan P. Pavloff, St. Petersburg; Sir Henry Swanzy, F.R.C.S.I., Dublin; Francis J. Shepherd, F.R.C.S.E., Montreal.

LIVERPOOL MEDICAL INSTITUTION.

At the Last Meeting held,
Mr. T. H. **Bickerton**, F.R.C.S., President, in the Chair,

The following cases were brought forward:—

Mr. **Colin Campbell** read notes of a case of "abscess of the lung" following pneumonia, successfully treated by intra-tracheal injections of Izal. Mr. Campbell exhibited the patient, a male, æt. 42, who had been placed under his care by Dr. McNair, of Manchester. The illness commenced with an attack of acute pneumonia on July 17th, 1907. On the 14th day a large quantity of pus was expectorated and the acute symptoms were relieved. Pus continued to be expectorated freely, empyæma was diagnosed, but exploration failed to find pus. His condition remained the same until October 29th, when he commenced the Izal injections. He was bringing up 10 oz. of pus daily. At the end of a week he was taking 2½ oz. of 10 per cent. Izal solution at each daily sitting.

On December 16th he discontinued treatment, cured, having gained 21 lb. He has remained well since and follows his usual occupation.

Mr. **Rushton Parker** related cases of completion of union by "bone implantation" in un-united fracture. His method is to graft small pieces of bone removed from the un-united fragments between the ends, after removing all unossified material from between them. He considered that in confirmed non-union we have, by planting minute grafts of living bone between the bared ends, a means of procuring re-union both easier and less deforming than by wiring or other methods of suture, and less dangerous. Radiographs were shown to illustrate the gradual increase of density of the callus.

CHRONIC COLITIS, WITH SPECIAL REFERENCE TO PERICOLITIS SINISTRA.

Dr. J. **Lloyd Roberts** read a paper on this subject. He expressed the opinion that this affection is more common than generally thought and deserved more attention. Pericolitis might occur in acute or chronic form.

The acute was usually circumscribed, and arose from ulceration of the mucous membrane of the colon, which might be stercoral, traumatic, tubercular, dysenteric, typhoid, or malignant in character. It spread through the walls of the bowel and led to circumscribed tumours outside and in contact with them. These tumours had often been mistaken for malignant growth. Occasionally the inflammatory product spread round the bowel and caused obstruction. These tumours were capable of resolution under appropriate treatment, as occurred in two cases of which details were given. Occasionally they suppurate and form abscesses which burrow along the length of the bowel. Two cases were mentioned in which abscesses were diagnosed and opened, one near the splenic flexure and one in relation to the iliac colon. Rarely peritonitis might occur from bursting of the abscess or extension from the underlying ulcer.

The chronic form was usually diffuse, and arose from spread of inflammation from neighbouring organs or the mucous lining of the bowel. The latter form, where the inflammation infiltrated through and involved all the coats of the bowel, generally occurred in the ascending colon or the iliac colon. The latter situation is most frequently affected, and the disease has been known as perisigmoiditis or pericolitis sinistra. Of this form Dr. Lloyd Roberts had met with nine cases, 4 in men and 5 in women—six of the nine occurring between the ages of 21 and 26. The clinical history and the physical signs were described. He showed that they were all preceded by long continued constipation, with retention of fæces within the colon. The fæcal masses became dry and rough, and set up irritative colitis. The walls became distended and pouches and diverticula were formed. All the layers of the walls became infiltrated and lymph deposited on the serous surface. This tended to form adhesions to neighbouring structures, and sometimes caused obstruction. In the early stage the bowel, when emptied, felt firm and of less diameter than normal, and was easily rolled about. This is the hypertonic or spastic type. Later on the muscular coat lost its tone and the bowel felt like a thick ribbon, with still thicker edges, soft and doughy to the touch. This is the atonic stage. Cases illustrative of the various types were described, and a portion of iliac colon removed from one patient by Mr. Newbolt was shown to confirm the changes above described. In discussing the pathology, Dr. Roberts suggested that the cause lay in a late origin and narrowness of the mesentery of the pelvic colon, owing to which the bowel became kinked near the bony brim of the pelvis. The medical treatment consisted of administering intestinal antiseptics, external application of mercury and belladonna, and, most important of all, daily douching of the colon with hot antiseptic douches, which should be persevered with for many weeks. Patients should be warned of the risk of recurrence should constipation again occur.

Dr. A. G. **Gullan** confirmed the statement that pericolitis sometimes resembled malignant disease, and quoted a case in point. He considered the pain of colica sinistra was usually definitely localised over the sigmoid or ascending colon, and in only very rare instances was the pain diffuse.

Mr. **Keith Monsarrat** considered that the worst cases of infiltrative colitis required some form of surgical treatment which gave rest to the affected part. Without this they tended to persist indefinitely. He considered that the suppurative and adhesive types of pericolitis required surgical treatment.

Dr. **Blair Bell** drew attention to pelvic peritonitis in women as a cause of pericolitis. Of the last 500 cases seen by him in the gynæcological out-patient room, 22 per cent. had pain in the left iliac fossa, and in one-third of these the cause had been ascribed to chronic constipation, with trouble in the pelvic colon. In cases of abdominal section he was surprised to note how many had adhesions around this part of the bowel, either from intrinsic or extrinsic causes.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 17th, 1908.

Treatment of Eclampsia

Eclampsia is not a malady. It is rather a clinical syndrome representing one of the forms of gravid intoxication. What should be specially borne in mind is that the treatment should be directed both against the exciting cause and the effect—that is to say, the convulsive attacks and coma produced by reaction of the central nervous system under the influence of toxins which have not been, as yet, either isolated or defined.

It is rare that convulsions set in suddenly; more frequently they are preceded for more or less time by other symptoms, as vomiting, ptyalism, irritability of temper, neuralgia, etc., but the most frequent of these manifestations is albuminuria. Consequently, for a very long time eclampsia was considered a complication of albuminuria. Recent urological studies, however, have proved the independence of these two affections, eclamptic attacks having been observed in women whose urine was free from any trace of albumin.

The prophylactic treatment of eclampsia should be based principally on the *régime* which all pregnant women should follow, to avoid auto-intoxication, and this *régime* should be particularly severe in the presence of albuminuria, and consists in absolute milk diet, rest in bed, repeated purgatives, and daily examination of the urine as regards both quantity and quality.

Where premonitory symptoms of eclampsia, accompanied or not by albuminuria, are observed, the milk should alternate with Evian water, a glass of one or the other every one or two hours; an ounce of lactose might be added to each bottle of Evian water. Besides rest and purgatives, a large enema of boiled water should be given every night, while 20 or 30 grains of chloral should be taken in some diuretic infusion.

If these premonitory symptoms become aggravated in spite of this treatment, a pint of blood should be taken from the arm.

When convulsions have set in, the treatment must be more active. Care should be taken to remove any false teeth if present, and a handkerchief should be placed between jaws so as to prevent the tongue from being bitten. The bladder should be emptied by means of a catheter, and the patient watched so as to avoid a falling out of bed. The medical treatment consists in administering chloroform during the duration of the seizure, and an enema of 1 drachm of chloral in milk and the yolk of an egg. If the patient is in coma, only water should be given as a drink, and the patient freely bled, a quart or more according as the pulse may permit it.

An important question presents itself—should delivery be provoked or should Nature take its course?

Forced delivery has been recommended and practised, but the results do not appear to have been favourable to the patient.

In the case where labour has commenced spontaneously, either during the attack or within a few days after, severe antiseptic precautions should be taken, as eclamptic patients are particularly predisposed to infection.

The best antiseptic is formol:—

Formol, 2 dr.
Sulphate of copper, 1 dr.
Ess. of geranium, ½ dr.
Proof spirit, 8 oz.

A tablespoonful for two quarts of boiled water given as injection.

As soon as the os is sufficiently dilated, delivery might be hastened, if necessary.

As hæmorrhage is not rare, particular attention must be paid to the patient during the first few days after delivery.

The milk diet must be maintained as long as albumin is found in the urine, and that the patient does not secrete more than a quart of urine in the 24 hours.

Such is the method of treatment adopted by Dr. Rudaux.

MILK DIET.

Milk diet presents its indications at each turn in medical practice. Yet many practitioners, says Prof. Surmont, complain of the difficulties of getting it accepted by their patients, who pretend to be unable to support it.

It is important to understand that many patients are only refractory in appearance to milk diet, and ill-support it because they do not know how to take it in a suitable form.

The maladies for which the milk *régime* is indicated may be divided into two groups—acute and chronic affections.

The utility of milk diet in acute diseases is patent, whether it concerns general infections, where renal complications are possible, as eruptive fevers (scarlatina, typhoid, spotted fever, septicæmia of divers origin, or in those affections in which phenomena of intoxication are predominant, as diphtheria, tetanus tonsillitis, pneumonia, cystitis, acute nephritis, uræmia, hepatic insufficiency and eclampsia.

It must be remembered that in acute febrile affections, digestive secretions are reduced, and consequently the susceptibility of the digestive tract must be taken into account before prescribing large quantities of pure milk.

Wherever digestive fermentation is well marked with a furred condition of the tongue, a saline purgative and a purely hydric diet should precede by 24 hours the ingestion of milk.

It is especially in chronic affections of the digestive tract, liver, heart, kidneys, urinary organs, skin and such intoxications as mercurial, saturnine, and certain auto-intoxications (uræmia), that the milk diet has given considerable therapeutic results.

In chronic maladies it is of the highest importance that milk be well tolerated by the digestive tract, since, in order to produce the desired result, its employment must be prolonged for weeks and months.

In certain dyspeptic patients, and especially those who present well-marked butyric fermentation, the milk, as soon as it arrives in the stomach, becomes decomposed and provokes tympanism, acid regurgitations, pain, vomiting, or diarrhœa—all the symptoms of indigestion.

Patients who have suffered from these troubles acquire a repugnance for the *régime* and refuse it absolutely. A previous disinfection of the stomach by a purgative and hydric diet (Vichy water) will prevent these accidents.

Should the milk be given in its natural state or boiled? As regards the question of digestibility, the former is more easily digested, it is certain, but, on account of the frequency of bovine tuberculosis, it is always safer to boil the milk before taking it unless its origin is certified. In any case, in towns boiled milk only should be prescribed.

As regards the quantity of milk to be absorbed in the day, the average would be about four quarts, but this amount is not easily tolerated by patients, who can scarcely consume more than three quarts, and frequently less. A glass of milk every two hours, or three pints a day, is the best way for a beginning. Afterwards the dose might be increased to double that amount as the patient may tolerate it.

It is important that each glass of milk should be taken by sips every two or three minutes, and not all at once, which might produce a large clot of casein, a frequent cause of indigestion. Hot milk should be preferred, as it is absorbed more readily, but when there is a tendency to vomiting, cold milk is more suitable.

The mouth should be rinsed with some alkaline water, Vichy or Vals, for instance, after each little repast, to prevent the accumulation of the residue of milk in the mouth, which ferments and develops inflammation of the mucous membrane of the cavity, as well as fœtidity of the breath.

Some patients show a complete disgust for milk which a little persuasion overcomes. The savour, in any case, can be masked by the addition of a little tea, coffee, chocolate, sugar, salt, seltzer water, cherry laurel water, or different liquors, Kirsch, rum, cognac, when the employment of these different substances is not contra-indicated.

Certain patients present an absolute gastric intolerance for milk (furred tongue, fœtid breath, gastric heaviness, palpitations, vertigo). For these the cream should be carefully removed, and lime-water or Vichy water given with the milk. Where diarrhœa is provoked by the milk *régime*, it is due to the coagulation of the liquid in an hyperacid stomach. In such cases milk and alkaline water should be given in equal parts, or the milk should be sterilised.

It sometimes happens that, in spite of all the precautions observed, cows' milk is not tolerated. Recourse must be had to asses' milk or kephyr. The former contains more sugar or lactose than cows' milk, but is less rich in albuminoids and fatty matter. It is less nourishing, but being more easily digested, it is particularly suitable for weak stomachs. However, it is difficult to obtain in towns.

A better method consists in utilising kephyr, which, as everyone knows, is composed of cows' milk subjected to special fermentation due to the combined action of a yeast and a microbe, *dispora caucasica*.

Under their influence, the lactose gives lactic acid, alcohol, and carbonic acid. The casein, precipitated, undergoes a primary digestion, transforming it into peptone.

Kephyr is an acidulated and sparkling drink.

The ferment can be bought in grains and added to the milk at a known temperature, but there exist special kephyr manufactories which give every guarantee of a pure article.

GERMANY.

Berlin, May 17th, 1908.

At the Verein für Innere Medizin Hr. Albu reported

Two Cases of Poisoning.

The first was one of poisoning by corrosive sublimate. Two grammes had been taken, and the clinical symptoms produced were remarkably slight. Hæmorrhagic diarrhœa appeared for the first time on the third day after the poisoning, then vomiting came on, the patient dying of exhaustion on the tenth day. The stomach showed the typical picture of diphtheritic inflammation; the whole of the small intestine was free from pathological changes, the most serious being in the large intestine; these consisted of necrotic patches, but they did not penetrate to the serosa. The kidneys showed the typical changes, acute nephritis with fatty degeneration.

(2) Carbolic acid poisoning. It was the case of a young girl who had attempted suicide on account of a love affair. The speaker did not see the patient until seven weeks after the poison had been taken; she complained of gastric troubles. There was a typical stenosis of the pylorus with an-acidity. Gastroenterostomy was performed. There were necrotic patches in the superficial layer of epithelium of the interior of the stomach.

Hr. Boenninger spoke on

Renal Diabetes.

He said that in diabetes mellitus the glycosuria depended on an increased quantity of sugar in the blood, hyperglycæmia. Glycosuria had now been repeatedly observed in men whose sugar constituent had not been increased, had been diminished even. For these glycosurias the cause must be sought in the kidneys themselves, they went by the name of renal glycosurias. By a few authors the occurrence of such cases had been disputed (von Noorden). The uncertainty regarding the subject depended on the difficulty of estimating the quantity of sugar in the blood. The speaker considered it necessary to examine, not the whole of the blood, but only the blood serum, as the blood corpuscles contained far less sugar, at least, as a rule. A correct estimate of the sugar in the serum would not be reached by an examination of the blood as a whole. On the other hand, as regarded the excretion of sugar by the kidneys, it was only the sugar contained in the serum that had to be considered. He had determined the normal sugar constituent of blood serum to be 0.09 = 0.10 per cent.

In renal diabetes it was desirable further to be independent of the carbo-hydrates. The speaker described such a case in which 0.1 to 0.5 per cent. of grape sugar was excreted daily. The glycosuria could not be influenced by the strictest diet, nor by a large allowance of carbo-hydrates. These cases were of great importance as regarded practice. Even if they seemed to appear only rarely it was important for the physician to recognise them, for it would be a needless torment and also very injurious to deprive such a patient of carbo-hydrates in his dietary.

Hr. Mohr was of opinion that the sugar constituent of the blood and the excretion of sugar did not run on parallel lines, the criterion of the normal sugar constituent of the blood was very uncertain. In order to differentiate between renal and ordinary diabetes, he proposed to examine the gaseous changes in respiration. If a large meal of albumen was given to a healthy man and the respiratory gas changes were examined every hour or every two hours afterwards the following would be noted:—The respiration quotient mounts rapidly and reaches its maximum of about 0.8 from two to four hours after the meal. In the latter hours it falls, and at about the eighth nearly reaches the hunger value. In the diabetic it was different. Corresponding to the greater or lesser excretion of sugar that takes place after the meal the respiration quotient at first sinks very low—below 0.7—rises again between the sixth and eighth hours, or later still, and then reaches its full value for the digestion of albumen. The reason for this was that the diabetic burnt sugar, but more slowly than the healthy man; hence the rise of the respiratory quotient. He suggested that the gaseous test should have a trial in some case of the kind.

Hr. Magnus Levy thought that, in addition to an abnormal permeability of the kidney for sugar, there was also an active renal diabetes, as was shown by the action of phloridzin. Pavy had given expression to the notion that under the influence of phloridzin the kidney secreted grape sugar as the mammary gland secreted milk.

Hr. Bleichroeder stated that in lying-in women who excreted milk sugar in the urine the sugar constituent of the blood was diminished by about one-half.

Hr. Felix Hirschfeld pointed out that the patient in Boenninger's case was an alcoholic. The changes in the liver and kidneys in alcoholics frequently caused a diminution of the glycosuria and perhaps in that way the absence of connection between the glycosuria and carbo-hydrates was explainable.

Hr. Boenninger, in reply, said that in his case he had always obtained a filtrate free of albumin. After giving large quantities of grape sugar he had performed venesection some hours later and had always obtained a low value. The serum must be examined, the sugar contained in the blood corpuscles did not count as far as the kidneys were concerned.

AUSTRIA.

Vienna, May 17th, 1908.

Orthostatic Albuminuria.

This subject is now monopolising every meeting of the "Gesellschaft der Ærtze." It was introduced in the form of a paper on the subject by Stejskals, which has excited a considerable amount of interest. Escherich thinks this form of albuminuria is very common in children, and asks how this can be reconciled with the erect posture. He had devoted some time to the hypothesis of Jehle that this morbid change in the urine in the erect position was entirely due to a lordotic bending of the spinal cord and therefore mechanical in its origin by disturbing the vascular circulation of the kidney, and was finally driven to the conclusion that there was some truth in the suggestion. He found, as Jehle, that when the orthostatic or upright position was assumed in the lordotic subject albumin was found in the urine. As soon as the lordosis was corrected the albumin disappeared, in any position. This surely points to a close connection of lordosis having something to do with the abnormal product, but whether the lordosis is a normal or pathological agent is another factor to be considered. His own opinion was the lordosis produced a congestion in the venous circulation of the organ with an albuminous result.

Strasser said he had found by experiment that the renal reflex was more sensitive than in any other organ of the body, therefore, he says two causes for the albuminuria may be found, viz., ischæmia and stasis. A simple hyperæmia is not sufficient of itself to produce albuminuria, but if a loss of tonus be associated with this in the renal vessels albuminuria is established. Innervation, therefore, may accompany the congestion. Stejskals is inclined to believe in the arterial path being interfered with rather than the venous, but was not sure if a nephritis previously existed.

Gerber bore testimony to Jehle's theory being the correct solution of this morbid product being in the urine.

Kapsammer was not pleased with such theories, and believed that a form of nephritis was the real cause of the albuminuria. Nephritis might be divided into primary and secondary. Secondary nephritis was an anatomical lesion following a neoplasm, stone, wandering kidney, or hydronephrosis, and primary when nothing but cold or exposure could account for the lesion. Now, is it possible to have unilateral primary nephritis? Kapsammer asks and answers it himself in the affirmative, as he has often met with this condition where the urine from one kidney is quite free from albumin, while that from the other is loaded with albumin. This he proved by giving floridizin. When we, therefore, meet with a case of orthostatic albuminuria we may expect a parenchymatous lesion. This parenchymatous lesion may exist without the functional disturbance of the erect posture, which we may look upon as an accident in a case of parenchymatous nephritis where no cylinders are met with in the urine, but simply albumin. With this explanation, orthostatic albumin is only a symptom, and not a disease *sui generis*, separate from nephritis, or what may be termed an inferior condition of the kidneys, which may have its origin in a pure mechanical irritation or a nervous reflex condition. In any case, we cannot separate this form of albuminuria from nephritis.

Schur thought it waste of effort to speculate on the disease when we could not exactly tell yet how albuminuria was produced. We were still without any exact evidence on the subject and therefore unable to approximate the cause.

Chvostek believed in the reflex vascular innervation. Jehle tells us the albuminuria is due to lordosis; but what is the cause of the lordosis? Is it not the same cause that produces the lordosis that excites the albuminuria? Both are under the same influence. Doubtless, there is some change in the kidney itself or its vessels, but how the morbid condition is brought about we cannot say, as it varies in different individuals. About puberty the secretions of all the organs are changed by a nervous influence, hard to explain. In orthostatic albuminuria the adrenalin secretion may have increased the gland and surrounding adnexa that may interfere with the functional activity of the kidney, and thus produce albuminuria in the same manner that pregnancy does. Novak recorded the history of 14 cases of orthostatic albuminuria which gave a similar result to Jehle's. He obtained the albumin not only when standing but in other positions, such as suspending the body, raising the legs and twisting the arms in different directions. Compressing the thorax and bandaging the limbs had the same effect. He suggested a twisting of the ureters or other pressure on the vessels might have the same effect. As to the lordosis being the true cause, he thought the anatomy of the organ was against it. In some of his cases no lordosis existed and yet the orthostatic albuminuria was present. There was a distinction made between passive and active lordosis in the production of the albumin. The former mechanism was when the spinal muscles were feeble and lax, the latter was the opposite condition when albumin was absent. In his own experiments he could not make this distinction.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Royal Maternity Hospital.—At the annual meeting, held on May 14th, it was stated that the in-patients for the year numbered 464, and the cases treated at their own homes 825. Just half of the intern cases were married women. The number of nurses trained was 57; in order to meet the requirements of the Central Midwives Board in respect to the number of cases a nurse must have under her own supervision, a branch of the hospital has been opened in Leith. Seventy students have been enrolled, as compared with 87 last year. During the year the hospital has received, as a memorial of Emeritus Professor A. R. Simpson, a gift of money to found a ward to be named after him. References were made to the loss the hospital had sustained through the deaths of Professor Annandale and Dr. Underhill.

Edinburgh Medical Appointments.—Considerable comment has been aroused by the comparatively small salaries offered for the posts of divisional police surgeonships, and in one division it is stated that there have been no applicants for this reason. It is understood, however, that appointments have been made in four of the divisions. The Public Health Committee recommend the appointment of a medical woman to act under the Notification of Births Act at a salary of £120 per annum. More important so far as the health of the city is concerned, however, does it seem to us that the salary fixed upon for the Medical Officer of Health is "not less than £800" per annum. To attract a first-rate man a higher bid ought to have been made, and it is to be hoped that the figure offered will be increased to £1,000.

BELFAST.

Cerebro-spinal Meningitis.—Though there is nothing like the epidemic of this fever which there was a year ago, there are still a few new cases every week. Three cases were admitted to the Purdysburn Fever Hospital last week, and three the week before, and 13 cases are under treatment in hospital. No doubt there are some being treated at home, as there has been a growing tendency to keep the cases at home since the fever has proved to be not markedly contagious. In the treatment of the hospital cases Flexner's serum is still being used with most satisfactory results.

Women's National Health Association.—The local branch of the Women's National Health Association has formulated what appears to be a very excellent plan for assisting in the anti-tuberculous campaign. They propose to engage the services of a specially trained nurse, and employ her in visiting consumptives, and specially those who have been discharged from hospital. Her duties will not be so much actual nursing as instruction in hygienic matters and putting the patients in the right way of living in their own homes. The medical men of the city will certainly wish the movement every success.

Election of Poor-Law Guardians.—A strong effort is being made to increase the number of lady guardians on the Belfast Board at the forthcoming elections. For several years there have been two or three ladies on the Board, and now, under the auspices of the Society for Brightening Workhouse Infirmary Life, there are six candidates going to the poll, while one has been returned unopposed, the wife of a medical man. The work hitherto done by the lady guardians in Belfast has been most beneficial to the workhouse and its inmates, as well as to the ratepayers, and they have worked, as a rule, in complete harmony with the medical attendants.

LETTERS TO THE EDITOR.

THE POPULATION QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your valuable paper this week "Veritas" discusses the question of the "Marriage of the Unfit," and the duties of the profession in view of the recklessness with which many of these unions are brought about. This question is important, but sinks into almost complete insignificance in presence of the new development of the population question as a whole. Within the past few days there have been published the quarterly returns of the Registrar-General, and these show once more the lowest birth-rate on record. If this fall continues at the present rate, in a very few years the population of these islands will have become stationary in numbers, so that, unless a change speedily takes place, the decline and fall of the British Empire will soon be well in sight, without the aid of the prophet's telescope or any scientific demonstrating apparatus. The last census showed that the whole Empire, including India, contained only 55,000,000 of people of European blood. The birth-rate in most of our colonies is falling as rapidly as that at home, and we shall in a few years have no men to send to these vast domains, three of them—Canada, Australasia, and Africa—being each equal in extent to Europe, and each capable of supporting in time populations of hundreds of millions. In the meantime, Germany has 64,000,000 at home, besides at least a few more millions in her colonies, and in other lands, who still retain their attachment to the Fatherland, and her population is increasing by nearly a million a year. France, whose pernicious example we have copied, makes no increase; she remains at 38,000,000, *plus* a few hundred thousand more or less really naturalised Swiss, Italians and Germans. Without allies she would be at the mercy of Germany. The French are always declaiming about their patriotism, and yet the whole people, with very rare exceptions, although fully aware that their safety and existence as a free nation depend upon it, refuse to make what they regard as the sacrifice involved in rearing a family of more than two or three children. The motive is not prudence—the wealthiest and the best educated are the worst offenders—but pure egoism, the cult of ease and luxury. The French are a decaying race, in spite of their magnificent gifts; and the same will soon be said with justice of the British. The example of restricting the number of the children has been set by the wealthy and well-to-do, not by the poor, who might plead some justification; and it is one sign among many others of the moral decay of this erstwhile mighty people. The nations of to-day, if they go to ruin, will go with eyes open. Every man of intellect can see whither the vices of civilisation must lead; and if the people will not listen to the latter-day prophets who reason from the basis of scientific fact, as well as from the testimony of history; if they will not listen to the preachers who exhort them to strive for high ideals, nothing seems possible to save them from the doom which from similar causes overtook all the not less mighty peoples of antiquity.

I am, Sir, yours truly,
A Student of Sociology.

LAW FOR LAWYERS AND LAW FOR DOCTORS.

To the Editor of The Medical Press and Circular.

Sir,—The *Times* this morning furnishes another illustration of the fact that it is impossible for an unqualified solicitor to exist under any pretence. At the East Ham Police Court yesterday, May 15th, a man was fined £2 and costs for "falsely pretending to be a solicitor." He had used no professional title, and had merely written a debt-collecting letter with words which a lawyer's intellect, but hardly any other, might construe into the false pretence alleged against him. On the other hand the papers this week have reported the case of an unqualified quack committed for trial for felony who has been practising for years as a doctor, and using full professional titles. No attempt had been made to interfere with him under medical law, and it had not been made, first because it was more than doubtful whether a conviction was possible, and secondly, because their exists no authority like the Law Society charged with the duty of putting the law in force. The responsibility, and the shame, of the present state of things, the degraded position of the profession in relation with the State, and the unchecked plunder and maltreatment of the poor and simple suffering classes, rests upon the profession. They alone know the facts; they alone are in a position to force them upon the attention of the Legislature.

I am, Sir, yours truly,
An Obscure Practitioner.

May 16th, 1908.

OBITUARY.

CHARLES JAMES CULLINGWORTH, M.D., D.C.L., LL.D., F.R.C.P.

It is with much regret that we announce that Dr. C. J. Cullingworth died on May 11th. Born in Leeds in 1841, he was educated at Wesley College, Sheffield, and afterwards studied for his profession at the Leeds School of Medicine. He was admitted a member of the Royal College of Surgeons in 1865, and afterwards was in general practice in Manchester. He early secured the appointment of medical officer to the C and D Divisions of the city police force, posts which he held for some time. He applied himself to a study of the diseases of women, and obtained a name for himself in this branch of medical science. In 1879 he was appointed lecturer in medical jurisprudence at Owens College, a position which he held till 1885. In that year Dr. Thorburn, who was Professor of Obstetrics and Gynæcology, died, and Dr. Cullingworth was chosen to succeed him. In the meantime—in 1878—Dr. Cullingworth had joined the staff of St. Mary's Hospital, Manchester, where his work was highly valued.

In 1888 Dr. Cullingworth severed his connection with Manchester. The post of senior obstetric physician at St. Thomas's Hospital, London, became vacant, and it was offered to Dr. Cullingworth and accepted. Dr. Cullingworth fully justified the choice which was made, and for sixteen years he laboured with signal success to maintain the reputation of the hospital. He retired from the post he had so ably filled in 1904. Dr. Cullingworth held a number of public appointments in medicine. He was an examiner of the University of London from 1890 to 1895, and of the University of Cambridge from 1896 to 1900; chairman of the Board of Examiners for Midwives of the Obstetrical Society of London in 1895 and 1896, and in the following year was elected President of the Obstetrical Society. He was Bradshaw Lecturer of the Royal College of Physicians in 1902, and Ingleby Lecturer at the University of Birmingham in 1904. Dr. Cullingworth wrote largely on questions connected with his special department of medicine. Among his works were:—"Puerperal Fever, a Preventible Disease"; "Charles White, a Great Provincial Surgeon and Obstetrician of the Eighteenth Century"; "Oliver Wendell Holmes and the Contagiousness of Puerperal Fever"; and numerous articles and papers on gynæcological subjects. Dr. Cullingworth was an enthusiast in his work, and everything he did was marked by thoroughness, patience, and close observation. His relations with his students both in Manchester and London were of the most cordial nature, and by those who had the advantages of studying under him he will be remembered as a clever and genial teacher.

He received the honorary degrees of LL.D. of Aberdeen and D.C.L. of Durham.

THEODORE DUKA, M.D. St. And., M.R.C.S.

We regret to record the death of Dr. Theodore Duka, at Bournemouth, in his 83rd year. Dr. Duka was by birth a Hungarian of noble family, and in early life played an active part in the political and military vicissitudes of his country. He was aide-de-camp to General Arthur Görgey, and at the battle of Komoru on April 26th, 1849, he was decorated on the field with the Order of Valour for a conspicuous act of courage. He also received promotion for his conduct at the siege of Buda. When the Hungarian forces finally surrendered at Villágos on August 13th, 1849, to the Russians, Dr. Duka became a prisoner of war; but he finally escaped and, after a long series of adventures and wanderings proceeded to London in 1850. Here he decided to adopt the profession of medicine, and for the rest of his career identified himself with the country of his adoption. He had previously studied at St. George's Hospital, of which in later life he became a governor, and in 1853 he had taken the degrees of M.R.C.S. (Eng.) and M.D. (St. Andrew's). In 1854 he obtained a commission on the medical staff of the Bengal Army, and in 1856 he was stationed at Monghyr and was there throughout the Mutiny. He retired from the service in 1877 with the military rank of lieutenant-colonel. Dr. Duka, who finally settled in London, was chairman of the Austro-Hungarian Aid Society here. He also for many years took a keen interest in the British and Foreign Bible Society, and had been one of its vice-presidents since 1884. In 1883 the Emperor-King Francis Joseph conferred upon him the Order of the Iron Crown. Dr. Duka was the author of a life of the Hungarian, Alexander Csoma de Körös, the earliest student of the Tibetan language, and he promoted in this country the movement which led to the erection of a memorial at Budapest to Semelweiss, the pioneer of antiseptic midwifery.

DR. TURNBULL OF KELSO.

The death is announced of Dr. George Hogarth Turnbull, one of the oldest medical practitioners on the Border. The deceased had for many years practised in Kelso, and was held in high esteem throughout the district. He died in harness, being at the onset of his last illness in actual attendance at the house of one of his patients. There he was suddenly struck down by an apoplectic seizure on May 9th, and died on the following morning. He was an ardent Volunteer, and up to quite recently was in command of the Medical Corps connected with the Scottish Border Brigade.

REVIEWS OF BOOKS.

PRACTICAL MEAT AND FOOD INSPECTION. (a)

Meat and food inspection is a most important factor in preventive medicine, and although the subject is receiving more prominence than formerly, it is eminently desirable that the student of public health should favour the matter with still more attention. Dr. Robertson's book is to be highly commended for his treatment of the matter in a way calculated to render the student's studies of most service to him. The sanitary aspect of sound and unsound food is not merely the approval of condemnation of food on the absence or presence of pathological, bacteriological, and chemical evidences. It goes far deeper than this and embraces the prevention of such abnormal conditions, by a suitable supervision over the conditions and methods of production. Hence the undoubted wisdom of devoting so much space to a consideration of what constitutes suitable and unsuitable cowsheds, piggeries, stables, slaughter-houses, to methods of slaughter, storage, carriage, and preservation of food. For this portion of the work we have nothing but praise, as unnecessary verbiage is non-existent, and the author possesses a remarkable grasp of his subject that allows him to speak with considerable authority. The specific appearances of meat in its various conditions, and the significance of the same are treated in a way that leaves little to be desired, and the only complaint we have with the book is that we should have liked more of it, as in order to give proper consideration to meat and milk, other articles of food have been neglected or ignored. To a certain extent this is remedied by the admirable collection of footnotes to the second part (The Laws relating to Food Inspection, by R. H. Miller, S.S.C., Public Prosecutor for Leith Local Authority), which will be found invaluable to all interested in the subject. Incidentally these footnotes allow a view of the scandalous ways in which the public may be defrauded without the law as it at present exists being able to afford them redress. Some of the cases cited are rulings that, however, are not invariably followed when justices follow the spirit as well as the letter of the law. The law relating to the subject of the various forms of food presents some curious issues, and this collection of legal notes affords a considerable insight into the difficulties of those who have to decide on the rights and wrongs of the matter.

DELAFIELD'S PATHOLOGY. (b)

In this, the eighth, edition of Dr. Delafield's well-known Pathology, the distinguished author has been replaced entirely by his junior colleague, Professor Mitchell Prudden, who now takes sole responsibility for all the statements made and views expressed. A good deal of revision and re-writing, of course, has been necessary in dealing with such a rapidly-widening subject as pathology, and Professor Mitchell Prudden has had the advantage of much help, which he duly acknowledges, from his colleagues, especially from Professor Wood, who has written the section on the Nervous System. The result is the production of a most admirable text-book, completely adapted to the requirements of students, and easily handled by a practitioner on the look-out for a reference. The book is, we hope, so well known that we look to this edition as to only a phase in its career of usefulness, for we imagine that at present it is, within the limits of its scope and intention, as well-written, well-composed, and well-formed a text-book as there is in the field. The chapters and descriptions are at times somewhat unsatisfying; but consideration of the enormous mass of facts to be dealt with reminds us that it is not the author's fault that he does not say more, but the demands of stern necessity. The illustrations are worth more than a passing word; they are uniformly successful in portraying the points at issue, and in some instances, notably, perhaps, in Fig. 312—Chronic Endocarditis with Calcification of the Thickened Valves; fig. 427—Miliary Tuberculosis of the Omentum; fig. 432—Fat Necrosis in the Mesentery; and fig. 563—Carcinoma of the Mamma—Fibrous Type—Scirrhus—we might be looking into the specimen-jar itself. Colour is used in some of the plates very effectively, and the full-page coloured illustrations of changes and the morphology of the blood, the lesions of ganglion cells, stained by Nissl's method, and so on, give all that the heart could desire. Bacteriology is only dealt with incidentally in this work, but as a guide to morbid anatomy and microscopical pathology it is a signal success.

AIDS TO OPHTHALMOLOGY. (a)

That this book should have reached a fourth edition seems a sufficient test of its utility. Originally, the *brochure* was written by Mr. Jonathan Hutchinson, but that gentleman no longer practices ophthalmic surgery as a speciality, and the new edition was given into the hands of Mr. Bishop Harman, F.R.C.S., than whom no one is more competent for the work. The book contains a clear and concise account of the chief diseases of the eye, together with a very good description of elementary refracton. This "Aids to Ophthalmology" should prove most serviceable both for students preparing for examination and to those engaged in general practice. Although the lapse of time has necessitated rewriting most of the material to bring it up to present-day knowledge, Mr. Hutchinson's practical methods and attractive style have, fortunately, been preserved by the new editor, whom we congratulate on the result of his congenial taste. The illustrations, 70 in number, are most excellent.

DISEASES OF OCCUPATION. (b)

It is always a pleasure to read a book written by a man who knows his subject, and Professor Oliver is generally acknowledged to be the highest authority in the country on occupation diseases. That alone would make the work before us a highly valuable one, but its worth is greatly enhanced by the author's literary skill. He writes with ease and lucidity, so that the reader follows him with a comfortable feeling through the mazes of a very intricate subject, or rather series of subjects. To explain the processes of a number of trades is no easy matter when it is not wished to go into technicalities, and we ascribe to the author the mastery of the great literary art of concealing art, and of presenting in a few bold strokes just what the reader wishes to know about a trade for the purpose of understanding its dangers, without wearying him with superfluous incidental detail. It is the fruit of this faculty which gives the volume its claim to be called "popular"—for it is one of Messrs. Methuen's "New Library of Medicine" designed for reading by the intelligent public—but from the very character of the subject it cannot be expected to supplant or compete with those books which present systems of "health" culture or prescribe dietaries for the neurasthenic or the hypochondriac. In a word, Professor Oliver's work is popular in the best sense—the intelligent layman, if he is thinking of others and not of himself, and is not averse to applying his mind to the subject, may find reading that is pleasant, profitable, and extremely important. To factory surgeons, medical officers of health, and medical practitioners generally, we can not only cordially recommend its perusal, but we unhesitatingly pronounce it the best manual, written singlehanded, that we know. One of its most important features is that the author does not by any means confine himself to British experience, but he has furnished himself with comparative information from all civilised countries, and he is thus enabled not only to lend further and fuller illustration to his points, but to reinforce and drive home his conclusions. The subject of "Occupation Diseases" is one that is being more widely studied every year, and under the Workmen's Compensation Act, 1906, it has, for the first time, assumed a definite legal importance. The matter cannot long rest where it is, for it is quite illogical that an employer should pay for lead-poisoning and anthrax contracted in his business, and be relieved of any obligation with regard to tuberculosis or anæmia caused by occupation conditions. It is true that medical science cannot yet asseverate positively that many diseases, such as tuberculosis, are solely the outcome of factory conditions, but the day may come when it will, and doubtless the employer's liability will be proportionately increased. But in the meantime, no one caring for the public health can afford to neglect what is already known, and he can derive such information with great facility and advantage from Professor Oliver's book.

(a) "Practical Meat and Food Inspection." By William Robertson, M.D.Glasg., D.P.H., Medical Officer of Health, Leith, formerly Medical Officer of Health, Perth and Paisley. Pp. x, and 372, with 40 illustrations. London: Bailliere, Tindall and Cox. 1908. Price 10s. 6d. net.

(b) "A Text-Book of Pathology." By Francis Delafield, M.D., LL.D., Emeritus Professor of Medicine, College of Physicians and Surgeons, Columbia University; and T. Mitchell Prudden, M.D., LL.D., Professor of Pathology, Director of the Department of Pathology, College of Physicians and Surgeons, Columbia University. Eighth edition, 13 full page plates, 650 illustrations in black and colour. London: Bailliere, Tindall and Cox. 1908. Price 25s. net.

(a "Aids to Ophthalmology." By N. Bishop Harman Fourth edition. Pp. 165., 70 illustrations. London: Bailliere, Tindall and Cox 1908. Price 2s. 6d. net.

(b) "Diseases of Occupation from the Legislative, Social, and Medical Points of View." By Thomas Oliver, M.D., F.R.C.P., Physician, Royal Victoria Infirmary, Newcastle-on-Tyne; Professor of Physiology, Durham University. London: Methuen & Co.

THE PYONEX. (a)

In the study of the history of medicine one cannot fail to be struck with the fascination which an universal remedy for disease has had at all times on the minds of some members of that profession. For ages large numbers of the learned men of the world devoted their lives to the search for the elixir of life, which was to banish all disease and confer on its fortunate possessors perpetual youth and health. Later, in spite of the growth of science, we continually meet with those who assert that they have found some remedy which will cure, not only many, but all diseases. If this assertion is made with sufficient frequency and loudness it is sure to gain a hearing, and if the personality of the author is sufficiently striking he is sure to gain a large following of believers. Paracelsus, Mesmer and St. John Long are examples of persons who have acquired fame and wealth by such means, and the income made in our own day by vendors of the various quack medicines is evidence that in this respect the public has not changed much from what it was in the days of Mesmer and Long. The author of the work before us does not claim an absolutely universal remedy, but he does claim that by the treatment which he prescribes most disease can be cured. Mr. Rule, however, differs from those who have gone before him in one important respect, for he claims these advantages for the method and not for himself, and he fully describes this method so that any one may make use of it.

What, then, is this method, and on what considerations is it based? There are three fundamental principles on which the treatment is based. "(1) That nearly all disease is caused by some abnormal, extraneous, or foreign element in the affected tissues or in the blood. (2) That congestion, pain, swelling, discolouration, inflammation, disorganisation and suppuration are only symptoms and sequences that are produced by the said foreign element. (3) That if the said foreign element be totally removed, the said symptoms disappear," Such propositions appear plausible enough, but they are quite incapable of bearing the superstructure which our author has raised on them. This superstructure is held together by the most curious smattering of pathology that it has ever been our misfortune to come across. The "extraneous or foreign element," whether it be animal, vegetable, or chemical poison, often causes in the human body the formation of pus, and from this our author is "led to the conclusion that diffuse purulent infiltration of the tissues is the cause of the majority of the more serious ailments," and if this pus is removed there will be a perfect restoration of the integrity of the tissues and of the health of the individual. The "pyonex" is the instrument by which this removal is effected. The instrument resembles a magnified Rose's vaccinator with 33 needles inserted into a metal boss, which is movable in the containing case. This boss is attached to a spiral spring, and when this spring is pulled out about half an inch and suddenly let go "a slight blow is thereby caused on the return stroke, when the needles come in contact with the epidermis. This blow is sufficient to produce minute pores in the epidermis, but the needles are not allowed to penetrate deep enough either to cause pain or to permit of very minute points of blood appearing on the surface." Five or six such applications are made to the skin at distances of about one and a-half or two inches from each other, and then over this area the pyonex oil is applied with a stiff brush. This oil consists of sweet almond oil, "lytta" and "euphorbium," but "it is open to any practitioner to compound the oil of such ingredients as may commend themselves to his judgment." This oil first acts as a stimulus to "the peripheræ of the nerves that are thus exposed," and then "enters the capillaries and becomes distributed to the surrounding parts." This oil sets free the morbid poisons in the tissues, which are then "brought together and expelled through the same artificial pores which served as an entrance for the oil." The occurrence of pustules at the site of the pyonex application is evidence of disease, and from the nature and quantity of this pus the severity of the disease is estimated.

All sorts of diseases are treated with success, and the pathological anatomy of some of them, as described by our author, is most remarkable. In cases of gout the pus shows on microscopic examination well-developed colonies of the gout bacillus, but this method of examination is not necessary, for "they come out in a dry condition and may be removed from the body between the thumb and finger." In a case of rheumatoid arthritis an examination of the blood was made under the microscope, "and showed adherent and matted corpuscles, and about double the right number of leucocytes; litmus paper showing the whole to be loaded with acidity." Of another case we read, "Very little pus was expelled, but my attention was drawn to an immense number of minute organisms which were expelled from the chest, back and other parts. The patient stated that for some years past they had been coming out, and that it was awful to have such things in her body. She also wished for information as to what they were. They could be picked off from the skin with the thumb and finger, and their expulsion was accompanied by intense itching. Several of these were collected and placed in a small phial; and on submitting them to an examination under the microscope I discovered they were all well-developed colonies of a bacillus, which was identical in appearance to the "anthrax bacillus." In another case a lady with severe dilatation of the heart was treated. In her case "the heart is so distended that it pushes the left arm away from the side," yet after two applications she is quite cured.

We have, however, said enough to indicate the nature of the book and the kind of teaching that it contains, it may at some future date be looked on as a medical curiosity, but we doubt if it will in any way advance our knowledge.

DISEASES OF THE SKIN. (a)

Dr. Henry W. Stelwagon's "Diseases of the Skin" is a fine example of what the systematic treatise on a special subject should be. It is full, exact, well-thought-out, well-arranged, and well-illustrated. We may also say that while the classification of skin diseases remains in its present chaotic condition, we support the author in the easy and natural scheme which he has adopted, and which can be made to cover all diseases except a few of uncertain pathology. Not only, however, is the scheme of the work commendable, but its execution leaves little to be desired. The descriptions of most of the conditions are clear and business-like, and a wealth of literary references is added in the case of rare and curious diseases. Although pathology and diagnosis are by no means neglected, indeed, they are very fully considered, the point that strikes us most is the amount of space given to treatment and the many suggestive plans therein set forth. In a word this is a practical book, and its value as such is enormously increased by the illustrations. Of these we must say a word. The coloured ones are quite up to the standard we have grown accustomed to expect from Messrs. W. B. Saunders, which we consider very high praise indeed, and the half-tones, to our mind, are even better than the coloured plates. What, for instance, could be better than the illustrations of variola, notably plate xvii., or that of a case of eczema seborrhœicum on plate x.? They are quite up to the best standard of half-tone work, and they give at a glance a natural, vivid, clinical picture. We do not quite agree with the author in all his views, that would, perhaps, be impossible to expect; but his teaching is thoroughly sound and luminous, and we wish his fifth edition even greater success than the preceding four.

(a) "The Pyonex: Its Theory and Practice." By W. B. Rule, M.R.C.S., L.R.C.P. 8vo, pp. xv. and 572. London: John Bale, Sons and Danielsson, Ltd. 1907.

(a) "Diseases of the Skin." By Henry W. Stelwagon, M.D., Ph.D., Professor of Dermatology in the Jefferson Medical College, Philadelphia. Fifth edition, revised. Philadelphia and London: W. B. Saunders' Company, 1907.

ST. BARTHOLOMEW'S HOSPITAL REPORTS. (*a*)

THIS volume contains fifteen medical and five surgical papers, as well as the usual statistical tables of the patients under treatment in the hospital during the year 1906, compiled by the medical and surgical registrars. As usual in St. Bartholomew's Hospital reports, the papers are all interesting and well repay perusal, and we regret that the space at our disposal does not permit of a detailed reference to each. We should like, however, to draw particular attention to the very interesting paper by Dr. A. E. Garrod, on "The Initial Stage of Myositis Ossificans Progressiva." In this paper is recorded the history of a child who at five months of age presented some lumps on the head. These completely disappeared in the course of a few months, but later fresh swellings developed in the back. Eventually all the swellings seemed to disappear, and the child was taken by its parents to South Africa. In June of last year Dr. Garrod obtained the following report from Dr. Gurney, under whose care the child was in Cape Colony:—"I see the boy from time to time; unfortunately the disease seems to be progressing. The biceps of the right arm is contracted and feels stony hard; the elbow-joint is fixed and also the right shoulder to a certain extent. There is also a nodulated lump about the size of a tangerine orange over the lower part of the infraspinatus which has the consistence of bone. There are several other lumps forming, the most noticeable of which are on the left side of the spine, about three inches distant from it, and three or four inches below the angle of the scapula. The child's health seems to be perfect."

We regret very much that some more information is not given in the reports concerning the statistics of anæsthetics. Two deaths only are recorded in 7,136 administrations, but we are not afforded any information as regards these two fatal cases.

MEDICAL NEWS IN BRIEF

Royal College of Surgeons of England.—Ordinary Council, 14th May, 1908.

AT a meeting of the Council of the College on Thursday last, May 14th, it was reported that 169 candidates were admitted to examination in Surgery at the Pass or Final Examination for the Diploma of Member, concluded on the 16th April, 1908, and that of these candidates the following 101 passed and received the M.R.C.S. Diploma, the remaining 68 were referred to their professional studies:—

Alex. R. Alguire, Kekobad C. Anklesaria, Charles J. Aveling, Ardeshir P. Bacha, Henry Bardsley, Dinshá D. Báriá, James W. Bennett, Charles T. V. Benson, Robert N. W. Biddulph, Bernard R. Billings, George S. Candy, Geoffrey D. H. Carpenter, George F. Carr, William J. Carr, Edmund V. Connellan, Ernest N. Cook, Cyril D. H. Corbett, Alfred E. Cullen, D. I. Dakeyne, Archibald Davidson, Thomas B. Davies, Edward J. Dermott, Harold B. Ellison, Robert C. T. Evans, Alfred W. Ewing, Edwin G. Fearnsides, Gaetano J. Fernandes, Harold H. B. Follit, Henry G. Frean, Harold S. Furness, Alexander H. Gifford, William C. Gilday, Henry L. Grabham, Harry M. Grey, Kenneth G. Haig, William R. Harris, Alfred E. W. Hird, Frederick W. Hobbs, F. G. Holder-Williams, Edward H. V. Hodge, Charles E. Howden, Howell T. Howells, Ernest E. Isaac, George L. H. Johnston, John M. Johnston, Ratanshaw B. Khambata, Framroze J. Kolaporewalla, Alfred V. Ledger, Walter E. Lloyd, Arthur A. Lynch, Charles K. McKerrow, Oswald W. McSheehy, Edward K. Martin, James B. Mennell, Alfred Miles, John G. Morgan, Reginald Mugliston, Berthold Muir, Bhola Nauth, Mark A. Nicholson, Rupert H. Nolan, Arthur C. Oliver, Max Onslow-Ford, Albert H. Owen, William N. A. Paley, Norman C. Patrick, Thomas G. Percival. William J. Petty, George H. Pooley, Dan A. Powell, John W. Power, Kenneth Pretty, Sharles E. Price, Robert C. Priest, Kenneth D. Pringle, Ernest A. Pywell, William E. Roberts, Hubert A. H. Robson, Harry A. Sanford, Chales F. O. Sankey, James E. Sawdon, Frank S. Scott, Clovis L. Seccombe, Francis R. Smyth, Robert Svensson, Arthur J. Symes, John Thompson, Percy S. Tomlinson, Geoffrey Viner, Basil Wallis, Paul I. Watkin, Charles H. S. Webb, Thomas A. Weston, Charles F. O. White, Samuel E. Whitnall, Harold F. Whittall, William Wijegoonewardena, Charles M. Wilson, Graham L. J. Wilson, Henry A. F. Wilson, Charles S. E. Wright.

The Irish Universities Bill.

MR. BIRRELL'S Bill for the establishment of new Universities in Dublin and Belfast respectively, passed its second reading by a large majority on the 11th inst. It has now been referred to a Standing Committee for the next stage. During the past weeks many public meetings have been held at which the Bill has been the chief subject of discussion. The Convocation of the Royal University of Ireland adopted a resolution stating that it was desirable that the exclusion of extern students should not be enforced for a period of ten years instead of after five years as stated in the Bill. Convocation also requested that the occasion of the transferring of graduates of the Royal University to the new University should not be made an occasion for the promiscuous granting of honorary degrees. The Senate of the Royal University have unanimously agreed that the sums allotted to the new Universities and their constituent colleges for buildings and maintenance are entirely inadequate.

Proposed Memorial to the Late Dr. Conolly Norman.

IT is felt that some steps should be taken to perpetuate the memory of the late beloved and honoured Medical Superintendent of the Richmond Asylum, of whom it may be truly said that his works live after him. By his exertions the largest asylum in Ireland was transformed from a place of misery to a hospital where the afflicted might regain mental health, or, if that was impossible, might have a home where they might receive care and kind treatment to the end of their days. He was at once the servant and the protector of the afflicted poor, and his life was devoted to those from whom most men shrink.

Dr. Conolly Norman was also a man who was most accomplished in his scientific work, and added materially to the literature of mental disease. It is desired, therefore, that any memorial that may be erected should be a tribute not solely from his medical colleagues, but from all classes. With this object a preliminary meeting was held at the Royal College of Surgeons on the 7th ult., when a General Committee was constituted. At this and subsequent meetings the following conclusions as to the form of memorial were arrived at, viz.:—That if sufficient money is collected it should be devoted to two objects: First, to the formation of a "Conolly Norman After-Care Association," to benefit poor and friendless patients on their discharge from the Richmond Asylum. Such a charity is sorely needed, as patients sometimes leave the asylum with no home to which to go or friends to assist them. These poor people might be helped to

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(*a*) "St. Bartholomew's Hospital Reports. Vol. XLIII." Edited by H. Morley Fletcher, M.D., and W. McAdam Eccles, M.S., F.R.C.S. London: Smith, Elder and Co. 8vo. Pp. xxvii, 252, viii, 187. 1908.

find work—often a matter of great difficulty in such circumstances—assisted with gifts of clothing, and maintained while they seek for employment. Such an Association would carry on his work and perpetuate his memory in the way most consistent with his life. Secondly, it is hoped that Dr. Conolly Norman's portrait may be painted and hung in the Royal College of Physicians, of which he was the Vice-President. Subscriptions will be received by the Honorary Treasurers—W. R. Dawson, Esq., M.D., Farnham House, Finglas, Dublin, and J. R. O'Connell, Esq., LL.D., 34, Kildare Street, Dublin.

"Medical Specialist" Sentenced.

BERTRAM MORTIMER, 50, described in the calendar as a "medical specialist," was found guilty at the Clerkenwell Sessions, on May 14th, of having stolen a Gladstone bag, containing property value £12, from the cloak-room at the Victoria Station of the London, Brighton and South Coast Railway.

Mortimer's son, who gave his name and description as "Hubert Sylvester, 23, physician," was acquitted of having been concerned in the theft, and was released.

The bag was issued by mistake to Mortimer, and he retained it.

Detective-Sergeant Barrett said the prisoner, Mortimer, had had a somewhat extraordinary history. For years up to 1881 he was a captain in the Salvation Army at Bath, but he was then allowed to resign through misconduct. For some time afterwards he went to sea as a sailor on board trading ships. In 1882 he was twice fined for assault, and in 1883 was sent to prison for seven days, in 1885 for one month, and in 1892 he was fined £5 for drunkenness and assaults. On November 26th, 1897, at Bristol Assizes, he was sentenced to fifteen months' hard labour for conspiring to procure a girl for an unlawful purpose, and in 1899, at the Wells Assizes, he received one year's imprisonment for bigamy. Since his release he had been travelling all over the country, calling himself "Professor Sylvester, medical specialist." His real name was Powell, but he had used various names —Browne, Fowler, Fox, Lynton, etc. He imposed on people by representing that he had discovered a speciality—a wonderful gold-dust cure. All that the "cure" consisted of apparently was to receive the fees, no remedy being supplied. For years past the Medical Defence Union had had numerous inquiries about him from all over the country, and they wished this fact brought to the notice of the Court. Witness read the following circular, sent broadcast by Mortimer:—

"A revelation to sufferers. To heal the sick. To cure the diseased. To restore the suffering to health. The great American doctor, Professor Sylvester (M.D., D.Sc., Boston, Mass, U.S.A.). This eminent American expert has opened a practice for the benefit of the sick and the suffering. Countless numbers have been saved from early graves, and hundreds are rejoicing who have been told their cases were hopeless. See this marvellous expert and be convinced. No quackery, no patent medicines. This eminently qualified medical specialist is at your service—absolutely free."

Mr. Robert Wallace, in ordering Mortimer fifteen months' imprisonment in the second division, said he would assume that that sentence would put an end to the other proceedings at Swansea.

Royal College of Surgeons in Ireland—Election of Examiners

AT a meeting of the President, Vice-President, and Council, held on Tuesday, May 5th, the following Examiners were elected for the ensuing year:—

COURT "A." — Anatomy. — Alexander Fraser, F.R.C.S.; Bertram C. A. Windle, B.S. Surgery.—Charles A. K. Ball, F.R.C.S.; Alexander Blayney, F.R.C.S.; E. Conway-Dwyer, F.R.C.S.; Robert J. Harvey, F.R.C.S. Physiology and Histology.—Denis J. Coffey, B.S.; E. L'Estrange Ledwich, L.R.C.S. Pathology and Bacteriology. — Arthur H. White, L.R.C.S. Midwifery and Gynæcology.—Frederic W. Kidd, L.R.C.S. Biology.—John J. Burgess, F.R.C.S. Ophthalmology.—Arthur H. Benson, F.R.C.S.; Herbert H. B. Cunningham, F.R.C.S. Sanitary Law and Vital Statistics.—Edward F. Stephenson, F.R.C.S., D.P.H. Engineering and Architecture.—James H. Fergusson, F.R.C.S., D.P.H. Languages.—Latham J. Woodroffe, M.A. Mathematics, Physics, Dictation, and English.—John W. Tristram, M.A.

COURT "B."—Anatomy.—Patrick J. Fagan, F.R.C.S.; Alexander Fraser, F.R.C.S. Surgery.—Charles A. K. Ball, F.R.C.S.; Alexander Blayney, F.R.C.S.; F. Conway-Dwyer, F.R.C.S.; Leveson G. Gunn, F.R.C.S. Physiology and Histology.—Denis J. Coffey, B.S.; E. L'Estrange Ledwich, L.R.C.S. Pathology and Bacteriology.—Robert J. Rowlette, M.D.; Arthur H. White, L.R.C.S. Midwifery and Gynæcology.—Frederic W. Kidd, L.R.C.S. Chemistry and Physics.—Edwin Lapper, L.R.C.S.; Robert J. Montgomery, F.R.C.S. Dental Surgery and Pathology.—George M. P. Murray, F.R.C.S.; William G. Story, L D.S. Mechanical Dentistry.—Daniel L. Rogers, L.D.S.; Edward Sheridan, L.D.S.

Society for Relief of Widows and Orphans of Medical Men.

THE annual general meeting of the above Society was held on Thursday last, May 14th, Dr. G. Fielding Blandford in the chair. Seven directors were elected to fill the vacancies in the Court. The report for 1907 stated that during the year 11 new members were elected, and 10 died. The invested funds now amount to £99,260, from which is derived in interest the sum of £3,118 2s. 5d., whilst £433 0s. 3d. was received in subscriptions and donations. Amongst the annuitants—namely, 49 widows and 17 orphans, the sum of £3,151 10s. was distributed. Forty-three widows received £50 each, four £40, one £30, and one £25, with £10 each extra at Christmas, and each orphan £12 and £3 extra at Christmas. During the year two widows in receipt of grants died. One, whose husband had paid in subscriptions £26 3s., received £490; the other, whose husband had paid in annual subscriptions £27 6s., received £2,824; she had been in receipt of grants since 1866. One of the widows still in receipt of grants has been on the books since 1854, and has already received over £2,060. The annual subscription is 2 guineas to residents within the radius of 20 miles from Charing Cross; every member who has paid this sum for 25 years becomes a member for life. Life membership may also be obtained by the payment of one sum, varying with the age of the applicant. Further particulars and application forms may be obtained from the Secretary at the offices of the Society, 11, Chandos Street, Cavendish Square, London.

Royal University of Ireland.

AT a meeting of the University, held on May 14th, the following degrees were conferred:—

M.D.—James G. Campbell, William H. Davis, Joseph P. Dee, Denis J. Keane, Thomas D. Luke, William Rice, and John Thompson. M.B., B.Ch., B.A.O.—Robert G. Kevin, Arthur H. Joy, Joseph G. Johnston, Marshall F. Huston, Thomas J. Hollins, B.A., Donal Barry, Arthur R. Boyd, Thomas A. Carson, James K. P. Clarke, Thomas P. Linehan, George H. Martin, Thomas Arnold, Raphael N. Berman, William Bradbury, Thomas G. Buchanan, Robert J. Clarke, Mary Cowhy, B.A., Edmund H. Flanigan, William S. Graham, Hugh J. Grant, Patrick J. Grogan, Richard G. C. M. Kinkead, Robert J. Ledlie, Solomon Levy, John C. Macaulay, Joseph M. Causland, B.A., Michael McNiff, James F. Neary, John F. Neary, John F. O'Brien, Michael Waldron, George P. White, Michael White.

The following Exhibitions have been awarded:—

The Second Examination in Medicine.—Exhibitions. —First Class, £25.—Henry L. Barniville. Second Class, £15.—William K. Calwell.

The Third Examination in Medicine.—Exhibitions. —First Class, £30.—William W. D. Thomson, B.A. Second Class, £20.—Walter Mooney, B.A.

The M.B., B.Ch., B.A.O. Degrees Examination.— Exhibitions, £21 each.—In Medicine Group, Robert G. Kevin. In Surgery Group, Arthur H. Joy. In Midwifery Group, Joseph G. Johnston.

Fire at Gordon College, Khartoum.

AN alarming fire broke out in the Wellcome Research Laboratories, Gordon Memorial College, Khartoum, on May 11th. Before it was got under control considerable damage was done.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for The Medical Press and Circular.

RECENT MEDICAL LITERATURE.

Purpura Hæmorrhagica with Cerebral Hæmorrhage.—Carruthers reports a case of the above (Clin. Section. *Proc. Royal Soc. Med.*, Vol. I., No. 6, p. 120). The patient was a woman, æt. 59, who first suffered from several cutaneous ecchymoses, which continued to spread, in spite of treatment. Ten days after the patient was first seen there was some hæmorrhage from the nasal and intestinal mucous membranes, and shortly afterwards symptoms of cerebral hæmorrhage showed themselves, there being, in addition to coma, jerky, spasmodic movements of the right side of the body. These symptoms suggested that the hæmorrhage was a cortical one. Death occurred suddenly in coma, apparently from a further medullary lesion. M.

Acute Suffocative Catarrh of Laennec and Allied Conditions.—West describes a case of Laennec's suffocative catarrh, and discusses the conditions with which it may be confounded (*Proc. Royal Soc. of Med.* Medical Section. Vol. I. No. 5, p. 161). His patient was a man, æt. 23, admitted to hospital suffering from extreme dyspnœa and cyanosis. He had been in perfect health till 36 hours previously, when he felt some tightness and contraction in his chest. On examination some sibilant rhonchi were audible, but otherwise the chest was normal. The temperature was 100° F., respiration 36, and pulse 120. Under treatment the condition quickly improved, crepitation appeared in the chest, and there was a little mucoid expectoration. This case West regards as a typical example of what Laennec described. He enumerates, under three headings, the conditions which may be mistaken for it, as follows:—(1) Acute suffocative pulmonary œdema. This he regards as due to sudden failure of the heart, and divides the cases into those with and those without antecedent cardiac disease. The characteristic symptoms are sudden onset of dyspnœa and cyanosis, accompanied by profuse expectoration of blood-stained watery fluid. (2) Certain acute inflammatory conditions. This includes some cases of severe capillary bronchitis, secondary broncho-pneumonia, and more especially acute primary broncho-pneumonia. (3) Collateral fluxion and respiratory failure. Under this heading is included conditions such as acute bronchitis occurring on one side in association with a pleural effusion, or consolidated pulmonary area on the other. These conditions will not be mistaken for suffocative catarrh, but are allied to it physiologically. M.

Erepsin in the Intestinal Canal of Fœtuses.—Langstein and Soldin have examined the intestine of a new-born calf for the presence of erepsin, and also the intestinal juices of human fœtuses from 4½ months to 7 months (*Jahrt. f. Kinderheilk*, Bd. 691, S. 9). They found that erepsin was present in the calf, and also in the intestines of viable fœtuses, but could not detect the presence of any in non-viable fœtuses. M.

Leukæmia in Dogs.—Outakakon has investigated some cases of leukæmia occurring in dogs (*Virchow's Archiv.*, Bd. 190, H. 2). He states that the lymphatic variety is commoner than the myelogenic. The post-mortem examinations showed general pallor of all the organs, with enlargement of liver and spleen, and a change of the yellow marrow to a greyish red colour. Microscopically there was diffuse cellular hyperplasia of marrow and spleen, and some cellular infiltration of other organs. There was a great increase of white cells in the blood, principally of a round mononuclear variety. No enlargement of the lymph glands was, however, found. M.

Hæmatemesis following Extirpation of the Spleen.—Leiblein has observed in Wolfler's clinic at Prague two cases of profuse hæmatemesis following excision of the spleen (*Centralbl. für Clin. Med. Wissenschaft.*, January 25th, 1908). With the exception of one other case recorded by Laing, these are apparently the only recorded instances of this extremely rare complication. The writer believes that the cause of the bleeding must be that in tying the pedicle of the spleen the vasa brevia of the stomach are included in the ligature. This can readily occur, since the vasa brevia, according to French writers, frequently arise, not from the main trunk of the splenic artery, but from one of the branches into which it divides almost immediately before it sinks into the substance of the spleen. Another possible cause is that during the operation one or other of the larger gastric vessels may be slightly injured, and may later on rupture and cause the bleeding. M.

Experimental Observations on Secretin.—Sweet and Pemberton (*Archives of Internal Medicine*, March, 1908) report on their work on secretin, which was done with especial reference to diabetes and malnutrition. The authors come to the following conclusions from their work:—(1) There would seem to be some factor which makes the preparation of secretin from human intestines more difficult than from the intestines of some animals. (2) This factor may depend on the relatively great abundance of membrane in these animals, and consequently greater amount of pro-secretin. (3) The abundance of mucosa may be, in fact, a provision of Nature in order that the strongly acid chyme of some animals may meet with a quantity of pancreatic juice sufficient to neutralise it and effect digestion. (4) Active preparations of secretin can be made with hydrochloric acid of widely varying strengths, and activity *in vivo* is apparently not dependent on the peculiar acidity of the chyme in any particular animal. (5) Dieting and fasting seem to have no appreciable effect on the activity of the extract. (6) The evidence so far adduced that secretin is absent in some varieties of diabetes does not seem conclusive. (7) The specific absence or deficiency of secretin in marasmus seems to remain as yet unproven. D.

Statistics of Serum Treatment of Scarlet Fever.—Pulawski (*Deut. Med. Woch.*, February, 1908) has treated 103 cases of scarlet fever since 1904 with a serum prepared by injecting a horse with streptococcus from a severe scarlet fever case. He used very small doses, and only one case was injected three times. His results were roughly three times as good as in those treated by the ordinary measures. There were no bad results from the serum. D.

The Oatmeal Diet in the Treatment of Diabetes Mellitus.—Herrick (*Journal Amer. Assoc.*, March, 1908) in the main confirms Von Noorden's claims for the oatmeal diet. In the milder types of diabetes there were no ill-effects, but the benefits seemed slight. In the cases of moderate severity it seems of especial help in establishing tolerance for carbohydrates, and in warding off impending coma. In Herrick's cases he found it to exert a very favourable influence in the diabetes of children, if employed early. D

Hysteria in Children.—Price (*Archives of Pediatrics*, New York, February, 1908) concludes that girls are more frequently, boys more severely affected with hysteria. Predisposing ætiologic factors are heredity, faulty environment, and education, any condition lowering the vitality or causing continuous irritation of the nerve centres. The symptoms are essentially the same as in the adult, but slightly modified. Suggestion in one form or another he regards as of paramount importance in the removal of symptoms, but we must never lose sight of the probability of an underlying neuropathy. Hypnotism he mentions only to condemn, holding that the experiments of Charcot, Babinski, Dercum and others have shown it to be only artificially induced hysteria. He presents four cases of the following less common forms:—(1) Hysterical tremor. (2) Hysterical joint. (3) Psychic type. (4) Hysterical dyspnœa. D.

Relation of the Parathyroid to Calcium Metabolism and the Nature of Tetany.—McCullum and Voegtlin (*Johns Hopkins Hospital Bulletin*, March, 1908) found that all the violent symptoms produced by parathyroidectomy, muscular twitching, fibrillary temors, increased rapidity of the heart, etc., may be almost instantly cured by intravenous injection of a solution of calcium salt. The acetate or lactate in a 5 per cent. solution was usually employed. Subcutaneous injection or the introduction by mouth seemed as effective, but acted more slowly. The tetany may reappear in 24 hours, but disappears immediately upon the renewed administration of calcium. Magnesium salts seem to have a somewhat similar effect, but the results are obscured by the toxic action of the salt. Potassium salts intensify the symptoms. Incomplete studies of the excreta and blood of the parathyroidectomised animals tend to show an increased output of calcium in the excreta and a diminished calcium content in the blood. The writers construct the working hypothesis that the parathyroids control the calcium metabolism of the body. D.

Typhoid Carriers.—Davies and Hall (*Bristol Medico-Chirurg. Journ.*, March, 1908) discuss the very interesting problem of the connection between typhoid carriers and sporadic outbreaks of typhoid fever. The death-rate from typhoid fever has steadily declined, for in the decade 1871-1880 the death-rate per million living was 322, while from 1891 to 1900 it was only 174, although during this period the case mortality has remained fairly constant at about 17 per cent. There seems to be no doubt that the decline in the prevalence of the fever is due to the general improvement in the drainage and water supply, but there still remain a residuum of cases which do not seem capable of explanation by any defects in sanitation. It seems more than probable that many of these cases may be explained by personal infection through people who are chronic typhoid carriers. There are on record several cases where this connection has been demonstrated, among which may be mentioned the Inebriates Home near Bristol, recorded in the *British Medical Journal*, January, 1908, by A. and J. C. G. Ledingham. It is stated that 4 per cent. of typhoid convalescents become carriers, and the condition has been known to persist for as long as ten years. It seems quite possible that it may be necessary to insist that typhoid convalescents must be proved to have their excreta free from typhoid bacilli before they are re-admitted to society, just as diphtheritic patients must be shown to be free from the diphtheria bacilli. K.

Notching of the Lower Incisors in Congenital Syphilis.—Wallis (*Brit. Journ. of Children's Diseases*, March, 1908) records a case in which this condition was well marked in a child, æt. 12, with other signs of congenital syphilis. He believes that the condition is not at all so uncommon as is thought. He has himself three such cases under his care, and records this one in hopes that further observations may be made by others with a view to finding out the percentage of cases of congenital syphilis in which the condition is shown. K.

Use of Chrysarobin in Psoriasis.—Norman Walker (*The Scottish Med. and Surg. Journ.*, April, 1908) publishes an interesting paper on this subject, illustrated by two excellent coloured plates. If good results are to be obtained from this treatment it is necessary that the patient should give himself up to the treatment, and if he expects to be cured without interfering with his ordinary avocations some other method than the chrysarobin one ought to be chosen. Walker believes that continuous application is the most important factor in the treatment, and the best preparation of the drug is the simple ointment of half a drachm of chrysarobin to the ounce of vaseline. The method which he adopts is as follows: The patient is given a bath and the scales removed with a nail-brush, and this is followed by a soft soap dressing which may remain on for twenty-four hours. This dressing is followed by another bath to remove any excess of alkali before the chrysarobin treatment begins. The exact distribution of the eruption is then noted, and the patient rubbed vigorously all over with a five per cent. chrysarobin ointment, after which dressings spread with the same ointment are carefully applied to every part of the surface from the neck downwards. In about seven days a well marked erythema of the healthy skin areas is developed, the psoriasis spots still remaining pale. It is of the greatest importance that the treatment should be continued till the affected spots show a distinct erythema, and this is the meaning of Pautrier's phrase, "Pas d'érythème, pas de guérison." The affected areas will be found erythematous in from about eight to eleven days after the commencement of the treatment. After this one or two warm baths are taken, and the patient will be found free from disease. It is important to make a thorough investigation of the patient once or twice during the treatment to see that there are no lagging spots, if such be found they should be treated by an ointment in which other drugs, such as salicylic acid, are brought to the aid of the chrysarobin. K.

Lupus Erythematosus associated with Nephritis.—MacLeod (*The Brit. Journ. Dermatology*, May, 1908) adds another to the list of acute cases of lupus erythematosus associated with nephritis, and having a fatal issue. The patient, a girl, æt. 17, was admitted to hospital in the beginning of August, 1907, with well-marked and typical evidence of the disease on the face and on the hands. The first appearance of the disease was noticed three months before admission to hospital. The patient was treated with salicin internally, 15 grains twice daily, and locally with Hebra's soap spirit lotion. The local condition improved very quickly, so that by November the 7th the lupus erythematosus had practically disappeared. The patient's general condition was not so good, and she complained of headache, morning sickness, and swelling of the legs. The urine was found to contain a large quantity of albumin. The patient died on December the 3rd, and at the time of her death she had profound anæmia, œdema of the ankles, and some purpuric spots on the feet. No post-mortem examination was made. K.

Asylum Workers' Association.

THE annual general meeting of this Society will be held at the rooms of the Medical Society of London on Friday, May 29th, at 3.30 p.m., Sir William J. Collins, M.D., F.R.C.S., M.P., President of the Association, in the chair. Dr. Robert Jones, F.R.C.P., Medical Superintendent L.C.A., Claybury, will give an address as Vice-President, and the following have intimated their intention to take part in the meeting:—The Lord Bishop of Barking, Sir James Crichton-Browne, M.D., F.R.S., Sir John H. Bethell, M.P., Dr. V. H. Rutherford, M.P., Drs. Hyslop, Savage, Percy Smith, and members of the Executive Committee. There will be a presentation of two gold and three silver medals, awarded by the Association for long and meritorious nursing service. All interested in asylum work and workers are cordially invited to attend.

IT has been officially stated that there were 793,000 deaths in France last year, as against 773,000 births. This state of affairs points to an extremely acute phase of the question of the limitation of births upon population.

A SERIOUS outbreak of cholera has prevented the 1st Battalion of the Royal Munster Fusiliers from joining the expedition into the Mohmand country under Major-General Sir James Willcocks. Twenty-seven deaths were reported on the 18th inst.

NOTICES TO CORRESPONDENTS, &c.

☞ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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THE IMAGINATION PATHOLOGIC.

In the new edition of Tennyson's works it is stated that he once heard a nightingale singing with such a frenzy of passion that it was unconscious of everything else, and not frightened though he stood close beside it. "I saw its eye flashing, and felt the air bubble in my ear through the vibration."

Pestis.—The plague mortality in Bombay, the United Provinces and Punjab during January, 1907, was 44,319; this year it was 7,445. In February of last year the plague deaths in this area were 78,063; this year they were 11,898. If we take the totals for the whole of India the results are: For January and February of 1907, 122,382; for the first two months of this year, 18,343. Unfortunately it is true that since the end of February the plague mortality has risen, and during March it averaged nearly seven thousand a week; but this is still mild in comparison with the terrible epidemics of recent years.

THE UNCERTAINTY OF LIFE.

From the womb to the tomb the road varies in length,
And it does not depend on the health or the strength.
A short journey for some we considered were strong;
Some drift down the stream, some are hurried along,
Till the river of life finds its way to the sea,
And we're lost in the Ocean of Eternity! A. D.

H. A. Russell.—Your list is an excellent one, but we would suggest the substitution of Prof. Buchanan's "Manual of Anatomy" for the other, as it is both systematic and practical, and includes embryology.

A WAY THEY HAVE IN THE NAVY.

A candidate who applied for the appointment of medical inspector of schools under the Edmonton Education Committee, when interviewed, mentioned that he was for two years in the Navy. Asked why he left, he replied, amidst laughter, "I used to work about five minutes a day, and I was afraid that if I stayed too long I should get used to it."—*Daily News.*

Mal-de-Mer.—There is a new invention for the prevention of sea-sickness. It is composed of a machine like a Luge spinning-top. On this the patients lie, and are spun round at a sufficient speed to keep it fairly perpendicular. The experiments, which have been carried out at Stettin, are said to have been successful, but the views of the patients do not appear to be known.

PREHISTORIC TUBERCULOSIS.

Dr. Paul Bartels says that he has discovered unmistakable traces of tubercular disease in the spinal column of the skeleton of a male belonging to the later Stone Age and found at Heidelberg recently, and that he can conclude with certainty that the man had suffered from tuberculosis. The only vertebræ showing traces of caries were those near the chest; they are in such a state that they point conclusively to tuberculosis. This is the oldest case of tuberculosis which has been discovered yet in Germany.

Meetings of the Societies, Lectures, &c.

Thursday, May 21st.

Royal Society of Medicine (Dermatological Section) (20, Hanover Square, W.).—5 p.m.: Cases: Dr. Radcliffe-Crocker: (1) Mycosis Fungoides (private); (2) Case for Diagnosis (private). Dr. Adamson: (1) Nodular "Ringed Eruption" (Granuloma Annulare); (2) Small Follicular Syphilide. Dr. Whitfield: A Case of Disseminated Lupus with Chronic Lymphangitis of the Face and Osteo-arthritis. Dr. Sequeira: Two Cases of Scleroderma. Dr. Parkes Weber: ? Multiple Xanthoma of the Face of the Diabetic Type in an Infant. Dr. Graham Little: (1) Varus Nodulosis (Brooke); (2) Pseudopelade (Brocq); (3) Pseudoxanthoma Elasticum.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. T. G. Stewart: Syphilitic Affections of the Spinal Cord.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical (Mr. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Throat Operations (Mr. Carson).

Hospital for Sick Children (Great Ormond Street, W.C.).—4 p.m.: Lecture:—Dr. Poynton: Pyo-pericarditis.

Friday, May 22nd.

Royal Society of Medicine (Epidemiological Section) (20, Hanover Square, W.).—8.30 p.m.: Paper: Sir Frederick Treves, Bart., G.C.V.O.: Preventive Medicine in Panama.

Society for the Study of Disease in Children (11, Chandos Street, Cavendish Square, W.).—5 p.m.: Wightman Lecture:—Mr. W. Cheyne: On the Defensive Arrangements of the Body as illustrated by the Incidence of Disease in Children and Adults.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. StClair Thomson: Clinique. (Throat.)

Saturday, May 23rd.

British Balneological and Climatological Society (Harrogate).—Meeting.

Appointments.

Butler-Smythe, A. C., F.R.C.S.Edin., Surgeon to In-patients at the Samaritan Free Hospital for Women, London.

Campbell, R. B., M.B., C.M.Edin., Medical Superintendent of the Larbert Asylum.

D'Alton, J., L.R.C.P. and S.Irel., Medical Officer to the Birr Board of Guardians.

Fremantle, F. E., M.B., M.Ch., F.R.C.S.Eng., D.P.H., Medical Officer of Health to the Hertfordshire County Council.

Keep, A. Corrie, M.D., M.C.Edin., has been appointed Surgeon to In-patients at the Samaritan Free Hospital for Women, London.

Lister, T. E., M.B., Ch.B.Vict., Resident Obstetric Officer at the General Infirmary, Leeds.

Morison, F. H., M.D., C.M.Edin., D.P.H., Medical Officer of Health to the Cumberland County Council.

Pickles, P. D., House Physician at the General Infirmary, Leeds.

Scargill, H. B., M.B, B.S.Lond., House Physician at the General Infirmary, Leeds.

Tebbs, B. N., M.D.Cantab., Assistant Physician to the Royal South Hants and Southampton Hospital.

Vacancies.

Leeds General Infirmary.—Resident Medical Officer. Salary £150 per annum, with board, residence, and washing. Applications to the Secretary of the Faculty at the Infirmary.

Leeds General Infimary.—Resident Ophthalmic Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary of the Faculty at the Infirmary.

Hull and Sculcoates Dispensary.—Medical Officer. Salary £210 per annum net. Applications, J. E. D. Stickney, Hon. Secretary, Crown Chambers, Land of Green Ginger, Hull.

City of Edinburgh.—Medical Officer of Health. Salary £800 per annum. Applications to Thomas Hunter, W.S., Town Clerk, City Chambers, Edinburgh.

Durham County Council.—Assistant County Medical Officer of Health. Salary £300 per annum, with reasonable travelling expenses. Applications to Ralph Simey, Clerk of the County Council, Shire Hall, Durham.

Inverness District Board of Lunacy.—Medical Superintendent for the Inverness District Asylum. Salary £500 per annum, with free house, fire, light, vegetables, and keep of one horse. Applications to Duncan Shaw, W.S., Inverness, Clerk to the District Board.

Births.

Hall.—On May 16th, at 19, Collegiate Crescent, Sheffield, the wife of Arthur J. Hall, M.D., F.R.C.P., of a daughter.

Peatson.—On May 13th, at 211, London Road, Croydon, the wife of J. C. S. Peatson, M.R.C.S., L.R.C.P., of a daughter.

Roberts.—On May 13th, at 128, Commercial Road, Portsmouth, the wife of Hamilton A. S. Roberts, M.D., of a son.

Marriages.

Cooper—Brennan.—On May 14th, at Wimbledon Parish Church, Edward Cooper, Fleet Surgeon, Royal Navy, H.M.S. "Swiftsure," youngest son of the late Alfred Cooper, Esq., of "Southampton Villa," Southsea, to Margaret Wilhelmina, daughter of the late Rev. William Brennan, M.A., some time Rector of Ballysadare, County Sligo.

Hall—Biron.—On May 13th, at Suva, Fiji, Frederick Hall, L.R.C.S. and L.R.C.P.Dub., eldest son of Lieut.-Colonel Frederick Hall, the Connaught Rangers, of Lisnaloe, Emsworth, to Mona, daughter of Rev. H. B. Biron, M.A., vicar of Lympne, Kent.

Lamplough—Eastlake-Smith.—On May 13th, at St. Bartholomew's Church, Sydenham, Wharram H. Lamplough, M.D., of Bredon, Alverstoke, Hants, to Gladys Shirley Eastlake, only daughter of Charles Eastlake-Smith, of Fairbank, Sydenham, Kent.

Deaths.

Raikes.—On May 12th, at Singapore, Cuthbert Taunton Raikes, M.B.Oxon. (Colonial Medical Service), of plague contracted while performing a post-mortem examination, son of Robert Taunton Raikes, of Treberfydd, Breconshire, aged 29.

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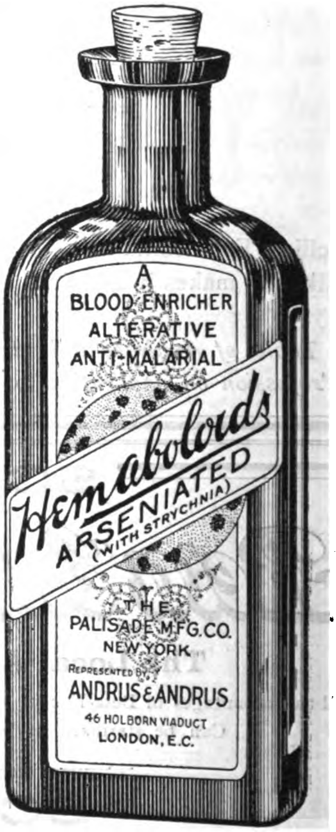
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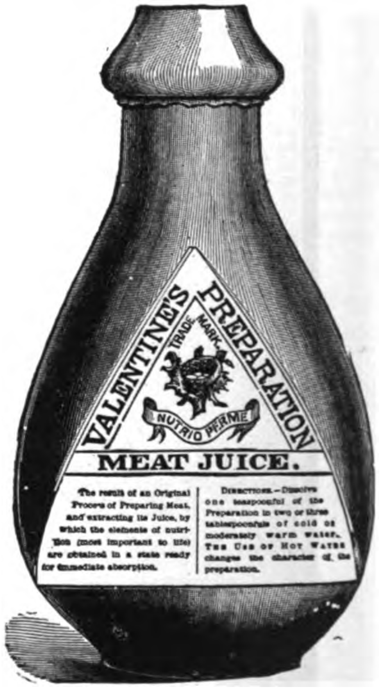
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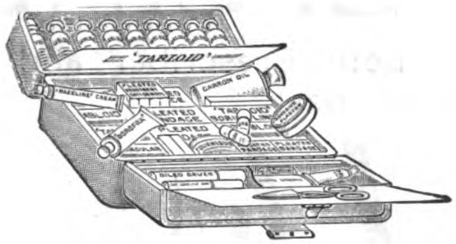

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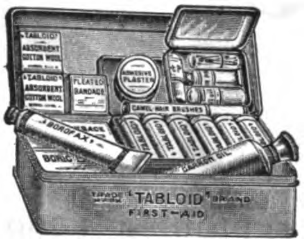

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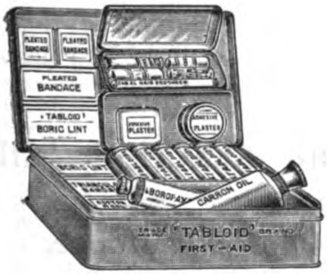

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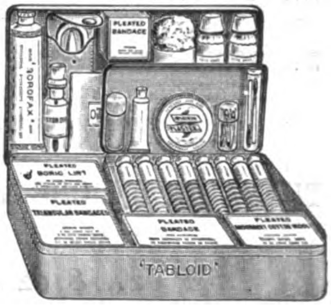

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"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, MAY 27, 1908. No. 22.

NOTES AND COMMENTS.

Medical Suffragettes.

WE read with a good deal of shame and disgust that among the suffragettes who took part in the latest vulgar escapade directed against the Prime Minister were two medical women. One of them was not arrested, but the other one, Miss Elizabeth Knight, M.B., was taken into custody by the police, and after the usual police court performance, sent to Holloway in default of paying her fine. The case will no doubt be reported to the General Medical Council by the police authorities in accordance with the standing arrangement that exists, and we trust that body will show that there is little sympathy in the profession with those of its members who can so far forget the respect due to the dignity of their calling as to indulge in obstreperous behaviour on the doorsteps of gentlemen's houses, be they Ministers or more humbly-placed individuals. There is nothing " political " in women masquerading as Apaches; it is mere hooliganism, and quite inexcusable under any circumstances, but for those members of the sex who belong to the profession of medicine, which demands at least a certain public decorum in its members, to engage in deliberately-provoked street brawls is disgraceful in the highest degree. The theatrical " martyrdom " which persons of the type affect can call forth nothing but disgust among those who have the good name and fame of the medical profession at heart.

Declining Birth-Rate.

THE further fall in the birth-rate disclosed in the recently-published Registrar-General's returns for 1907 has led to the usual display of fireworks in the correspondence columns of the press. That the nation is foredoomed to sink to the level of a second-class power is the least of the evils prophesied by our Jeremiahs, and one is left to infer that no man or woman has done their duty to the State till the largest number of procreations of the species have been effected by him. Indeed, these good people apparently take the view that the country is a kind of Franco-British Exhibition, into which the largest number of individuals must be hurried in the shortest possible time, irrespective of their temporal or spiritual welfare. We do not wish to argue that there are not evils in bachelordom or spinsterhood, or late marriages, or limited families, nor is it wholly encouraging for the birth-rate to fall, as has been the case in London, from 36.5 to 28.8 in forty years, but the fact remains that the highest birth-rate, the highest infantile mortality, and the highest general death-rates almost invariably go hand in hand. Dublin enjoys the pre-eminence of being about the most unhealthy European city, and it is the only one in which the birth-rate has actually increased in the last twenty years. Although selfish and sordid motives mingle with other and higher ones, the present general lesson would seem to be that where care, forethought and prudence are exercised in the raising of children, the number of young ones is not indiscriminately raised for the mere sake of loading the olive tree with branches, and that the future development of man is likely to take place on other lines than that of weeding out the unfit by the slaughter of the weaklings.

Schoolmasters' Liability.

IT is so frequently one's unpleasant duty to chronicle cases in which through some *hiatus* in the law or through some mode of trickery, medical men are deprived of their fees for attendance, that it is a relief to turn to one in which a medical man succeeded in establishing a claim which theoretically exists, but is hard practically to substantiate. At the Clerkenwell County Court the other day the headmaster of a school was sued by a medical man for attendance on one of his pupils. The boy was taken dangerously ill, but by the doctor's exertions and skill his life was saved, and recovery eventually became complete. The boy's guardian was in Paris, and telegraphed to say, " Spare no expense. Have everything necessary," but when the time came to pay he took no notice of the letters written to him. As the doctor had been summoned by the headmaster, he told that authority that it was to him he must look for payment; but still no fees were forthcoming. The action, therefore, was entered, and defended on the ground that the schoolmaster disclaimed all authority in the matter. Judge Edge remarked, very wisely that in the case of a boy living with a schoolmaster, the latter was bound to call in medical assistance, and could only rid himself of responsibility by informing the doctor that he would not be liable for any further attendance. Judgment, therefore, was given for the plaintiff. Although this result may seem rather hard on the defendant, it is clear that it is more just that the onus of recovering expenses incurred by a boy should fall on a schoolmaster, under whose charge the lad is than on the doctor who has no hold of any kind on the parent; the former at least has the boy and his belongings to hold as hostage.

Medical Certificates in the Law Courts.

WE have several times urged that an official medical man should be attached to every court of law to certify, when ill-health is alleged, whether persons summoned to appear are or are not in a fit state to obey their subpœnas. The plan of requiring a certificate from the patient's own attendant throws an invidious responsibility upon him in many cases, and lays his *bonâ fides* open to most unpleasant criticism in court and among the other interested parties. A curious case of the kind occurred the other day at Cheltenham County Court. A woman was subpœnaed against her will to give evidence in a certain case, and along with her letter saying her evidence would be no good, she enclosed a medical certificate to say she was unfit to attend the court. The solicitor thereupon wrote to say that the doctor's certificate was no good unless an affidavit was sworn, and that he would apply for the woman to be committed for contempt of court. Consequently an affidavit was sworn by the doctor in due form, and the expenses attendant thereon sent to the solicitor, who refused to pay. An action was consequently brought against him, and the Judge very properly said that a medical certificate without an affidavit was quite sufficient, but that as the solicitor insisted on the affidavit he would have to pay for it. The defendant said this was a "new and novel" point of law on which he should like to appeal, but his demand was refused. As usual, remarks were made as to ulterior motives operating, and we cannot but think that the duty in these cases should not devolve, at any rate wholly, on the private medical attendant.

Methylene Blue and Thieves.

A little knowledge may be a dangerous thing, but a little elementary chemical knowledge may be very useful at times. The nurses at the London Hospital having been annoyed by thefts of small artticles from their rooms, hit on an ingenious plan last week. A purse containing several coins was treated with methylene blue, and the coins likewise, and then put away in a cupboard where it was suspected the thief would pry. In due time it was missed, and in the room of the suspected party were found a towel, a pair of gloves, and a handkerchief, all stained with that sturdy and penetrating dye. The owner of the stained articles stoutly denied the theft, but could not account for the cerulean hue of her linen, and she was haled before the magistrate in consequence. In court she broke down and pleaded guilty, and as her hospital record was an excellent one she was treated under the First Offenders' Act. This item of chemical knowledge thus brought into prominence may be found of value by Scotland Yard, which, in spite of its responsibilities, is in many ways far less scientific than the experts whose doings it is its duty to reveal.

Millionaires and Rabies.

One of the most patent facts in life is that people in this country love a lord, and it is equally true that in America they love a millionaire. This is not the place to discuss which is the more amiable, the aristocrat or the plutocrat, but it is certain that however much rank tells on this side, the populace do not throw themselves into frenzied transports whenever a lord is discovered in forgery, or suffers from an illness of a commonplace nature. Great excitement prevailed in New York last week over a Mr. Marsh, whose great title to fame was the possession of a successful manufacturing business. This gentleman had a dog suffering from rabies, and he became infected with the complaint through attending to the animal. It was not till the symptoms were well developed that the disease was diagnosed, and at the Pasteur Institute he was refused treatment, as it was too late to hope to do any good. The unfortunate gentleman returned home and died in a day or two. In the course of his brief illness it is stated that the Medico-Legal Society of New York went so far as to file charges against the Pasteur Institute before the District Attorney, on the ground that the nature of the illness was doubtful, and that the patient was dying of opium poisoning administered by his attendants. The post-mortem examination showed that the correct diagnosis had been made at the Institute, and that Mr. Marsh had died of rabies. The whole affair has been trumpeted about in the papers in the best "New York Sewer" style, and it is difficult to know what to believe. But the action of the New York Medico-Legal Society seems incomprehensible.

LEADING ARTICLES.

HOUSING.

The housing of the nation is clearly a matter of supreme importance in relation to the public health. The two things are inseparably united in the sense that the less is contained in the greater. To grasp this connection is to throw both into proper perspective and to realise more accurately a relationship that is apt at times to be somewhat undervalued. So far as the actual housing of the nation is concerned at the present moment, it is hardly too strong a statement to make if we assert that the natural law whereby good housing is rendered essential to a proper maintenance of the public health might almost as well be non-existent for the influence it has upon our social environment. For what are the facts of the case? In spite of Housing Acts and Public Health Acts, we find a fifth of the population of the United Kingdom living in slumdom. There are some eight millions of our fellow-countrymen existing under conditions that are not only a disgrace to our boasted civilisation, but constitute a continual danger to the safety of the community. This is the section of our population declared by Mr. Sidney Webb to be "housed, washed and watered worse than our horses." Yet this deplorable state of affairs persists in spite of numerous well-intentioned efforts of the legislature. That it is due to some defect in our social administration seems clear enough, for no sane persons would voluntarily elect to live in bad in preference to good houses. Nothing clears a slum more effectually than the plentiful provision of good dwellings: it is Hobson's choice that forces the poor into noisome and over-crowded tenements. The whole question has been recently discussed by an able writer in *The Nation,* Mr. George Haw. He points out in a forcible way what he describes as a defect in Mr. John Burns' Bill, namely, the failure to include the far-reaching adaptation clauses of the original Shaftesbury Act of 1851. The central principle involved is that in and around the centres that drift into slumdom are many solid old-fashioned houses that have been divided into tenements, with a family to each floor, or in some cases to each room. Such buildings are clearly unfitted for such sub-division as regards kitchens, water supply, sanitary conveniences, rubbish disposal, ventilation—in a word, they are wanting in all the decencies and essentials of a self-respecting household economy. Yet it would be possible, without any great expenditure of money, to convert such dwellings into first-rate flats, for that is what they would virtually become. The simple addition of an outstanding wing, containing kitchen, bathroom and lavatory accommodation, with the provision of a rubbish shoot and good staircase ventilation, would transform a series of slum tenements into respectable, if not ideal, dwelling quarters. Lord Shaftesbury recognised this possibly when he laid it down as essential that the local authorities be given power to renovate existing dwellings, as well as to build new accommodation. Giving evidence before the Housing Commission thirty-three years later, he was compelled to admit that the local authorities had not given his Act a trial. Mr. Haw quotes his further statement to the Commission: "If you were to look at the terms of my Act, you would see that it would meet everything that is required at the present moment." Could the illustrious philanthropist return to Parliament, he would find to his sorrow that Mr. Burns has ignored the far-reaching adaptation clauses in the Housing Act of 1851. Happily, experience is not wanting to show that such a proceeding is both practical and advantageous. One London local authority has carried out the principle of adaptation on a large scale, and has been able thereby to transform a slum-quarter that was the despair of Charles Booth into a healthy, law-abiding district, and that without displacing a tenant or raising the rents. The two last-mentioned facts, be it noted, constitute the great rocks ahead in all attempts to provide housing for the working classes by municipal enterprise. The credit of this achievement is due to the Camberwell borough Council, which now owns over 500 tenements, all having been adapted under Part III. of the Housing Act. The value of this object lesson to future legislators is incalculable. It is to be hoped that the question of adaptation will be brought pointedly before the attention of the House of Commons during the consideration of the Bill introduced by Mr. John Burns. That measure is admittedly open to amendments of a manifold and far-reaching nature. Now that the matter has been so ably raised in the public press, we may rest content that it will secure a due amount of consideration from the author of the new Act. Meanwhile the question of housing may be profitably discussed by the various bodies concerned with public health, for in spite of the great strides made in the scientific study of that subject, the lamentable fact remains that eight millions of our population are at the present moment permitted to dwell under conditions that constitute a blot upon our social system.

CURRENT TOPICS.

The Medical Examination of Engine Drivers.

Not many weeks have elapsed since the desirability of instituting a periodical examination of certain railway men, principally engine drivers, stokers, and signalmen, was urged in these columns. It is clear that these men cannot be expected to perform properly the arduous and exacting duties demanded of them unless they be in a state of perfect physical health. Then, again, the hours of labour exacted from every one of the classes under consideration are so long as to lay an undue tax upon human endurance. Only last week the engine driver of an express train died on the footplate a few minutes after leaving Newcastle. A coroner's jury found a verdict of fatty degeneration of the heart, and the Coroner suggested the advisability of a periodical examination of engine drivers and firemen. Quite recently the railwaymen made an indignant public protest because it was suggested that an engine driver had fallen asleep for a few minutes and had thereby caused an accident. Without going into the merits of any particular case, it may be stated broadly that it is a natural sequence of events for an overworked man to fall into a state of partial or of total somnolence for a few moments. It would be far more to the point if the railwaymen were to insist on a reasonable maximum limit of hours of labour, both consecutively and cumulatively. For their own interest, moreover, it would surely be advantageous to be under constant medical supervision, for no man is competent to judge of his physical state of health. In our own opinion, a step of the kind is urgently needed for the protection of the travelling public.

Red Tape and Pneumonia.

Early in the present month a tragic occurrence reported from Middlesbrough suggests the need of sweeping reforms in the methods of Poor-law administration pursued in that town. The facts of the case are simple, but they present a picture that could hardly be surpassed in the worst days of bumbledom. A man was seized with pneumonia at a common lodging house where he was staying, and was promptly ordered by a medical man to be taken in a cab to the workhouse infirmary. He was put, however, in a tramcar, and had some distance to walk to the workhouse. There he found he had mislaid the doctor's order, and was refused admission. On returning to the lodging-house he found the order, which he handed to the lodging-house deputy, and then, to quote the newspaper report, "being exhausted, he lay down and died." The jury returned a verdict of death from pneumonia, but expressed their regret that there had not been more consideration shown to the man at the lodging-house and at the workhouse. It is to be hoped that the Local Government Board will not permit the matter to stop here. If the facts be as reported the man's life has, in all probability been sacrificed to the iron-bound rule which would not admit him at once to the infirmary. To send away a man suffering from pneumonia, whether he have an order or not, is to commit an act of gross inhumanity. Surely it would be the right course to admit any obviously serious case at once into a Poor-law infirmary, and to get the order, if necessary, later. In the present instance, the order had actually been granted, but a man suffering from pneumonia could hardly be expected to look after details, or, indeed, to be in a fit state to take care of anything at all. The Local Government Board may well make a public inquiry into the whole Poor-law medical administration of Middlesbrough. Any organisation that could send a man suffering from pneumonia to hospital in a tramcar stands self-condemned. Why was not the patient taken in a cab?

The Position of Professors of the Queen's Colleges in Ireland.

The position in which existing professors of the Queen's Colleges in Ireland will be placed should the Irish Universities Bill become law has been so far most uncertain, and consequently considerable anxiety has been felt, especially in the Colleges at Cork and Galway. During the past week, however, some information has been forthcoming. In reply to Mr. Featherstonhaugh, who asked the

Chief Secretary for Ireland whether, in withdrawing the charter under which the Queen's Colleges were constituted, and introducing a new charter, it is intended to give those professors of the Queen's Coleges who do not care to take service on the new terms an opportunity of retiring on fair terms as to pension as was done in the case of some officers of the late Queen's University in Ireland, Mr. Birrell said that the existing professors will be offered equivalent posts in the reconstituted colleges, but it is not proposed to give them compensation if they should not choose to accept such equivalent posts. He thought Mr. Featherstonhaugh would find no option was given in the cases to which he referred. The enactment governing those cases appeared to be the Universities Education (Ireland) Act, 1879, section 14. Mr. Birrell has further given notice of his intention to move a new clause in Committee providing that if any existing officer holding his existing office during the pleasure of His Majesty or the Lord Lieutenant, is offered and accepts an office in either of the two new Universities, or in any of the constituent Colleges, he shall hold the office which he accepts on a similar tenure.

Guardians and Medical Salaries.

The inadequacy of the average medical income is one of the standing subjects of discussion in the professional journals. Nowhere is it better illustrated in the shape of a striking object-lesson than in the case of various Poor-law medical appointments. A particular instance is reported in the *Birmingham Post* of the 12th instant, wherein the proceedings of the Aston Board of Guardians are recorded. It was proposed to raise the salary of the medical officer of the Sutton Coldfield District from £50 to £80 per annum, and of the Erdington District from £50 to £70. The proposal was vigorously opposed by a member, who urged that if the Board practised economy in the wages of a gardener and of a boiler attendant, they must do so equally in the case of doctors. After some discussion the proposed addition to salaries was adopted. When compared with an ordinary surgical fee of fifty or a hundred guineas, it seems preposterous to ask a member of a highly skilled profession to give a whole year's arduous and responsible work for the paltry sum of £50 or £80. If we turn to the law, we find barristers receiving a fee of one hundred guineas a day as a "refresher," in addition to a huge sum of money paid down at the outset as a "retainer." It is certain that nothing will ever secure better remuneration for the rank and file of the medical profession except through the agency of a united organisation. The lack of initiative in the Local Government Board does not encourage the hope that Government will interfere with the object of securing "fair wages" for Poor law medical men. Indeed, the only recent action of that Department has been to curtail vaccination fees to a most illiberal and inadequate scale.

A Death under Anæsthesia.

Now that the authenticity of statistics of deaths under anæsthesia has been called in question, thanks to the Coroner for the City of London, we may hope for more accuracy in dealing with the matter. Opportunities for investigation are, unhappily, only too abundant. The fallacies surrounding the subject, however, are of manifold origin, some of them being quite apart from fatalities. Last week a death occurred under ether at the Miller Hospital, Greenwich. The operation consisted in the removal of an abdominal tumour, and during its performance two ounces of ether had been administered. Post-mortem showed healthy organs, if we except the "flabby" heart well-nigh inseparable from these enquiries. Death was ascribed to heart failure, owing to the sudden alteration of blood pressure consequent on the removal of the tumour. The Coroner stated that this was only the second death under anæsthesia that had occurred in that particular hospital since it was founded twenty-five years ago. If that be the case, the record is not a little remarkable, for we have reason to belive that a good amount of surgery has been undertaken at that institution. It would be interesting to learn the details of these two deaths, especially as one was under ether. Further, has the hospital an absolute record of every occasion upon which an anæsthetic has been administered? If so, the figures would have a considerable value. In any case, should the statement as to the two fatalities be correct, and it be further known that a large number of administrations of anæsthetic drugs have been made, the computive issues thereby raised would be of grave public import. The point to be ascertained, both for the safety of the public and the scientific education of the medical profession, is why there should be more deaths under anæsthesia in some institutions than in others, apparently administered under similar conditions.

The Research Defence Society.

We are glad to hear that the recently-founded Research Defence Society is gaining many important adherents all over the kingdom. The object of the Society is to educate the public in the questions regarding scientific research, and in the advantages to the community arising from the encouragement of research. It is not merely an agency to counteract the pernicious effects of the various anti-vivisection societies—though this will not be the least of its activities. In this respect there is no doubt that its teachings are badly needed, for many people are prejudiced against scientific research because they have only heard the arguments against it. The anti-vivisectionists conduct their campaign with sufficient noise, and it is right that some society should be ready to expose their misrepresentations. As regards research in general, moreover, the English public is singularly ignorant, and, in consequence, research in these countries is practised under great difficulties. Rich endowments are necessary, and the country should learn that money spent in this way is often one of the wisest investments.

Society for the Destruction of Vermin.

The present is emphatically the age of societies. Every fresh phase of our complex civilisation, from the fine arts to ping-pong and diabolo, demands its formal association. One of the most recent additions is a society for the destruction of vermin. The definition of the term "vermin" appears to be elastic enough to include rats, mice, fleas, mosquitoes, and house flies. Probably, if there is one point on which mankind is ever likely to approach unanimity, it is as to the desirability of exterminating the common rat. Even in the chambers of the most rabid anti-vivisectionist we doubt if any very real protest would be raised in favour of the common sewer rat. Unpopular as the animal was in former days, the discovery of the fact that the rat is the chief instrument in the spread of plague has turned dislike from a passive to an active mood. War is now waged against rats in every civilised country throughout the world. It is well that an energetic society should encourage the campaign against disease-bearing pests of all kinds. At the same time, it seems to be taxing one's sense of humour to be told that rat skins are not commercially profitable. Considering the filthy habits of the creature, it is earnestly to be hoped that the skins will follow the rats to destruction. Nor is the tone of the society raised by a purely gratuitous estimate attributed to its Secretary as to the existence of 20,000,000 rats in the United Kingdom, where they do £5,000,000 of damage annually, and cost £10,000 for repressive measures in London only. If the society can do something to lessen the plague of flies in the land it will deserve a nation's gratitude. Perhaps the statistician who tackled the rats would favour us with an estimate of the number of flies in the United Kingdom during August.

Medical Men and Public Lectures.

WE have commented once or twice during the past few months on the benefits likely to accrue to the community from the teaching of hygiene in the form of public lectures by medical men. It is of great importance that the public should be instructed in the elementary principles of hygiene, and there is no one so competent to give this instruction as members of the medical profession. In the giving of lectures on medical subjects, however, there are certain limitations which are well established by the sense of the profession, and it is necessary at the present moment to draw special attention to them. It is well recognised that details of the medical and surgical treatment of disease are not fit subjects for popular lectures, and that nothing should be admitted which could be regarded as savouring of advertisement of the lecturer's personal skill. It is a matter for deep regret that some of the lecturers in connection with the Women's National Health Association in Ireland are apparently oblivious of these wise restrictions. Thus, last week Dublin had the unedifying sight of a hospital surgeon of good repute lecturing on "The Surgical Treatment of Tuberculosis," and illustrating his lecture by demonstration of patients and apparatus. We have no doubt this gentleman was actuated by the best of motives, but the example is one which we hope will not be followed. The Women's National Health Association owes much of its success to the cordial support it has received from the medical profession. It cannot afford to estrange their friendship by the repetition of indiscretions of this sort.

PERSONAL.

VISCOUNT MILNER will preside at the annual dinner of King's College, London, to be held on June 23rd.

DR. WILLIAM JAMES HOWARTH, Medical Officer of Derby, has been appointed County Medical Officer for Kent.

MR. A. P. PARKER, M.B., F.R.C.S., has been appointed University Lecturer in Applied Anatomy at Oxford.

WE regret to learn that Mr. Francis Fowke, for thirty years secretary of the British Medical Association, has recently died at the age of 68.

VISCOUNT MORLEY, of Blackburn, will be the guest of the evening at the dinner of the Indian Medical Service Officers to be held on June 18th, at the Gaiety Restaurant.

ON May 16th the members of the British Balneological and Climatological Society held a meeting at Harrogate, the President, Dr. W. J. Tyson, of Folkestone, in the chair.

LORD CHEYLESMORE has received from Mr. Charles H. Berners a further contribution of £100 towards the maintenance of the Middlesex Hospital Cancer Charity.

DR. A. E. GARROD will give the Croonian Lectures of the Royal College of Physicians of London next month. His subject will be: "Inborn Errors in Metabolism."

THE members of the Imperial Yeomanry Hospitals Committee, staff, and some of its principal subscribers, have sent £221 11s. towards the "Hall-Edwards" Fund as a mark of appreciation of the services rendered during the African War by Mr. Hall-Edwards.

DR. J. J. BUTTERWORTH, medical superintendent of schools for Salford, has been appointed to a similar position for the County of Lancashire at a salary of £500 per annum, rising by £50 yearly to £650, together with office and the necessary clerical assistance.

THE festival dinner of the West London Hospital was held on May 19th at the Trocadero Restaurant, the Duke of Abercorn, President of the hospital, occupying the chair. The subscriptions received during the evening were announced as £4,254.

ON May 18th Sir Almroth Wright, M.D., F.R.S., was presented with the Fothergill gold medal at the annual *conversazione* of the Medical Society of London. The medal is awarded triennially to a medical man who has done exceptionally valuable work in some branch of practical medicine or surgery. In 1803 the first Fothergill medal was given to Edward Jenner.

A LARGE assembly met at the Cardiff Infirmary, on May 19th, on the occasion of the formal opening of the new out-patient department, which has been erected at a cost of £8,000. Major-General Lee, Chairman of the Board of Management, presided, and he was supported on the platform by Professor William Osler, M.D., F.R.S., who accepted the committee's invitation to perform the opening ceremony.

THE annual dinner of the Pharmaceutical Society of Great Britain was held on May 19th, at the Hôtel Métropole. Mr. J. Rymer Young, the President, occupied the chair, and the company, numbering about 180, included Mr. T. Lough, M.P., Mr. Idris, M.P., Sir R. Douglas Powell, Sir John McFadyean, Dr. W. H. Martindale, Dr. A. Newsholme, Sir B. Redwood, Sir Thomas Stevenson, and the Master of the Society of Apothecaries.

THE PRESIDENT (Mr. Henry Morris), the Vice-Presidents (Mr. Rickman J. Godlee and Mr. W. Watson Cheyne), and the Council of the Royal College of Surgeons entertained at dinner, on May 21st, Viscount Selby, Lord Aldenham, the Treasurer of the Middle Temple (Mr. Justice Phillimore), Mr. Justice Eve, the President of the Royal College of Physicians (Sir R. Douglas Powell), the President of the Royal Society of Medicine (Sir William Church), the Vice-Chancellor of the University of London (Sir William Collins, M.P.), and a large company of distinguished guests.

A Clinical Lecture

ON

HOW TO SET TO WORK IN ORDINARY OBSTETRICAL PRACTICE.

By PROFESSOR R. DE BOVIS, M.D.,

Professor of Obstetrics at the Rheims Medical School.

[Specially Reported for this Journal.]

In spite of the progress that has taken place in obstetrics, and the methodical teaching of which it is the object, it must be admitted that, from the point of view of antisepsis, ordinary obstetrical practice leaves much to be desired. Since a scapegoat must be found, it is necessary to gird at the midwife, and that she plays a conspicuous part for evil cannot be gainsaid. At a distance from hospitals, unable to keep herself abreast of scientific improvements, stuck fast in the chronic filth of the environment in which her work lies, the midwife, especially if advanced in years, is rarely up to the mark. I am, of course, referring to the prophylaxis of infection, for in other respects the service rendered by these modest practitioners is indisputably very great. But things that may be impossible for the midwife are possible for the doctor, and he it is who should preach by example. Yet we are constrained to admit that, as a rule, we fail to fulfil this our duty.

It is to be feared that far too many students quit our lying-in hospitals under the impression that there is nothing worth remembering of all they have been taught, simply because most of it is inapplicable in daily practice, or would prove unnecessarily troublesome. When he is called to his first case of difficult labour, the student, now a practitioner, finds himself in a small, ill-ventilated, ill-lighted room, beside a dirty bed, with, to wash his hands, a bowl instead of a basin, the water for which has been poured from a saucepan dipped into a bucket. Then, indeed, it is difficult to avoid contrasting his hospital experience with the grim reality of general practice. However, he does his best, and manages to deliver his patient in a fairly cleanly manner. All the same, he leaves the bedside feeling certain that his patient will infallibly succumb to acute infection in three or four days, and his relief is great when it turns out otherwise. The first time this happens he is immensely surprised, but ultimately he gets used to it, and ends by looking upon the elaborate precautions enforced in hospitals as somewhat unnecessary. When the time comes, and he loses a patient from puerperal infection, he is prone to attribute it to the heart, kidneys, or lungs of the defunct, and to take very little blame to himself.

I must admit that good old Mother Nature is in a certain measure responsible for the indifference that comes over us. I cannot give you the exact proportion of deaths from puerperal fever in town and country practice, but it is certainly pretty low. When I say low, I mean in respect of the total number, for if we contrast the figure with what it ought to be, it is very high. If we add to this that even a busy doctor only attends a comparatively small number of confinements, it is easy to understand that he may go on for years without seeing a death from infection, and during this time he has been acquiring bad habits, those of the midwife have got worse, and it becomes impossible to go against the current.

This, then, is the root of the evil. It is for you to remedy it; but it will, I fear, be under circumstances and in an environment of a discouraging kind. My present object is to warn you of certain difficulties and to advise you how to obviate them.

The first practical question is how to avert the risk of puerperal fever. You will often be asked by patients belonging to certain classes of society whether it is advisable to make use of injections during the period of gestation. That amounts to asking whether it be possible to lessen the chances of infection by measures taken before labour. The answer is somewhat doubtful; indeed, it does not seem to have been sufficiently thought out. Certain accoucheurs, holding that the vaginal canal of the pregnant woman is aseptic, or at any rate avirulent, disadvise any intrusion into this domain. Others hold that it would be impossible to allow a woman suffering from vaginitis or cervicitis to go to term without any attempt to improve her condition. My own experience inclines me to adopt the latter view.

Our parturient patients belong to two classes: the "expectants," who come several days or weeks before labour is due; and those who are in labour on admission. For women of the first category the maternity is a kind of "waiting-room"; they are servants out of place, deceived and deserted girls, and low-class prostitutes, all persons the state of whose genital organs leaves much to be desired. During 1907 these "expectant" women gave 10 per cent. of febrile cases, whereas the others, who were in labour on admission, gave 11.6 per cent. During the previous year the two classes gave the proportions of 9 and 15.7 per cent. respectively. These "expectants" were duly bathed and subjected to the most perfect genital disinfection possible, so that the slight advantage in their favour, notwithstanding their doubtful sanitary condition, may, I think, be fairly ascribed to the prophylactic measures of which they were the object.

In order to attain this result, however, we must have recourse to very strict genital disinfection. For instance, in 1905, we merely gave injections, and the result was *nil*. Since then the parts are soaped, rubbed, even scraped, and sometimes we leave in a strip of iodoform gauze, with, as you see, somewhat better results. Consequently, in women who are open to the suspicion of genital infection, you will be fully justified, if you get the chance, in adopting preventive measures. In the others this is unnecessary. Unfortunately these precautionary measures are not always available—at any rate in regard to baths; but a hip bath can usually be compassed, and I advise you to advocate its use.

We now come to labour itself. When you get to the lying-in room the first thing is to secure an ample supply of hot and cold boiled water. The former can be had easily enough, but not the latter, so you had better advise your parturient patients never to go to bed during the last fortnight without having boiled a cauldron of water and set it aside to cool. Get as much boiling water as you can—one never has too much of it. Boil your rubber gloves if you have any, as well as the tube and nozzle of the enema, wrapping them in a towel to prevent their being burned. Take advantage of the opportunity to boil your instruments. Then wash your hands.

Whether the patient be rich or poor, this is always a matter of some difficulty. If you ask to wash your hands they hand you the traditional basin half-filled with water and there you are, dabbling in dirty water just before making an examination. Should there be a tap use that rather than the basin, it is far preferable. Another plan, however, is to fill the douche-can with boiled water and, hanging it on the wall, to wash your hands in the running water thereof. After that you can dip them in perchloride solution or spirit, if you please, for you will have accomplished mechanical asepsis, after which all else is more or less superfluous. In any event, never do what I have so often seen done, viz.: to dip your hands for a few seconds in a solution of perchloride before making an examination or proceeding to turn or apply the forceps. You may think you have taken antiseptic precautions, but in such cases the perchloride will have done us very poor service, indeed, it merely cloaks uncleanliness.

Then, too, you will have done nothing to render the external genitals aseptic. This, although universally recommended, is rarely carried out in practice. Yet the necessity for it is obvious. Without it the hands, instruments, etc., are liable to be contaminated by contact with the thighs and the labia, and may carry a whole series of micro-organisms into the vagina. What would you think of a surgeon who proceeded to operate without the least sterilisation of the skin? You must look upon a confinement as a surgical act, to be treated accordingly. The fœtus leaves behind it tears, wounds, and erosions. Therefore imitate the surgeon who disinfects the field of operation before commencing. The difficulty in practice is to accomplish this, but it can be done by the aid of the douche-can, which is always available at present. Hang up the can at the head of the bed. Allow the boiled water to run on to the external genitals, rub the parts well with soap, and in this way you can cleanse the vulva, anus, gluteal region and inner sides of the thighs. Rub well and long, then wash the parts clean with the running water. Then, having cleansed your own hands *de novo*, wipe the parts dry with sterilised cotton.

I have not referred to the use of any antiseptic, but you must not suppose that I disdain their use. I wish to insist first of all on the mechanical agents of disinfection. Nowadays the surgeon relies on little else and you will lose nothing if you follow his example. Is it to be supposed for an instant that a little perchloride solution trickling over the perinæum will remove the fatty layer which is a true culture medium for microbes. At the present time, now that the practice of washing the hands has become general, the great danger of puerperal infection lies in neglecting the toilette of the external genitals. As a matter of fact, even the partially-cleansed hand is vastly less septic than the "'tween leg" region. The hand, it is true, is exposed to many doubtful contacts, but the very frequency of contacts brings about a sort of automatic scraping, whereas nothing of the kind is brought to bear on the region aforesaid. Perspiration, the secretion of the sebaceous glands, vaginal discharges and peri-anal contamination, all contribute to render this region dangerous. Soap will remove all that, and if you can get this done beforehand so much the better, and this is an argument in favour of *ante-partum* baths.

Washing with spirit or ether and scrubbing, on the other hand, are inadvisable, the perineo-vulvar tissues being too tender; in fact, this should only be done on women who are under an anæsthetic. Nothing prevents your washing the parts with perchloride after washing them, but never use the perchloride at the same time as the soap, for they are mutually antagonistic, so that the cleansing process will be incomplete in consequence. When you have finished washing your patient and your own hands you may make use of the soap you have been using to lubricate the fingers. If there be any reason to suspect syphilis, however, a fatty substance is preferable. Beware, however, of pots of vaseline into which fingers have been dipped, and this is why I advise soap. Nor should you make use of salad oil unless you can sterilise it first.

Ought we to make an injection after examining? This is unnecessary if you have made yourself aseptic; nevertheless, if by any chance your patient should be suffering from a genital infection, it may be well to start with a simple injection, but to be of service you will have to rub the vaginal walls with the soaped finger or you will leave them with the microbial colonies as before. On the other hand, an injection made without previous cleansing of the external genitals is likely to do more harm than good. Having in view the importance of keeping the obstetrical field free from contamination, only give an enema at the onset of labour or before the head has come down, otherwise the descent of the head will extrude the remainder of the enema, bringing about more extensive contamination than solid matter would do.

You have now done all that is necessary so far, and you can proceed to prepare for coming events. Select a small table, cover it with a clean towel, and place thereon everything you are likely to want: a large basin of boiled water, another (smaller) containing a solution of perchloride or spirit, leaving your sterilised gloves in basin No. 1. You will thus be enabled to clean your hands as required, for in the houses of the poor there is not always someone at hand to move the bedclothes, etc., hence you are continually liable to contamination. The soap may be left in the spirit or perchloride, it will not dissolve and is thus kept aseptic. In a soup-plate you place a catheter, thread to tie the cord, a hypodermic syringe, a suture needle for ruptures, and some catgut.

You may be surprised at my referring so frequently to spirit—and I mean methylated spirit—as an antiseptic. It is really a very convenient agent, you can leave your hands and instruments therein as long as you like, and it is quite as effectual as the perchloride employed in obstetrical strengths. It is everywhere to be had, at all times of day and night, which is no small advantage in antisepsis. Put half-a-dozen clean towels on your table, some absorbent cotton—in its paper wrapper. Place the table behind the spot where you will be during the stage of expulsion, so that you can reach the things yourself without the risk of their being handled by third persons.

These towels will serve to keep the operating field clean. Theoretically, of course, they ought to be sterilised or boiled, but if boiled your patient would have to come into contact with wet cold linen, apart from the fact that there may be no time for this. Moreover, clean linen is tolerably aseptic, vastly more so than the parturient's own skin. In any case, a clean towel is much more aseptic than the sheet on which the patient has been turning and twisting for hours, and which may be the only one available. Moreover, they are mainly of use at the stage of expulsion when you have to dam up the tide of amniotic liquid, blood, clots and fæces that would otherwise inundate the bed. By interposing the towels you avoid contaminating your hands and prevent contamination of the genitals. Please bear in mind that the absorbent cotton must always be carefully wrapped up and not allowed to lie round on the counterpane, a warning that is by no means unnecessary. I mentioned that it would be well to leave your rubber gloves in the antiseptic-basin. I cannot insist too strongly on the advisability of making use of them. They cannot be employed when examining or operating, but they are invaluable under all other circumstances. With certain precautions it is easy enough to thoroughly cleanse the hands, but it is practically impossible to keep them clean for hours together and it is even less possible for the midwife, who has other, more servile, duties to perform. You may be suddenly called upon to assist in delivery before you have time to clean your hands afresh, whereas, if you put on the gloves, these can readily be cleansed if accidentally soiled, which is not the case with your hands.

You may feel inclined to put a finishing touch by the application of an antiseptic dressing to the vulva, but you would be taking a lot of trouble for very little purpose. It soon gets twisted and uncomfortable, and, if applied, it ought to be moist in order to lessen the risk of perineal rupture. In obstetrics, as elsewhere, "*le mieux est parfois l'ennemi du bien*," and when you have done what is necessary do not further interfere with the layer of amniotic liquid that bathes the vulva, its presence there is to guard against perineal rupture.

May this lecture impress upon you the importance of a refined cleanliness, the daughter of antisepsis, and the superiority of mechanical agents of disinfection, and so disabuse your minds of the fetish of antiseptics. In obstetrics the perchloride is not everything, it does not dispense with the necessity of absolute cleanliness.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Wm. St. Clair Symmers, M.B., C.M. Aberd., Professor of Pathology, Queen's College, Belfast. Subject: "Some Landmarks in the Study of Tuberculosis."*

ORIGINAL PAPERS.

ON THE
DANGERS AND TREATMENT OF MYOMA OF THE UTERUS. (a)

By CHRISTOPHER MARTIN, M.B.Edin., F.R.C.S. Eng.,

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LECTURE I.

The more I see of myoma or fibroid tumour of the uterus, the more impressed am I by the risks of the condition. To-day I propose to call your attention to certain of these dangers, and in my second lecture to discuss the methods of treatment.

Hæmorrhage.—Hæmorrhage from the uterus is the commonest symptom of myoma, and is present in the great majority of cases. It varies much in different cases. In some, with even a large fibroid, it is only a rather profuse or prolonged menstruation. In others, with perhaps quite a small growth, there are terrific floodings. The nearer the tumour to the cavity of the uterus, the more severe the flooding. Thus in the subserous growth it is slight, in the interstitial it is profuse, in the submucous and polypi it is excessive. In some cases, there is a constant dribbling of blood-stained watery fluid, with monthly exacerbations. In others, there are sudden and alarming floodings, with intervals of weeks or months with little or no loss.

It is rare for a patient actually to bleed to death from a myoma. She usually develops a condition of marked chronic anæmia. She has dilated pupils, œdema of the face and feet, loud hæmic murmurs, palpitation, breathlessness, and faintness on the slightest exertion.

Pain and Discomfort.—Uncomplicated myomata do not, as a rule, give rise to much pain; certainly there is nothing approaching the agonies of cancer.

Pressure Symptoms.—The pressure symptoms of myomata are numerous, and frequently call for surgical treatment. Pressure on the rectum causes constipation and hæmorrhoids. Pressure on the iliac veins causes varicose veins of the legs and vulva. Pressure on the sacral plexus of nerves causes neuralgic pains, sciatica, and cramps, though seldom paralysis. Pressure on the uterus may cause backward displacement or even total prolapse of the organ.

By far the most serious and distressing group of symptoms are those due to pressure on the urinary organs.

Lesions of the Ovaries and Tubes.—Disease of the uterine appendages frequently complicates myoma. In some cases, the surgeon opens the abdomen to remove a myoma, and finds unexpected lesions in the ovaries and tubes, which the tumour had masked. Or he may operate for disease of the appendages, and find in addition a small fibroid of the uterus.

The question arises: Is the myoma responsible, in any way, for the tubal or ovarian disease? I think, in many cases, it is. On the other hand, I see no evidence that diseased conditions of the ovaries and tubes can ever cause a myoma to develop in the uterus.

Heart Lesions.—It has been shown that myomata, especially those of large size and causing much hæmorrhage, exercise a very pernicious influence on the heart. The repeated hæmorrhages produce chronic anæmia; and, as a result, the heart is badly nourished. A large myoma causes mechanical obstruction to the circulation, and increased peripheral resistance. The result is that the heart muscle undergoes fatty degeneration and brown atrophy.

Degenerative Changes.—Myomata are peculiarly liable to various kinds of degeneration; indeed, I know of no other tumour so prone to secondary changes. They are found in about 20 per cent. of the cases. We may divide them conveniently into three great groups:—

(*a*) Non-malignant degenerations *without* necrosis; occurring in about 14 per cent. of myomata.

(*b*) Non-malignant degeneration *with* necrosis; occurring in about 4 per cent. of myomata.

(*c*) Malignant degenerations and complications; occurring in about 4 per cent. of myomata.

Let us consider each group in turn.

Non-Malignant Degenerations.—This group is a large one, and includes many different pathological processes. Amongst the mildest and most innocent are fatty degeneration, hyaline degeneration and calcareous infiltration. These are found in tumours which have ceased active growth, and may be looked upon as signs of their old age. They do not, as a rule, call for active interference.

But there are other degenerations characterised by marked activity and rapid growth of the tumour. These include acute lymphatic œdema, myxomatous softening, cystic degeneration, angiomatous changes, adenomatous growths, and the curious condition known as red degeneration.

There are certain clinical features common to nearly all these degenerations: (*a*) the tumour is usually, but not invariably, single; (*b*) after a period of quiescence it suddenly begins to grow rapidly, with increased pressure symptoms, and often severe pain; (*c*) the tumour changes in consistence, becomes more elastic and softer; in the cystic variety it fluctuates, and gives a thrill like an ovarian cyst; (*d*) in many cases it becomes more vascular, the enlarged arteries being felt pulsating in its walls, and a loud bruit being heard on auscultation. These changes may come on at any age, but are most common about the menopause. They may even come on years after the cessation of menstruation.

Amongst my 380 abdominal sections for myoma, I found non-malignant degeneration recorded in 19 cases (5 per cent.), of which no less than 13 were examples of cystic degeneration.

Red Degeneration.—Let me briefly call your attention to the curious condition known as red degeneration. It is sometimes called "hæmorrhagic degeneration." It is probably a form of acute aseptic necrosis, and hence is termed by some writers "red necrobiosis." In Noble's collection of 2,274 cases of myoma, it is recorded 13 times, or 1 in 175. Whenever it does occur it causes serious symptoms, and calls for immediate operation. Its essential cause is unknown. It is specially liable to occur in young pregnant women. The onset is sudden. There is acute pain, with vomiting, a rapid increase in the size of the tumour, and often some degree of fever.

Necrosis.—We now come to the cases where necrosis, or death of a fibroid, occurs. It happens in about 4 per cent. of all myomata. When a cystic fibroid undergoes necrosis, the fluid contents become converted into a kind of pus, and then the growth is termed a suppurating fibroid. It is rare for an interstitial myoma to necrose, probably because it is well supplied with blood on all sides. The submucous and polypoid varieties are, however, very prone to do so.

There are other modes by which a submucous myoma may become infected and necrose:—

(*a*) By the passage of a dirty sound in examining the uterus.

(*b*) By an intra-uterine operation, such as curetting, done with dirty hands or instruments.

(*c*) By the puncture of the growth with Apostoli's electrolytic needles. This was a fertile source of disaster when this method was in fashion.

However produced, when once necrosis has set in, it is unmistakable. The stench of these cases is sometimes appalling, filling the whole house. At the same time the patient becomes infected and poisoned by toxins absorbed from the gangrenous tumour; and, if not speedily relieved by operation, will die of septicæmia or pyæmia. In some of my most putrid cases, however, I have been amazed by the absence of any systematic infection, the patient being only distressed by the disgusting smell of her discharges. This, no doubt, must be explained by the slow onset of the process, allowing for self-immunisation.

These cases of sloughing fibroid may be mistaken for advanced cancer of the uterus—an error which would be disastrous if it led the surgeon to treat the case as hopeless, and not attempt to remove the growth. It is not always easy to differentiate without a thorough examination under an anæsthetic. If the cervix be softened and dilated by a tumour being forced through it, the tumour is a fibroid, and not a cancer. If, beyond the necrosing part, a smooth rounded mass can be felt, covered by mucous membrane, it is probably a fibroid. If the protruding part be brittle, and friable, and crumble under the finger, it is a cancer. A sloughing fibroid can be pulled away with forceps in stringy shreds or rounded masses; and, on close investigation of these fragments, some trace of the fibrous structure of a myoma may be seen. If still in doubt, a microscopic examination of a bit of *débris* will clear up the matter. It is of the utmost importance that a correct diagnosis be made, as an early operation will save the life of the patient if it be a fibroid. Indeed, I know of no cases which yield more brilliant results to timely surgical interference.

(a) Abstract of the Ingleby Lectures, delivered at the University of Birmingham, May 7th and 14th, 1908.

Malignant Degeneration.—The researches of modern pathologists and gynæcologists show that there is a marked tendency for a myoma to become directly transformed into a sarcoma. Winter examined microscopically 500 myomata, and found sarcomatous changes in 4 per cent. Martin found sarcomatous degeneration in 6 out of 205, Cullingworth in 1 out of 100, Schadlied in 6 out of 100, Haultain in 2 out of 120, Hirst in 3 out of 189, and McDowol in 20 out of 1,000 cases. In my own 380 abdominal sections for myoma, I found sarcomatous changes in 9 cases. Adding these cases together, we find it occurs in a little over 2 per cent. But this list includes only the sarcomata recognised as originating in myomata. Probably many other cases, thought to be primary sarcomata, have originated in unrecognised myomata. Hence I think that Winter's figures give the truer proportion—viz., 4 per cent.

Relation to Pregnancy.—Myomata tend to cause sterility. Mann found that 55 per cent. of married women with fibroids never conceived. Amongst married women generally only 15 per cent. are sterile, so there is nearly four times more sterility in myomatous women than in other women. It is fortunate it is so, as there can be no doubt that the occurrence of pregnancy adds greatly to the dangers of myoma. A woman with a fibroid is safer single than married, and a married woman with a fibroid is safer sterile than pregnant. Some authors, noting that myomatous women are often sterile, have suggested that sterility is a cause of myomata. They suppose that these women ardently long to have children, and that their unsatisfied maternal desires keep up a congested condition of the uterus, and, in some mysterious way, produce a myoma. I do not believe in transcendental pathology, and I think these theorists put the cart before the horse. The myoma causes the sterility, and not the sterility the myoma. It is, moreover, easy to understand how the presence of one or more fibroid nodules, embedded in the womb, may stimulate its sensory nerves, and awaken strong maternal passions.

Let us now consider the results of pregnancy in a myomatous uterus. Whilst some women, with moderately large fibroids, go through pregnancy and labour without a hitch, it is usually a serious complication. If the tumour be submucous or interstitial, the patient generally aborts about the fourth month; and this is the best thing that could happen to her. I have seen several cases of severe uncontrollable vomiting, in pregnant women with interstitial fibroids, due, I believe, to the inability of the uterus to expand with the growth of the pregnancy. In most of these cases abortion had to be artifically induced. When abortion occurs, whether spontaneously or induced, there is apt to be retention of placental tissue, and alarming hæmorrhage from imperfect contraction of the uterus. Another risk is that, following an abortion, a submucous myoma may necrose and be a source of sepsis. I have already referred to the special tendency of red degeneration to occur in pregnancy.

A fibroid may be so large that it may mechanically prevent the normal development of the pregnant uterus, and necessitate surgical interference. Some years ago, I had sent to me, by Dr. Davidson of Coventry, a patient with a huge myoma and also a five months' pregnancy. She was in great distress, and there was no room, apparently, for any further growth of the pregnancy. So I opened her abdomen and removed the entire uterus.

In some cases, the fibroid is impacted in the pelvis below the pregnancy in such a way that it is obvious the child cannot be born *per vias naturales.* Wherever situated, a large fibroid adds greatly to the risks of a full time labour. It may interfere with the contractions of the uterus, and so delay delivery. It may, by preventing contraction after delivery, cause retention of the placenta or alarming hæmorrhage. As a result of bruising or torsion, the growth may undergo necrosis, and cause fatal sepsis. It will thus be seen that the combination of pregnancy with a *large* myoma is a grave one, full of danger for the patient and anxiety for the medical attendant. The mortality is great, as in many cases surgical aid is not called in till it is too late.

Summary of Risks.—Let me now briefly summarise the risks a woman with a fibroid tumour runs :—

(1) More than half the cases suffer from severe hæmorrhage and chronic anæmia.

(2) Many cases develop heart disease, phlebitis, thrombosis and embolism.

(3) Others get retention of urine, cystitis, pyelitis, and hydro-nephrosis.

(4) In about one-third of the cases, the ovaries and tubes become diseased.

(5) In about one-fifth of the cases, some form of degeneration occurs, ending in nearly 5 per cent. in necrosis of the growth, 4 per cent. develop sarcoma, and another 4 per cent. cancer.

(6) More than half the patients are sterile; but, should pregnancy occur, the dangers increase with the progress of the gestation.

Natural cure of Fibroids.—There are three modes by which a "natural cure" of a myoma may take place :—

(1) A submucous fibroid may necrose and slough away; or it may be extruded through the cervix as a polypus, and drop off.

(2) A myoma may participate in the involution of the puerperium and disappear.

(3) It may undergo atrophy at the menopause.

The first mode—by necrosis and sloughing away of the tumour—I have already discussed. Needless to say its risks are much greater than those of the most formidable of the modern operations for fibroids. The gradual conversion of a submucous fibroid into a polypus, followed by its extrusion and separation *en masse*, does undoubtedly occur. But it is a long, tedious, and dangerous process, more likely to kill the patient than to cure her.

The second process of natural cure, viz.—by its sharing in the involution of the uterus after delivery—is also uncertain, and is more apparent than real. Myomata are very sensitive to changes in their blood supply. When pregnancy occurs, the increased vascularity of the womb causes the tumours to take on active growth. They often become more mobile—due no doubt to the softening of the surrounding uterine wall. An interstitial fibroid seems sometimes to be converted into a subserous one, by being pushed outwards toward the peritoneum by the growing ovum. Should the patient pull safely through the pregnancy and labour, the blood supply of the uterus rapidly diminishes. The tumour then shares in the process of involution, shrinks in size, and in some cases, seems to disappear. This fortunate result is, however, by no means a certainty; and in many cases the tumour, so far from shrinking, takes on more active development. It is probable, as Dakin says, that very few fibroids are absorbed; but many degenerate, become inflamed, or undergo necrosis. Only a few months ago I had to operate on a lady who had a large subserous fibroid growing from the top of her uterus. She had been confined three months before, when the tumour was discovered by her medical attendant (Dr. Peirce, of Langley). Instead of shrinking during the puerperium, it took on active growth. I opened her abdomen, and found a large cystic fibroid attached by a broad pedicle to the top of the fundus. I removed it by dividing the pedicle, saving the rest of the uterus.

Lastly, a natural cure may occur by the absorption and disappearance of a fibroid at the menopause. This phenomenon was at one time looked upon as almost a certainty. The woman was told that, if only she would wait till the change of life, the growth would disappear, and all her troubles would be at an end. But a sad experience shows that these hopes are illusory. As a matter of fact, the presence of a fibroid delays the natural change of life; and instead of the hæmorrhages ceasing at 45, they go on with increased vehemence until she is 50, 55, or even older.

Even if hæmorrhage ceases, this removes only one of the many risks of the condition. It is just at this period that the most serious forms of degeneration are apt to supervene. Noble, in his study of 4,880 cases, says he is not acquainted with a single authentic case in which a fibroid has entirely disappeared at or after the menopause.

Realising, on the one hand, the manifold dangers of myomata—the pressure symptoms, the cardiac and renal complications, the risks of degeneration, necrosis and malignant disease—and, on the other hand, the safety and the certainty of cure offered by modern surgical operation, I hold that we are not now justified in advising a patient with a troublesome fibroid to wait for the menopause.

THE PROMOTION OF UNIFORMITY IN THE REGISTRATION OF DISEASES IN HOSPITALS. (a)

By R. F. TOBIN,
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GENTLEMEN,—"Order is Heaven's first law," and although it is possible to make out a case for disorder in certain relations—for instance, Herrick tells us that

> "A sweet disorder in the dress
> Kindles in clothes a wantonness,"

and that it creates

> "A winning wave deserving note
> In the tempestuous petticoat"

—still, I do not think that there is anyone in this audience who will have the hardihood to stand up and say a word for it in connection with registration of diseases. My object in speaking to-night is to suggest a simple means for forwarding what I have set forth in the title of this paper, and perhaps the best way I can introduce the subject is to tell you how I have been led up to the place where I now stand.

Some months ago the Board of Superintendence of Dublin Hospitals receiving Government grants, of which I am Secretary, decided that it would be well to amend the form on which the hospitals with which it is concerned send in a classified annual return of patients admitted, and I was directed to look into the matter. There was certainly necessity for the change, for the old form was quite obsolete—the classification being alphabetical, with the inclusive term abscess holding first place on the list. I shall not delay you by mentioning those with whom I have corresponded. Science does not recognise nationalities, and the list is therefore a long one; but I shall take this opportunity to thank all on that list for their letters and suggestions.

Anyone carrying out an inquiry such as I have been busy on will be struck, first, with what an excellent book is the "Nomenclature of Diseases of the Royal College of Physicians"; how far it is in advance of all other classifications; and then with how very little the profession generally know about it. My own ignorance of it was the first thing that was brought home to me, and then came the consolation of finding how widespread was my shortcoming. Of course, everyone knows that there is such a book; that it has a yellow cover, with a red linen back. But how many could lay their hands on it within five minutes? How many of us know the advances that have been made as new editions have come out? How many of us have studied it as we have the leads in a "no trump declaration"? My feelings towards the book are now those of a converted collier towards temperance. The care bestowed on its compilation, the eminence of the men who have worked at it, the difficulties as regards classification that have been overcome, the education that lies in an intimate acquaintance with it, are ever before me, as also is the fact that thousands of my brethren—of course, I except the learned men now listening—are still plunged in the ignorance that was mine until the other day. The means I suggest for spreading the light and for promoting uniformity in the registration of diseases in hospital is a very simple one. It consists in putting in every admission and discharge book alongside the column for the names of diseases a column for the numbers given to those diseases in the nomenclature, and in using, when the annual returns are being prepared, these numbers as a means of bringing together the various diseases in their proper order. This simple means of classification is in use in preparing the returns of the Army Medical Service, and it is found to work well. The numbers identify the words, and the necessity for looking out the number leads one to using the proper word. It banishes such terms as struma, scrofula, etc.

And here let me remark that, since my conversion, it has been a wonder to me why the Registrar-General does not give us a space for these numbers in the certificates of death, and ask us to fill them in.

In conclusion, may I point out that the addition of the number in each entry of a disease in the admission and discharge book, in place of giving increased trouble, has, as is always the case with what tends to order, a quite different result. In a very short time one comes to know the numbers of all the principal diseases, and so the initial trouble disappears, while thus advantage is permanent that from an admission and discharge book so filled up, any clerk can make out a classified return of diseases. Infective diseases, malignant diseases, diseases of the various systems that are not either infective or malignant, are compelled to fall into proper order, and a bracket to define the sections is all that is necessary to complete the return.

I now produce the front page of the form furnished to the hospitals under the superintendence of the D.H. Board, as it furnishes an illustration of how the system works. On it, as you perceive, the number of infective cases, of malignant cases, of injuries, etc., are seen at once.

A CLASSIFIED ANNUAL RETURN OF THE DISEASES OF PATIENTS.

TREATED IN..............................HOSPITAL DURING THE YEAR ENDED 19 .....

The following entries are made with a view to illustration.

No. in Nomenclature.	Disease.	No. Treated	No. Died	Class.	Totals of each class.	
					Treated	Died
13	Enteric Fever	6	1	Infective.	36	5
38	Scarlet Fever	4	2			
44	Tuberculosis, Lung	20	2			
44	" Knee-Joint ...	3				
44	" Abscess Tibia	1				
44	" Lupus	2				
50	Alcoholism	4	1	Intoxicants.	6	1
59	Plumbism	2				
79	Lipoma Circumscribed; Back	4		New Growths Non-Malignant.	5	
79	Papilloma, Villous, Vesical	1				
80	Sarcoma, Spindle-celled, Femur...	2	1	New Growths Malignant.	10	2
80	Sarcoma, Spindle-celled, Testicle	1				
80	Carcinoma, Scirrhus, Breast	4	1			
80	" Epithelioma, Lip	3				

As there are here to-night representatives of many hospitals, may I ask them to give this system their consideration, and if they approve it, to try and introduce it into the institutions with which they are connected. I have said it is in use in the Army Medical Service, and it may be in more general employment than I am aware of. If so, so much the better. It is for its universal adoption that I raise my voice to-night. Why should not each disease carry a like number in every land? This, I believe, will come. Let Ireland lead the way towards such a consummation, and let there be at least this one point of Union between her sons.

(a) Paper read before the Section of State Medicine, Royal Academy of Medicine in Ireland, May 1st, 1908.

THE SUPPORTS OF THE FEMALE PELVIC VISCERA. (a)

By RICHARD H. PARAMORE, M.D.LOND., F.R.C.S.,

Clinical Assistant, Department for Diseases of Women, St. Bartholomew's Hospital.

THE author introduced his paper by saying that the supports of the pelvic viscera could not be discovered by anatomical research alone, but that it was necessary to conjointly investigate the actual living processes which occur in the body. The pelvic cavity was shut in below by the levator ani muscle, the coccyx muscles, and their connective tissue attachments. This muscular sheet, called the pelvic floor, limited the abdomino-pelvic cavity inferiorly; and in uniformity with the other limiting musculation of the body cavity, it was clothed by a layer of subperitoneal tissue, and was lined by peritoneum. Within this subperitoneal tissue the pelvic viscera were embedded; and these protruded into the cœlomic cavity and elevated the peritoneum from off the pelvic floor. Besides viscera, this layer contained the blood and the lymph vessels, the lymphatic glands and the nerves and the ureters. In places it was composed of soft loose cellular tissue, containing more or less fat; in other parts the tissue had become condensed to form ligamentous strands which contained unstriped muscle fibres, and which were especially related to the pelvic blood vessels, and, therefore, had been styled the perivascular connective tissue sheaths. Owing to their strength and to the fact that they were attached to the bone, it had been supposed they constituted the chief and the only supports of the viscera.

The speaker then showed the similarity between the condensations of the pelvic visceral connective tissue and the condensations which occurred in other parts of the cœlomic cavity, and especially in connection with the duodenum (suspensory muscle, &c.). He did not, however, believe that this ligament suspended the duodenum, which he thought was supported by the viscera below it, and which in turn were kept in place by the tonic contractions of the belly-wall musculature; but he considered this ligament merely served to anchor the duodenum to the spine and thus prevented too great excursions of it.

He said there was no essential difference between the condensations of the subperitoneal tissue in one place and that in another, and thought the visceral ligaments of the pelvis did not normally support the uterus, although on glancing at the pelvis it might appear that they did so. A comparison, however, of the visceral connective tissue apparatus with the pelvic diaphragm placed beneath, showed that whilst the pelvic diaphragm, on account of its striated muscle, was a highly elastic obturator, the visceral connective tissue was little if at all elastic. It was this lack of elasticity, the impossibility of yielding to excessive pressure from above without stretching, and the equal impossibility of returning to a previous position after such stretching, that made it impossible for the visceral connective tissue sheaths to play the part of a support adaptable to all the requirements of the pelvis.

He considered these ligaments to function during the act of defæcation, and that the pelvic floor descended during this act they undoubtedly prevented a too great descent of the uterus.

Dr. Paramore said the pelvic floor was to be considered identical in structure and in function with the anterior abdominal wall. The fact that the abdominal and pelvic cavities were, indeed, one cavity indicated, that they were enclosed by a universal means, similar alike in anatomical structure as in physiological function; nor should the presence of the genito-urinary rectal passages, complications as they were, be sufficient to blind them to the essential similarity between the two parts. These in the living body acted as antagonists to each other, in that increase of contraction of the one reflexly caused increase of contraction of the other. The outcome of the simultaneous contraction of these two groups of muscles, in the superior one of which the thoracic diaphragm must, of course, be included, was the intra-abdominal pressure.

This pressure acted by thrusting the pelvic viscera still further downwards upon the pelvic floor; and in the presence of this down thrust the viscera were maintained in their position by the levator ani muscle. The proof that this was so was shown by the invariable occurrence of prolapse when this muscle had been sufficiently injured, and the intra-abdominal pressure periodically became sufficiently high; and, as Halbam and Tandler had pointed out, was exhibited in the most beautiful way in cases of congenital paralysis of the muscle in association with spina bifida.

CLINICAL RECORDS.

CORNUAL GESTATION IN ONE HORN OF A BICORNUATE UTERUS—RUPTURE—RECOVERY. (a)

BY J. B. HELLIER, M.D.LOND.,

Lecturer on Gynæcology, University of Leeds, &c.

THE patient, æt. 33, enjoyed good health previously. Her first pregnancy terminated in normal labour, April, 1907. She ceased to menstruate in the following November, and was perfectly well until March 15th, 1908, when about 12 p.m. she received a violent blow on the lower part of the abdomen on the right side. Either she was directly kicked in this region, or was driven against a sharp corner. She felt faint at once, and was unable to lie down properly on account of vague abdominal pain. She became seriously ill next day, and on March 17th required catheterisation, and was admitted into the Leeds Infirmary. The lower half of the abdomen was full and tender, respiratory movements in this situation were defective, and there was some dulness in the right flank. The pulse was weak and rapid. The usual signs of pregnancy were present. It was considered that the case was one of internal hæmorrhage, and that either the uterus was ruptured, or some vessel in the pelvis. There was no vaginal bleeding.

Abdominal section was performed the same day, and a four months' fœtus, enveloped in the amnion lay superficially as soon as a median incision was made. A very large quantity of blood clot was in the abdomen and pelvis. The sac lay on the right side and looked very much like a matured uterus with retracted walls, the placenta having escaped into the abdomen, but retaining a slight attachment to the interior of the sac. On the left side of the sac there was a uterus of normal size, to which it was attached by a thin fleshy pedicle about 2¼ inches broad and ¼-½ inch thick. This was ligatured and divided, the ovarian artery being separately secured. The abdomen was cleared of clot, and closed without drainage. The pulse varied from 144 to 156 immediately after the operation, and the temperature rose to 101° on the second night. After this the patient made an uninterrupted recovery, and was discharged quite well on April 11th. On examination of the specimen, which was also shown, the sac-wall appeared to consist of muscular fibres exactly like the uterine muscle, and this was confirmed microscopically. The Fallopian tube was attached on the distal side of the sac. The uterine end of the round ligament was attached in front of and slightly below the tube.

(a) Abstract of Paper read before the Royal Society of Medicine (Obstetrical and Gynæcological Section), May 14th, 1908. For discussion see page 584.

(a) A Note read before the North of England Obstetrical and Gynæcological Society, May 15th, 1908.

The cornu did not communicate with the cavity in the left side of the uterus. It was a curious coincidence that the blow, which certainly caused her symptoms, should have fallen the gestation side, and if the patient had succumbed to the injury, an interesting medico-legal question would have been raised, which might have been compared to cases where blows on the chest have ruptured aneurysms.

OUT-PATIENT'S ROOM.

KING'S COLLEGE HOSPITAL.

Old Potts' Fracture.

By PEYTON BEALE, F.R.C.S.

Amongst the out-patients was a man, æt. about 40, complaining of very marked flat foot. He had suffered from a fracture of the lower end of the fibula about two years previously, and it had been treated at the time with a back and side splints, being subsequently put up in plaster. The present condition showed that the broken ends of the fibula had united forming an obtuse angle outwards, thus causing the typical displacement of the foot. The case had probably been one of Potts' fracture with rupture of the internal lateral ligament of the ankle. Mr. Beale said that he had for long advocated in these cases when it was thought advisable to use a back splint that the footpiece of the splint should be set on the slant in such a way that the foot was kept at right angles to the leg, but at the same time markedly *inverted*. He considered the best splint for cases of Potts' fracture was undoubtedly Dupuytren's, as this, if properly applied, necessitated the foot being strongly *inverted*. In his experience most of the troubles which occurred after fractures of the tibia and fibula were due to neglect of the precaution of putting up the foot in a markedly inverted position. In the present case he suggested that the patient should be admitted to hospital, and the fibula divided close to the seat of the original fracture, the ends would then be levered outwards, the foot at the same time being forcibly inverted, thus leaving a gap between the ends of the fibula. A Dupuytren's splint would be applied for the first fortnight, and then the foot and leg would be put up in plaster, the foot being markedly inverted.

Double Parotid Tumour.

A woman, æt. about 35, complained of an enlargement in front of and below both ears. She stated that she had noticed it first on the right side three years ago, that it was painful, particularly on moving the lower jaw. Shortly afterwards she noticed the swelling on the left side, and both had steadily increased up to the present time. Occasionally, and particularly at menstrual periods there was considerable pain in the parotid region. It was quite obvious that the swellings were enlargements of the parotid glands. At the time the patient presented herself both were rather tender, as her menstrual period was just beginning. The tumours felt hard and adherent to deeper parts, but there was no evidence of enlargement of lymphatic glands or of any cachexia, so it was supposed that the tumours were in all probability myxo-chondromatous. It was suggested that the patient should be admitted and carefully watched, the abdomen being examined in order to ascertain whether there was any enlargement or disease of the ovaries, tubes or uterus. It was fairly common, Mr. Beale pointed out, to find a parotitis in association with ovarian or testicular disease; such parotitis was as a rule subacute to commence with, but might persist in a chronic form for many months, and was sometimes exceedingly difficult to diagnose from a chondroma. Many of the chondromata of the parotid when removed were found to be in part at any rate endotheliomata. He imagined that they started as connective tissue tumours, and developed endotheliomatous characters later on.

TRANSACTIONS OF SOCIETIES.

ROYAL SOCIETY OF MEDICINE.

Obstetrical and Gynæcological Section.

Meeting held May 14th, 1908.

The President, Dr. Herbert Spencer, in the Chair.

Dr. R. H. Paramore read a paper on the

SUPPORTS OF THE FEMALE PELVIC VISCERA,

in which he contended that the supports of the pelvic viscera could not be discovered by anatomical research alone, but that it was necessary to conjointly investigate with the actual living processes. A full abstract of the paper will be found on page 583. In the discussion that followed,

Professor **Paterson** (Liverpool) submitted that a great deal of sound anatomical work had been done in recent years in regard to the mechanical supports of the pelvic viscera. With regard to the means of support of the pelvic viscera, he was inclined to lay little stress on the so-called "intra-abdominal pressure," nor did he ascribe great importance to the power of the pelvic ducts, vessels, and peri-vascular, connective tissue to maintain the viscera in position. There were, however, two series of structures essentially responsible for the maintenance of normal conditions within the pelvic cavity. The structures comprising the pelvic floor formed, in his opinion, the chief factors in supporting the viscera—the symphysis pubis, triangular ligaments and compressor urethræ, perineal body, levatores ani and external sphincters, and the ano-coccygeal body. Any laceration or weakening of these structures would predispose to prolapse of the superimposed viscera. The rectal ampulla, when distended by fæces, is capable of serving as a support for the vagina and uterus. It is the genito-urinary passages—prostatic urethra or vagina and urethra—that are bound down to the pelvic walls and floor in their course to the perinæum. This is effected by means of a special investment of the pelvic fascia (suspensory ligament of the vagina and urethra), which, springing from the sides of the pelvis in the neighbourhood of the ischial spine as a well-defined sickle-shaped fold sweeps inwards to envelop the urethra and vagina, leaving a clear portion of the pelvic cavity behind for the passage of the rectum. This fold of pelvic fascia is very vascular. It separates into two layers, of which one sweeps across the middle line (recto-vaginal layer), and, separating the vagina from the rectum, is attached below to the perineal body. The upper layer has an attachment to the white line, and becomes the lateral true ligament of the bladder. Below the bladder in front it becomes the anterior true ligament of the bladder on each side, and gains attachment to the symphysis pubis. The ligamentum transversale colli of Mackenrodt is probably represented by the free edge of this band of pelvic fascia, which gains attachment to the lateral fornix of the vagina.

Mr. **Arthur Keith** said that his investigations led him to infer that prolapse, partial or complete, of the pelvic viscera is primarily prevented by the action of the musculature of the pelvic floor. It is necessary to distinguish two distinct problems:—(1) The manner in which the uterus is maintained in its normal relationship to the pelvic floor; and (2) the manner in which the uterus is maintained in its normal relationship to the pelvic viscera. It is with the first of these problems with which we are chiefly concerned. At the present time three structures are regarded as normal uterine supports:—(1) The musculature of the pelvic floor; (2) the visceral ligament of the pelvic fascia; (3) the strong perivascular and perineural sheaths which surround the pelvic vessels and nerves. It is not to the perineural and perivascular fibrous supports that the primary duty of supporting the uterus can be ascribed. They serve primarily to safeguard the blood and nerve supply of the uterus. The manner in which a Hodge's pessary supports a uterus which tends to become prolapsed is simply by expanding and keeping expanded and rigid the vagina, whereby the damaged levatores ani which can get no purchase on a flaccid vagina can obtain a hold on and keep up a rigid vagina.

Dr. W. E. **Fothergill** (Manchester) adhered to the views he had previously expressed as to the supports of the pelvic viscera. It required but a slight mental effort to imagine a woman with a perfect levator ani and perinæum, in whom the uterus, vagina and bladder had been completely freed from their attachments and lay loose within the pelvis resting upon the upper surface of the pelvic diaphragm. Did anyone suppose that the organs would remain there for long? The pelvic diaphragm and the sphincter layer of muscles could not prevent the escape of the fœtus or of a mass of fæces. Why should it be supposed that they prevent the escape of the plastic mass formed by the uterus, vagina and bladder? It was obvious that these organs were normally supported by the connective tissue intervening between them and the sides of the pelvis, and the important portion of this connective tissue was that forming the perivascular sheaths.

Dr. **Hastings Tweedy** (Dublin) said that the author had furnished them with anatomical data which clearly showed that strong ligaments crossed the lateral fornices and formed, in Dr. Ovenden's words, "easily defined and striking objects": that they were of themselves capable of supporting the uterus in a normal position; that when they were severed the cervix sagged downward, and this in spite of the fact that all the other uterine ligaments were uninjured. There is convincing proof that these ligaments, when acting normally, keep the cervix tucked upwards and backwards, and when performing this function they are subjected to no greater strain than those which affect other similar structures; as, for instance, liver ligaments. The levator ani muscle is essentially the muscle which keeps the vagina from deformity, and, offering a counter-force to the intra-abdominal pressure, it enables the anteflexed uterus to lie between these forces with little aid from its ligaments. If, however, the cervix descends it is powerless to maintain the uterus in anteflexion, nor can it do so if the uterus has once fallen into retroflexion. A tear in the pubo-coccygeal fibres will inevitably result in the occurrence of cystocele and rectocele, with slow descent of the cervix. He had never seen a procidentia due to childbirth in which the cervix was not torn. His operative experience furnished him with further evidence as to the importance of these ligaments.

Dr. **Briggs** (Liverpool) held, on both anatomical and clinical evidence, that the pelvic viscera were supported by (*a*) the levatores ani, (*b*) their dense lateral pelvic fasciæ, (*c*) the perivascular and other loose cellular tissue. The integrity of the pelvic supports, like the integrity of a joint, did not depend upon ligaments. Fascial structures were purely passive and were maintained or restored by their muscles. The widening of the linea alba during the later months of pregnancy was corrected in vigorous women after labour by the tonicity and subsequent re-approximation of the muscular recti abdominales. Similarly in planning operations in suitable cases of uterine prolapse, Dr. Briggs believed the restoration of the levatores ani and their fasciæ by extensive buried sutures in, under and around the vaginal walls without the removal of any tissues, was still to remain the main aim of the surgeon. The operative treatment of prolapsus uteri rests upon the restoration of the muscular and fascial strata.

Dr. **Alexander Macphail** (Glasgow) remarked that the full and complete contributions of other anatomists to the discussion had left very little of practical value to be added from that point of view. He would emphasise, however, the distinct attachment of the levator ani to the vaginal wall close to the cervix, and the close connection established there with the visceral layer of the pelvic fascia, the latter probably being the more important in the matter of uterine support. It appeared to him that in the course of the discussion a tendency had been shown to wrongfully assign a supporting function to one set of structures to the exclusion of others. The *via media* of attributing this both to the "suspensory fascia" and to the "pelvic diaphragm" seemed to him to be the only sound course from the anatomical point of view. As to the priority of the lesion in these structures in the incidence of prolapse, he had nothing to add from personal observation, nor had he been able to gather a definite conclusion from the experience of others; but it seemed to him that nothing short of the testimony of a watchman in the parametrium at the moment of its occurrence would justify dogmatic statements on the point.

Dr. **Macnaughton-Jones** still believed that there was a combination of forces at work in the pelvis in resisting any downward pressure on the uterus and maintaining it in its normal relation to the other viscera. The chief of these, no doubt, were the pelvic fascia and the levator ani. It was universally acknowledged that the suspension structures in the vault of the pelvis had but little power to prevent prolapse. Still, they played a certain part, and clinical experience, as well as the results of operations on those suspensory structures proved this.

Dr. W. S. A. **Griffith's** view of the levator ani was that it is an auxiliary means for the support of the pelvic organs put into action to resist special strains, while the general pelvic fascia which forms a continuous sheet varying in density in certain positions was the chief support against ordinary conditions of pressure. The injuries produced by childbirth were the great determining cause of prolapse.

Dr. **Inglis Parsons** could not agree that the uterus was maintained in its position by the intra-abdominal pressure with or without the pelvic floor. The other chief factor, according to Dr. Paramore, in holding up the uterus was the pelvic floor. How did he account for those cases where the pelvic floor was ruptured completely, and yet the uterus did not come down? Further than this, complete procidentia sometimes occurred in virgins with an intact pelvic floor. Prolapse did sometimes follow rupture of the perinæum and sometimes did not. The only explanation of this phenomenon was that the ligaments in some women are strong enough to keep up the uterus without assistance, whereas in other cases the ligaments were weaker and could not stand alone, but required the help of the pelvic floor. Without being an egoist, he might point the results of his own operation of injecting the broad ligaments so as to increase the strength of the pelvic band. This operation demonstrated that the uterus could be kept up by even one ligament if it were strong enough. At the same time repair of the pelvic floor did undoubtedly help matters, but was not necessary to success in all cases. In conclusion, he would say:—(1) That the chief factor in supporting the uterus is the connective tissue with elastic and muscular fibres passing from the uterus in various directions to the walls of the pelvis, first described by Savage. (2) That the pelvic floor also helps indirectly to keep up the uterus by preventing prolapse of the vagina. (3) That intra-abdominal pressure does not keep up the uterus, but is the chief factor in causing prolapse.

The **President** (Dr. Herbert Spencer) said that the Section was indebted to the author for his valuable *résumé* of the views held on the supports of the uterus and to the distinguished anatomists who had taken part in the discussion, and who had taken a wider view of the matter than that of Dr. Fothergill at a previous meeting. The truth appeared to be that the supports of the uterus were of a composite character, including atmospheric pressure, muscles, ligaments and fascia. Some confusion, he thought, arose from speaking of the uterus being supported by intra-abdominal pressure; it was rather extra-abdominal or atmospheric pressure, the retentive power of the abdomen of Matthews Duncan. He was rather surprised to hear that the cardinal ligament of Mackenrodt was inserted only into the vagina. His own operative experience led him to believe that it was inserted into the cervix.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of State Medicine.

Meeting held Friday, May 1st, 1908.

The President, Dr. W. R. Dawson, in the Chair.

A PLEA FOR UNIFORMITY IN THE REGISTRATION OF DISEASES IN HOSPITALS.

Mr. Tobin read a short paper on the above subject, said that his object was to suggest a simple means for forwarding what he had set forth in the title of his paper. He enlarged on the excellence of the nomenclature of disease of the Royal College of Physicians, London, and on the small acquaintance with it shown by the bulk of the profession. He proposed as a means for promoting uniformity the putting, in every admission and discharge book, alongside the column for the names of diseases, a column for the numbers given to these diseases, in the nomenclature of disease, and in using, when annual returns were being prepared, these numbers as a means of bringing together the various diseases in their proper order. He handed round forms showing how the system worked. Mr. Tobin's paper will be found on page 582.

Dr. **Kirkpatrick** said the important thing about a classification was that it should be a general one, enabling them to compare the returns of one hospital with another. Under present arrangements such a thing was impossible. Objection might be taken to the classification in the nomenclature of disease. The Royal Army Medical Corps were compelled to make their returns in accordance with the nomenclature, and if a disease were returned which was not in it, the return was sent back to be made out according to the books. This he had heard complained against, as some diseases were not mentioned in the nomenclature, while others were put down under more or less obsolete names. The method, however, was one that could be universally adopted. The difficulty would occur not so much with hospital registrars as with the terms in which the diagnosis would be put down when the patient was discharged. Different names would be used in the diagnosis of the same disease, and there were diseases which were not easy to put in any class. Besides, it was impossible to expect that hospital physicians and surgeons, when diagnosing, to turn up the book to find a number. They would enter the name of the disease, and leave the classifying to the registrar, and difficulty would arise with omissions or differences in the nomenclature. It seemed to him a great pity that, while they had in Dublin a number of hospitals—none with large numbers of beds, but the aggregate considerable —they had no hospital statistics of any great value from the Dublin school. He heartily welcomed Mr. Tobin's suggestion, though he thought his plan would require some modification which might be brought about by a meeting of the Registrars of Hospitals.

Dr. J. **Magee Finny**, speaking as a member of the Board of Superintendence of the Dublin Hospitals, corroborated Mr. Tobin's account of the difficulties they had in getting uniformity in the returns for their annual report. The Board was unanimously in favour of some such step, and although there was room for improvement in the scheme—such as columns for cancerous and tubercular disease, and for the different fevers—the more one thought of it, the more one saw the necessity for adopting some such plan, and he hoped it would extend beyond Ireland.

Dr. **Little** thought the scheme would do as much as any scheme could to get over the inherent difficulties of the subject. They would get cases in which a lesion was clear, but more often in hospitals they would find a patient suffering from a combination of diseases which would require classification under several headings. A vague term might be accurate, and a precise term erroneous.

Dr. **Drury** pointed out the difficulty of registering, according to the nomenclature, in the case of Bilharzia, an example taken at random, which, registered under the scheme proposed, would come under a quite erroneous heading.

Dr. **O'Farrell** instanced the difficulty he had met with in trying to get registration done by the nomenclature, not only as regards classification, but also as to obtaining right diagnosis, previous to his adopting, as Registrar of St. Vincent's Hospital, the plan proposed by Surgeon Tobin.

The **President** said it was clearly impossible to adopt any final system of classification which would be universally agreed to. All that could at present be done was to adopt a working system that would enable statistics to be compared. He could personally appreciate the great advantage of uniform classification. At present they had to squeeze round diseases into square holes, but such was unavoidable in their present state of knowledge, and probably would be for centuries to come. Any system which could be universally adopted would produce better results than the haphazard classifications which had been in vogue.

Mr. **Tobin**, in reply, said the inconsistency shown by Dr. Drury was exceptional. He had not once come across a similar case in his work with the returns. If the subject had been taken up in the past the book would not now be deficient. The difficulty of classification was due to the shortcomings of their pathology. He trusted it would be possible to bring the Registrars of hospitals together to talk the matter over. If they could all work together they would have continuous improvement, and would soon find out the points in which the nomenclature failed.

VITAL STATISTICS OF THE OLD MEN'S ASYLUM.

Dr. **Ledwich** read a paper on the above, in which he stated that during the twenty years he had been physician to the Institution ninety-eight old gentlemen had been under his care. Of these seventy-one had died, twenty-two are still living, and five had resigned. Of the total number who died, five lived to be over ninety years of age, and one to be over one hundred. The records of death only deal with sixty-five cases, because in six cases the notes have been lost. In these sixty-five cases senile degenerations account for 24.6 per cent. of the deaths, while lung diseases are responsible for 15.3 per cent., and apoplexy for 9.2 per cent., an interesting feature of the statistics being that there were only three cases of malignant disease and four cases of enlarged prostate. Another feature of interest was that in the summer of 1891 there occurred an epidemic of contagious skin disease resembling pityriasis rubra; eight of the inmates and three female servants were attacked. He remarked that a similar epidemic took place at the same time in London at the Paddington and Marylebone Infirmaries in December, 1891. He then referred to longevity, and showed an interesting table in which he had recorded the ages, ages of parents, and, where possible, of the grandparents of thirty-seven of the old gentlemen. This table also showed their past habits as to alcohol, tobacco and exercise, and the state of their hearts and blood vessels. On studying the table, Dr. Ledwich said that he was forced to the conclusion that heredity had more to do with longevity than had habits, as nearly all of the men who had lived to a great age could show longevous parents, while many of them had been addicted to the use of alcohol and tobacco in immoderate quantities.

Dr. **Drury** said the statistics were most interesting, as being the result of accurate observation of a clearly defined class, who had lived their lives under somewhat similar conditions as to work and environment.

Dr. **Kirkpatrick** inquired as to whether Dr. Ledwich had found signs to any great extent of atheroma of the arteries, and whether inmates having such a condition died soon. They had been accustomed to regard syphilis as one disease of youth which was most likely to shorten life, and he was, therefore, extremely interested to hear that over 18 per cent. of the inmates had a history of syphilis. Was this history verified by scars? It was also remarkable that so few had died of malignant disease, a fact which was of very considerable importance in view of statements which had been made as to the increase of malignant disease in the country. They had been taught that malignant disease was essentially a disease of the latter half of life; but the majority of patients whom they now saw with malignant disease were probably under fifty.

Dr. **Matson** was anxious to know something of the diet of the patients. He had himself tried to follow out a scheme of diet in a similar institution, but had to give it up, and allow the patients what they liked. His own observations in regard to alcohol and heredity were much the same as Dr. Ledwich's.

Dr. **Ledwich**, in reply, said he would add the statistics regarding the blood vessels to his table. He had great difficulty in obtaining information about syphilis, and had not examined for scars. The inmates got meat once a day. Alcohol was stopped on admission to the asylum, and he had never found any harm from the sudden stoppage.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

The President, Dr. **James Ritchie**, in the Chair

A CLINICAL meeting, illustrative of the subject of
DERMATOLOGY,
was held in the Royal Infirmary on May 20th, 1908.

Dr. **Norman Walker** gave a *résumé* of the work of the Skin Department of the Infirmary for the last 16 months, with special reference to groups of interesting cases and to those subjects at present attracting attention. He prefaced his remarks by saying that he had recently adopted the system of card indexing all the cases, and that in this way statistical inquiries were facilitated. In Edinburgh, however, where skin cases underwent a process of sifting at various dispensaries before they came to the Infirmary, he thought that in the latter institution there must therefore be an undue proportion of the rarer forms of skin disease. Taking up the diseases to which he wished particularly to call attention, he first alluded to alopecia areata. It appeared to be about twice as frequent relatively to the total number of patients seen as in either London or Glasgow. Without pressing the argument, he thought that this supported the view (which he held) that the disease was infectious. Favus was next referred to. It was notoriously common in Edinburgh, but he doubted whether many of his audience realised that he could have, had he wished, collected 60 cases to show. He spoke strongly of the serious state of things this represented. In private practice, as was well known, favus could be cured readily enough. Among the poor, however, it was frequently incurable. The reason for this was simply that the patients would not, and that there existed no means of compelling them to, attend regularly. In consequence these children suffered from a disfiguring malady, their education was utterly neglected, and their future careers blighted. If means could be found to enforce the attendance of such children until a cure was effected, favus could easily be stamped out. Impetigo contagiosa showed a definite epidemicity among the cases. In some months (not the same each year) the disease was much more common than in others. Herpes zoster also showed a similar incidence. Lupus erythematosus was held by many authorities, particularly in France, to be tuberculous in origin. It was not alleged that the lesion was due to a local tuberculosis, but that it was caused by the toxins of tubercle bacillus located in a distant focus. Certain post-mortem examinations had cast doubt on this, and Dr. Walker had investigated the point by the use of Pirquet's cutaneous reaction. He had only one positive result among several cases of the disease. This he thought was strongly against the idea that it was tuberculous. He protested against the indiscriminate use of the Calmette reaction, as one patient on whom he had tried it had almost lost the sight of one eye. Speaking of lupus vulgaris, he thought that not the least of the benefits of the introduction of the X-ray and light treatment was that from them we had learned the importance of patient, prolonged, and persevering treatment. He showed a number of cases which were practically cured as the result of years of treatment. The London Hospital lamp had been tried, but was not very serviceable. He regarded the persevering application of oleate of mercury as occupying nearly as high a place in the therapeutics of lupus as the X-rays themselves. He had been struck by the number of times he had observed epithelioma develop in the course of the X-ray treatment of the disease. Several cases were shown illustrative of this. Excision had been employed in one case affecting the face, but there had been extensive recurrence. In other cases he had obtained a cure by scraping and the application of caustics. Potassa fusa, arsenious paste, and chromic acid were the caustics used. The second was undoubtedly highly efficient, its disadvantage being that it was extremely painful, which prevented its application being continued. Patients required to be kept under morphia when it was used. Whatever the relation of the cancer to the X-rays was, he thought it ought to be looked out for, and though it did not necessarily mean that the rays must be discontinued, it certainly was wrong, in his opinion, to say that if epithelioma developed, larger doses of the rays were indicated. Molluscum contagiosum was not a very common disease in his series. He had noted, however, among the cases a group of five patients who had all been in the habit of frequenting the same public bath. Acne rosaceæ was commonly ascribed to digestive disorder; he was able to say that this was relatively rare in his cases. He showed a patient suffering from the disease associated with seborrhœa, and he believed that there was a connection between the two disorders. With regard to ringworm, they had not found that the X-ray treatment gave such precise results as in Paris. Cases of ringworm of the nails were shown, and it was remarked upon as worthy of note that, although in some of these the disease had lasted for months, and although the organism was the large spored trichophyton (the same which causes tinea circinata), no instance of infection of the skin from the nails had been met with. Turning, in conclusion, to the general question of vaccine therapy, Dr. Walker showed a severe case of sycosis which had been quickly cured by vaccinations with his own staphylococci. In lupus, if tuberculin were to be of any practical use it must be given in some way which did not necessitate the estimation of the opsonic index. His practice was to give 1-1,500 mg. of tuberculin every fourth week, and he was satisfied with it as an adjuvant to local treatment. Dr. Walker also showed a case of actinomycosis cured by large doses of iodide.

Dr. **Gardiner** showed a somewhat unusual case of erythema multiforme, which in some respects resembled a dry eruption; (2) a patient after a recurrence of ringworm of the scalp. In the first attack the small spored fungus, on this the large spored fungus, had been found.

Dr. **Cranston Low** showed a patient who now suffered from pemphigus foliaceous, and who had previously been under treatment for dermatitis herpetiforme. Such a sequence of events had been described in other instances, and whether the condition be named as dermatitis herpetiforme or pemphigus foliaceous, it was a well-defined clinical entity. The patient was receiving vaccines of an organism cultivated from the vesicles. He also showed a commencing case of actinomycosis fungoides.

Dr. Low showed (for Mr. Miles) a patient with unusually well marked rupia.

Dr. J. S. Fowler showed an infant suffering from urticaria pigmentosa. The case was quite characteristic: the eruption dated from the sixth week, and was distributed all over the trunk and limbs. Factitious urticaria could be readily produced, and when the eruption was irritated the pigmented spots took on temporarily the appearance of wheals. Histologically the essential feature of the lesion was a deposit of mast cells.

Mr. Wade showed specimens of hyperkeratosis plantaris and of mycetoma.

A demonstration of casts, photographs, etc., was also given in connection with the meeting.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

Meeting held Friday, May 8th, 1908.

Dr. William Ewart in the Chair.

The Chairman read a paper on the "empty bronchus" treatment by posture in the bronchiectasis of children. His paper was devoted mainly to the management in children of the postural and respiratory aspects of the treatment, which was likely to be successful in proportion to its early adoption. He said that continuity of treatment was essential. The bronchus must be kept empty and the lung must be kept active for a nocturnal as well as diurnal treatment. The costo-abdominal elastic belts worn continuously stimulated the thoracic respiratory mechanism as well as abdominal. In the continuous postural method introduced by him, the declining of the bronchial and tracheal outlet was provided by the inclination of the bed during the night and during intervals of resting in the day.

Dr. Philip G. Lee (Cork) reported the following case for diagnosis:—The patient was a strong and healthy child of two years and six months. Four weeks previously she had marked wry neck, but otherwise was perfectly well. A week later she had extreme retraction of the neck. While on her way to see him she fell, and when he saw her both legs were paralysed. Four days later she had three convulsions, and the retraction of the neck completely disappeared. Subsequently the calf muscles wasted with the reaction of degeneration. There was no paralysis of the bladder or rectum. The peculiar features of the case were the nature of the onset, and the entire absence of fever and malaise.

Dr. O. K. Williamson showed a case of aortic and mitral stenosis.

Mr. Hugh Lett showed:—(1) A case of supernumerary digits on hands and feet in a baby, two months old. A similar condition was exhibited in the mother and a brother of the patient. (2) A girl, æt. 10, with forward dislocation of the inner end of the clavicle. (3) A case of multiple ecchondroses in a boy, æt. 9. The ecchondroses were extremely numerous, and were present not only on the long bones, but on the scapulæ, ribs and skull. (4) A child, aged 15 months, with hydrocephalus, genu recurvatum, and talipes valgus.

Dr. Porter Parkinson showed a case of abdominal tumour.

Mr. Russell Howard showed specimens of:—(1) Achondroplasia; (2) An anencephalic fœtus; (3) Intra-uterine amputations.

For the week ending May 16th there was not one death registered for the whole district of Penge and Anerley, which has a population of 23,918.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting held Friday, May 15th, 1908.

The President, Dr. A. J. Wallace (Liverpool) in the Chair.

Mr. R. Favell (Sheffield) exhibited a specimen of fibroma of the ovary successfully removed by abdominal section from a patient, æt. 25, who had complained of abdominal pain for three years. Menstruation was regular, of the 28-day type, and lasted 3 days. The tumour was of the diffuse variety, undergoing cystic degeneration, and microscopically proved to be a pure fibroma. There was no ascites. Mr. Favell also recorded a case of Cæsarean section performed on account of labour obstructed by ovarian cyst. The patient was vi-para, æt. 39, previous labours having been normal. Labour pains commenced at 9.30 a.m. on January 9th, and the membranes ruptured at 5.30 the same evening. She was admitted to hospital at 11.30 p.m. As the pains were so frequent and severe it was decided to perform Cæsarean section, together with the removal of the tumour, rather than vaginal ovariotomy. This was accordingly done, and recovery was uneventful.

Dr. Hellier (Leeds) related a case of cornual gestation in one horn of a bicornuate uterus, in which rupture was attributable to a blow. (This will be found on page 583 of our present issue.)

Dr. Lloyd Roberts (Manchester) communicated a case and showed the specimen of epithelioma of the left labium majus, recurring in a woman, æt. 45, eighteen months after the removal of the clitoris and right labium majus for a similar growth. Complete relief followed for twelve months, when a painful nodule appeared on the left side. It did not seem to be a direct extension from the original growth, as healthy tissue intervened between it and the scar. No glandular infection was found. The growth was widely excised. The chief feature of interest lay in the possibility of the second growth being due to direct contact and infection from that in the right labium.

Dr. Croft (Leeds) mentioned a case of Dr. Walter Thompson's of the pyelo-nephritis of pregnancy in a primiparous patient, æt. 26. Persistent vomiting, abdominal pain and pyuria, with severe febrile disturbance, were present, and it was deemed advisable to terminate the pregnancy at the sixth month. The membranes were punctured, and, following the delivery, all the symptoms subsided, and the pyuria was gradually disappearing.

CENTRAL MIDWIVES BOARD.

Meeting held Thursday, May 21st, 1908.

The President, Dr. Champneys, in the Chair.

Before passing on to the usual business of the meeting, the Chairman briefly alluded, in terms of deep regret, to the recent death of Dr. Cullingworth, mentioning the fact that he was one of the first members of the Board, on which he represented the Midwives Institute from November, 1902 to March, 1905. During the early days of its existence the work of the Board was extremely arduous, and beset with many difficulties, but Dr. Cullingworth never spared himself any trouble. As a colleague he was always generous, fair and most courteous, and in all differences of opinion he showed a loyal public spirit and the spirit of self-sacrifice. After March, 1905, ill-health prevented his accepting re-election, and the Board unanimously passed a resolution of sincere regret for his loss, and desired to place on record their deep sense of the great services he had rendered to it. Several other members of the Board endorsed the Chairman's sentiments, and a resolution was unanimously passed to the effect that the Chairman should write to Mrs. Cullingworth and convey to her the Board's deep sympathy with her, and their deep regret for her and their own loss.

Princess Christian had applied for recognition as a training school for her Maternity Home at Windsor, which trains four pupils per annum, giving them six months' training. After some discussion, the resolution "that the application be granted" was passed *nem. con.*

In the report of the Standing Committee a letter was dealt with from the General Secretary of the British Medical Association as to the question of bringing to the notice of midwives the importance of the earlier recognition of uterine cancer. It was agreed that the General Secretary of the British Medical Association be thanked for his letter, and that he be informed that the Board has already had the subject under its consideration, and proposes to send a leaflet on the subject, prepared by the Chairman at the request of the Board, to teachers and local supervising authorities for distribution among midwives. With reference to a letter from the Clerk of the Worcestershire County Council respecting deaths of infants from pemphigus, it was decided that he be thanked for his letter, and informed that the Board considers that the sanitary officers should be encouraged to prosecute further inquiries into this interesting and important epidemic should the opportunity occur.

In reply to a letter from the Under-Secretary for Ireland as to providing facilities for the examination in Ireland of candidates for the Central Midwives Board certificate, it was decided that the Under-Secretary be referred to the following resolution passed by the Board on January 31st, 1907:—"That the Board realises the difficulties of an extension of the Midwives Act, 1902, to Ireland, but would look with favour on a new Act for Ireland framed on the lines of the present Act."

The Penal Cases Committee reported some 30 women to be cited to appear before the Board on various charges. Their cases will be heard at the C.M.B. on July 9th and 10th. Several convictions of midwives were reported, one being for failure to notify births of children under the new Act. It was remarked that this was the first conviction for this offence.

In receiving the report of the Finance Committee, the Chairman remarked that the time was coming when the Board would have to look for subsidies. The Secretary's report on the April examination showed a total of 298 candidates, of whom 234 were successful in passing the examination, making the percentage of failures 21.5.

The following resolutions, put forward by Mr. Fordham, were carried without opposition:—(1) That it is desirable that an annual report of the proceedings of the Board should in future be prepared and presented to the Privy Council, with a view to its issue as a public document. (2) That, in the meantime, a summary of the proceedings of the Board for the five years ending March 31st last be prepared. (3) That the Privy Council be approached in order to obtain their assent to these arrangements.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD

FRANCE.

Paris, May 24th, 1908.

Injections of Gray Oil.

From time to time cases of mercurial poisoning, due to injections of gray oil, are published, but in reality these injections present no danger if care is taken to observe the rules which should govern this intensive treatment of syphilis. Account should be taken of the condition of the patient before and during the treatment. The majority of practitioners, says Prof. Queyral, neglect to examine the urine of their patients before commencing the treatment; this examination is, however, very necessary, for if albumin is detected insoluble preparations of mercury should not be employed. An examination should also be made of the condition of the teeth and gums, and if their condition is defective they should be treated before having recourse to injections of gray oil.

Further, the patient should be enjoined to pay particular attention to the mouth by using a gargle of chlorate of potash after each meal, to abstain from spiced foods or sauces; and, above all, from alcohol and tobacco, the two great enemies of syphilis. During the course of the treatment the condition of the gums should be examined before each injection, and where they appear slightly swollen or spongy the injection should be adjourned to the following week. The injections should also be suspended if the preceding injection produced induration, for there lies the danger of stomatitis. The induration contains a large quantity of mercury, which may be eliminated at any moment, and if one or more injections were made at the same point a toxic dose would be the result.

The needle, an inch and a-half in length, should be inserted into the muscular mass, about two fingers' breadth above the great trochanter, and care should be taken that no blood comes out of the needle, so as not to expose the patient to the inconvenience of fatty embolus, etc.

As to the quantity of gray oil to be injected each time, the dose should not exceed 1 grain of mercury at the beginning, but this dose might be gradually increased to 2 grains if the patient supports it. A series of 8 injections, covering two months' treatment, should be separated from another series by six weeks or two months.

Polyarthritis Deformans.

Polyarthritis deformans is a malady of nutrition into which enter several pathological elements. In the majority of patients there exists an anterior infection due to gastric fermentations and retention of toxic products. The phenomena of this rheumatism consist in rarefaction and progressive decalcification of the bones. An increase of phosphates, lime and magnesia salts, as well as chlorides, is observed in the urine, while examination of the blood shows a slight decrease of hæmoglobin.

Up to recently, the treatment of this affection was more or less empiric, and consequently uncertain in its results. All kinds of drugs have been tried, and generally without success. Tincture of iodine, however, as recommended by Lasègue and Trousseau, produces an attenuation of the suffering on the condition that it is given in large doses (10 to 60 drops daily).

Unfortunately, the stomach can ill bear this treatment. Arseniate of soda has been prescribed in the form of Fowler's solution, and Guéneau de Mussy employed arsenical baths (2 dr. with 5 oz. of bicarbonate of soda). Salicylate of soda and aspirine, this latter especially, alleviate the painful phenomena, but iodide of potassium, salol trinitrine, cod-liver oil, etc., are of little or no value. The practitioner, says Prof. Robin, will derive more benefit from employment of a treatment addressed to the different therapeutic indications.

If there are gastric fermentations, a severe alimentary *régime* will be prescribed, with antiseptics appropriate to the different ferments. In case of lactic fermentation:—

Fluoride of ammonium, 4 gr.
Water, 10 oz.

A tablespoonful during dinner and supper.

For butyric fermentation:—

Iodide of bismuth (erythrol), 1 gr.
Carbonate of lime, 4 gr.

For one wafer, to be taken during the repast. An excess of HCl is best treated by suppression of animal food, and

Bicarb. of soda, 1 dr.
Phosphate of soda, ½ dr.
Sulphate of soda, 10 gr.

For one powder dissolved in a pint of water, of which a Bordeaux glass is taken on rising in the morning, another at 11 o'clock, at 4.30, and at 9.30 in the evening. Besides, the patient will take an absorbent powder (prepared chalk, calcined magnesia, bicarbonate of soda) after each meal, while the use of table salt will be diminished.

After three weeks of this *régime*, the gastric functions will be about re-established, when stimulating treatment may be adopted. The patient will be given preparations of strychnine, hypophosphites, glycerophosphates, while small igni-punctures might be made twice a week along the vertebral column.

Hypophosphites exercise a special action on the osseous nutrition:—

Hypophosphite of lime,
,, ,, soda, } 10 gr.
,, ,, potash,
,, ,, magnesia,
,, ,, quinine, } 2 gr.
,, ,, of iron,
,, ,, strychnine, ½ gr
Arseniate of soda, 1/5 gr.
Tincture of rhubarb co., 2 dr.
Water, 5 oz.

A tablespoonful at each meal (2).

The glycerophosphates may be given subcutaneously, or in a mixture:—

Glycerophosphate of lime, 1 dr.
,, ,, soda,
,, ,, magnesia, } 15 gr.
,, ,, potash,
,, ,, iron, 10 gr.
Tincture of nux vomica, 10 drops.
Pepsine, ½ dr.
Maltine, 15 gr.
Ext. of kola, 1 dr.
Syrup of orange, 6 oz.

A tablespoonful at each meal.

At the end of a month of this treatment, iodide of potassium with arsenic might be tried:—

Iodide of potassium, 1 dr.
Arseniate of soda, 1 gr.
Water, 10 oz.

Two tablespoonsful daily.

The local treatment is addressed to stimulation of the osseous nutrition, and to check the muscular atrophy accompanying this affection, massage after a sulphur bath of half an hour meets this end.

The bath is composed thus:—

Monosulphide of sodium, 1½ oz.
Chloride of sodium, 3 oz.
Sub.-carb. of soda, 3 oz.
Gelatine, 2 oz.

Gentle active and passive movements may be practised morning and evening. Electricity is daily employed—Faradic currents for muscular atrophy, galvanic currents for pains and as a modificator of osseous nutrition. Baths of heated air (248°) have given relief, while baths of turpentine vapours are appreciated by the patients. Painful attacks may be relieved sometimes by aspirine (10 gr. four or six times a day), pyramidon (6 gr. two or three times a day), or Dover's powder (6 or 8 gr. at night).

Hydro-mineral treatment comprises the thermal waters of La Bourboule, Archambault, Bourbonne-les-Bains or Barèges. Mud baths might be recommended after a season at one of the preceding places. They are found at Dax and Saint Amand.

GERMANY.

Berlin, May 24th, 1908.

RENAL DIABETES.

IN connection with the paper on this subject by Hr. Böllinger, read before the Verein für innere Medizin on March 16th, Hr. Lepine, of Lyons, sent a communication of which a German translation was read to the society by Dr. Magnus Levy, the purport of which was a reminder that M. Lepine had published a communication on the same subject more than two years ago. "I am," he continued, "the more time elapses the more firmly convinced that the sugar in the blood, in opposition to the view of Ascher, exists in a more or less firm combination. My dialysis experiments are in favour of this. The various kinds of glycosuria, without glycæmia, would then be explainable by an absence of that combination. Up to the present no fact is known that speaks for an increased permeability of the kidney for sugar. On the contrary all the labours of myself and Boulud on virtual blood sugar show that the blood sugar under certain circumstances readily becomes free from its combinations.

"That happens for example under physiological conditions in the capillaries of the lungs; it happens in the capillaries of the kidney in the phloridzin dog, and also in other capillary circles; by this is explained the hyperglycæmia that takes place occasionally in certain animals in phloridzin poisoning.

"Like Hr. Böllinger I hold the separation of the blood sugar into that of the plasma and that of the blood corpuscles as very useful."

Hr. A. Plehn then showed a case of

PROGRESSIVE MUSCULAR ATROPHY.

The patient was a workman, æt. 48, about whose family history nothing could be learned. It appeared, however, that his work had always been laborious, and for years he had worked in water in the sewers. He had also carried very heavy weights, for which he had always used the left shoulder. For the last eight or ten years he had suffered from pains in the back and shoulders, and he had noticed a loss of power, and also that the muscles in both upper arms had been getting smaller. Notwithstanding this he was able to continue his heavy employment in a cement works until last December, since then he had not been able, and he sought relief in the hospital for pains and weakness in the arms and back.

In looking at the man the first thing noticed was the falling away of the shoulder blades from paralysis of the serratus. It was excessive, for not only was the serratus anticus almost completely atrophied, but the trapezius up to the upper part and the rhomboideus major. The latissimus dorsi was also affected, and the lower muscles of the back so that it was difficult for the man to straighten himself up. The supra- and infra-spinatus were mostly retained, as was also the levator scapulæ. The triceps and biceps, the brachialis anticus, and the coraco brachialis had mostly disappeared, but on the other hand the muscles of the lower arm had retained their power. The appearance of the deltoid was remarkable; the shoulder portion was atrophied, the arm portion was retained, and if anything, seemed to be rather hypertrophied.

The electrical excitability was in parts completely extinguished, in others very much diminished. The parts of the muscles in which irritability was retained gave slow twitchings to strong direct Faradic currents. There were fibrillary twitchings in the parts in which the retention was partial.

The case was one therefore of complete bilateral atrophy of the region of the nervus accessorius and of certain branches of the brachial plexus. The question now was whether the affection was primarily myogenous or spinal. The speaker believed the lesion to be chiefly a spinal one, a degeneration of the anterior cornu of the cervical cord in the sense of Duchenne-Aran. He thought this from the strikingly equable distribution in the corresponding nerve regions of both sides.

Hr. Cassierer thought the case was one of myogenous dystrophia; atrophy and hypertrophy were present together.

Hr. Rosenstein remarked that such cases were not hopeless from the point of view of treatment. He had seen a similar case in which V. Eiselsberg obtained good function by suturing the two scapulæ together.

Hr. Karewski knew the case referred to; he had had to have the scapulæ separated again on account of the great trouble caused by their being united.

Hr. Plehn, in reply, acknowledged that the nature of the lesion was still uncertain. He was not sure about the hypertrophy of the deltoid. He had seen no change of the facial musculature, although he had looked for it carefully. Oppenheim had also remarked that there were atypical cases that united the symptoms of both diseases. For that reason the case shown was one of interest.

AUSTRIA.

Vienna, May 24th, 1908.

Cysticerci in the Brain.

Falta, at the Gesellschaft, produced a male patient, æt. 58, with cysticerci in the brain. Their presence was diagnosed by the burrows in the skin resembling tubercles or peas on the surface, and which, when carefully examined with a lens, were found to contain the cysticercus. According to the history, the patient suddenly lost the power of speech, the right angle of the mouth had an inclination to fall backwards, while the fingers of the right hand were void of feeling. At a later period convulsive movements of the facial muscles, vertigo and cephalalgia set in. Shortly before exhibition he had had a severe fit.

"Ultra-Konien."

Neumann and Kreidl reported their work of investigating this peculiar constituent of animal milk that does not exist in the healthy human fluid. These researches found it in the mare, elephant, goat and rat. They confirmed its absence in the human subject. On a former occasion this ultra-constituent was discovered in the cat and dog, which excited considerable curiosity, and a strong desire was expressed that further investigation should be made to discover the cause of dissimilarity between animal and human milk. Neumann and Kreidl now affirm that the fine particles present in animal milk and not human are casein, not soluble in ether, but dissolving easily in pepsin and pancreatin, and coagulating with rennet and acids. This is an important explanation of the fact that all the supposed fat of cows' milk will not dissolve in ether. If this so-called fat, however, be dissolved in lye, ether can then be used as a solvent. From these results they consider this ultra-constituent to be a "haptogenic membrane." These ultra-particles must be distinguished from the ordinary coagulation of the milk. By ultra-microscopic examination, the coagulation with rennet or acids will be observed to have fallen in flakes, as distinguished from the fine particles under consideration. The best rennet coagulation is done with 10 cubic centimetres of a 1/10 per cent. acid solution in 100 c.c. of milk; other substances with heat may do the same, and the particles obtained by shaking with either. Escherich thought this was important in the distinction of human milk versus animal milk.

Myasthenia.

Flesch presented a case of sudden myasthenia, which came on four years ago, producing right-sided lagophthalmos and left-sided ptosis with paralysis of the uvula. These symptoms seemed to improve gradually up to nine months ago, when diplopia appeared, which, two months later was followed by double-sided ptosis and general debility, the latter disappearing gradually, but the ptosis still continues. This debility or general malaise is characteristic of the disease, and by repetition of this enfeeblement the patient is reduced to the condition of having to recline when taking food. The Faradisation showed strong muscular contractions at first, which gradually die off until finally no movement can be produced. He also showed a young man, æt. 23, with paralysis in ocular co-ordination where both of the interni muscles were involved. He had double vision, both objects lying in the median line, but somewhat apart and crossed. The converging movement of the eye is impossible, but the pupil still reacted to light.

Atypical Tabes.

Strasser showed a male patient, æt. 50, who, 30 years ago, contracted syphilis, and 10 years ago had the first symptoms of polyneuritis, associated with endocarditis, after a severe injury. The tabes did not appear till five years ago, and greatly improved after a few mercurial inunctions. A little later, however, he was seized with emotional disturbance, anuria, and complete paralysis of the extremities, while sensibility and temperature disturbance was very little affected. In the course of a few days progressive atrophy and degeneration of the paralysed muscles were observed. Hydrotherapy and electric treatment were vigorously pursued with beneficial results; the movement of the muscles soon returned and their volume rapidly increased.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

The Secretary for War on a Territorial Army Nursing Reserve.—During a visit to Edinburgh on May 21st the Right Honourable R. B. Haldane, M.P., Secretary of State for War, attended a gathering of nurses in the Royal Infirmary, and presented the prizes to those who had been successful in the examinations. Mr. Haldane was accompanied by Miss E. S. Haldane, and among others present were the Lord Provost, Lord Salvesen, Mr. Geo. Berry, Sir Halliday Croom, Professors Wyllie and Greenfield, Drs. Barbour, Bramwell, Macgillivray, Haig Ferguson, and Playfair, and Messrs. Dowden, Alexis Thomson, Cotterill, and Stuart, and a number of other members of the staff. After the formal ceremony was finished, Mr. Haldane expressed the interest he felt in the training and work of those who were present. An infirmary was only possible on the basis of a very high kind of organisation, and a kind of organisation which could only be real when it was based on high science. To his mind, organisation based on science was one of the most necessary needs of the country, and any institution which presented an example of it was of value to the State far beyond its own particular department. Speaking of the advances in the nursing profession, he said that there was little in common between the old and new generation of nurses, except the name. In the old days people looked to the physician and surgeon, and to them only; the nurses came in nobody knew exactly where. To-day the work of the physician and surgeon was divided; the health of the patient and his restoration to health was largely left to nurses. More and more were nurses being called upon to intervene in the affairs of State and of public life; they were wanted for the business of local self-government, not to care merely for the sick, but for the study of those who came near the sick—the poor. They were wanted in great hospitals, in private life, and in country districts. The demand was now so great that the supply was hardly adequate. He had been very busy trying to fashion out a comprehensive organisation for the country for national defence. That meant organisation for war, and organisation in peace which was based on preparation for war. He had had to survey the whole field, and in the process of building up he came to a point where the work of Army surgeons and Army nurses became vital, and where further organisation was necessary. So remarkable had been the progress in Army medical work that they had been able to reduce the provision which they had to make for the sick and wounded by a considerable percentage. They had been able to make far better provision, which presented them with a smaller percentage of men who required to be deducted from the fighting force. That is, they were able to restore people to work more quickly than under the old conditions. They had created a reserve of nurses—those who had engaged with the State to go to the theatre of war, and there do their part in the organisation for the treatment of the sick. This had been carried out so far as the regular forces were concerned. As regards the second line, or home defence—the Territorial or Home Army—he hoped before long to see in operation an organisation of Territorial Army nurses, who would take the same part in home defence as would be taken by their sisters who went abroad with the troops. These things showed them what a far-reaching profession theirs was—he knew of none which had more scope than the profession of the highly-trained nurse.

New Fever Hospital for Dumfriesshire.—This new hospital, situated about half a mile from Lochmaben, was formally opened on May 16th, by Lady Buchanan Jardine, of Castlenuek. It consists of an administrative block with kitchen annexe, providing quarters for a matron and eight nurses. There are three pavilions of corrugated iron for scarlet fever, typhoid, and diphtheria, and two observation wards. Accommodation is provided for 28 patients, being one per 813 of the population of the district.

Dr. Leslie, on behalf of the Local Government Board, spoke very highly of the planning of the hospital.

THE FELLOWSHIP OF THE ROYAL COLLEGE OF SURGEONS.—At a meeting of the College held on the 18th inst., the following gentlemen were elected Fellows :— Leo F. Bianchi, L.R.C.S.E., M.R.C.P.E., D.P.H., Edin.; Walter H. O. Garde, L.R.C.S.E., Staff Surgeon, Royal Navy; John L. Gilks, M.R.C.S., Eng.; Dirk J. H. Hamman, M.B., Ch.B., Cape Colony; William C. Horton, M.B., Ch.B., Birmingham; John Jardine, M.B., Ch.B., D.P.D., Penicuik; James B. Lockerbie, M.B., Ch.B., Dumfries; George Ross, M.B., M.R.C.S., Eng., Melbourne; Charles W. Smith, M.B., L.S.A., Sheffield; and Raymond H. Swindells, M.B., Ch.B., Fairfield.

THE BATHGATE MEDAL.—The medal and set of books presented to the College by Colonel William Lorimer McPhune Bathgate, F.R.C.S.E., Lecturer on Materia Medica in the Extra Academical School, was awarded, after the usual competitive written examination in Materia Medica, etc., to Miss Lucy Mary Muir, 12, Buccleuch Place, Edinburgh.

BELFAST.

THE IRISH UNIVERSITIES BILL.—This Bill has been discussed at several public meetings in Belfast during the past week, and as a general result one may say that, while certain extreme parties maintain their first strong opposition to all that Mr. Birrell offers, there is, on the whole, a tendency to a more reasonable attitude in many quarters. It is seen that, as far as Parliament is concerned, the opposition to the Bill is almost negligible, and many who at first objected to it from a deep-rooted objection to anything that looked like sectarian education, are now inclined to accept the Bill as the best way out of a difficult situation, and concentrate their energies on obtaining such amendments as they think would improve it. The first meeting of the week was that of the so-called Royal University Graduates' Association, which is really only an association of those who are opposed to a Belfast University. In spite of great efforts to raise a meeting, the attendance was very small, and, as far as the medical profession went, representative men were conspicuous by their absence, the Chairman and Secretary, Drs. John Campbell and R. W. Leslie being the only hospital men present out of some forty or fifty holding hospital appointments in the city. Several lawyers and a number of clergymen were present, and took part. They were brought there to curse, and curse they did with a hearty goodwill. There were, however, no new arguments against the Bill. Perhaps the most interesting remark was that of Mr. R. J. McMordie, who is reported to have said that three men had been marked out for knighthoods, apparently as a reward for supporting Mr. Birrell!

The Ulster Liberal Unionist Association, which includes a large number of influential business men, held a largely attended meeting in the Ulster Reform Club on the 22nd inst. After reaffirming their objection to any form of sectarian education, they proceeded to advocate certain amendments in the Bill. These are:—(1) The appointment of all officers and professors by the Crown. (2) The admission of affiliated colleges only by the decision of Parliament. (3) The continuance of the present form of declaration made by professors in the Queen's Colleges, promising not to interfere with the religious opinions of any of their pupils. (4) That the charters of the new Universities should be fully discussed by Parliament before being presented to his Majesty for signature. Probably these amendments would be generally acceptable in Belfast, though it is very doubtful if some of them would be received with favour in Dublin.

The Ulster Unionist Council met in Belfast on the 22nd inst., and passed a resolution approving the action of the Ulster Unionist members in opposing the Bill, and "strongly urging them to press for such amendments in committee as will remove from the Bill all provisions which are at variance with the principles of religious equality and freedom from ecclesiastical control."

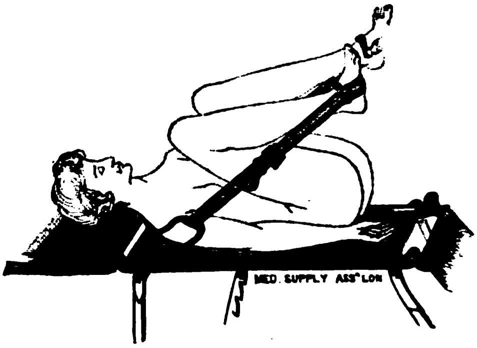
PUBLIC HEALTH.—In the report of the Belfast Health Commission, lately published, the chief cause of the prevalence of typhoid in the city was suggested to be the consumption of contaminated shellfish, especially cockles, from the shores of Belfast Lough. Professor Symmers has, consequently, been making further examinations of these at the Bacteriological Laboratory at Queen's College, and he reports that every specimen examined was unwholesome, most of them swarming with colon and allied bacilli, undoubtedly derived from the sewage discharged into the Lough. Active measures are now being taken to prevent the sale of these cockles in the city. Large quantities are exported. It is said that they are used for bait in the North Sea, but their destination is being carefully watched. In medical circles the general opinion is that the report attaches too great importance to this source of infection, for though it is undoubtedly one source, it is far from being the only one. Numbers of cases of typhoid occur among the better classes of the city, who never see the cockles, and some less obvious cause must be sought to explain these cases.

LETTERS TO THE EDITOR.

CLOVER'S CRUTCH SUPERSEDED.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The accompanying illustration represents a simple plan for obtaining the lithotomy position, more especially in private practice, the strain on the shoulders being equable and the rubber-covered collar being more comfortable than the strap; the appliance is light and portable, and can be carried in any surgeon's carriage. When adjusted the patient is not attached in any way to table, or couch, an obvious advantage, and the cross-bar or crutch dispensed with altogether.



The appliance has been suggested by me, and neatly made by the Medical Supply Association, of 228 and 230 Gray's Inn Road, London.

I am, Sir, yours truly,
ALEXANDER DUKE.

London, W.
May 25th, 1908.

CHARGES IN NURSING HOMES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some months back a letter appeared in your columns on the above subject. It would be most interesting to hear the experiences of other medical men in this direction. A recent incident has forced the question upon my attention in a most unpleasant way. A patient had a little boy at school in a medium-sized town on the upper reaches of the Thames. One day she was informed by telegram that the child had been taken with measles. On going to the school she was told the boy must be removed, and she accordingly took him to a nursing home in the neighbourhood. She was charged four guineas a week for the boy, a small mite nine years of age, two guineas a week for the special nursing of an infectious case, with extras of every conceivable kind, and a fee for disinfecting everything at the end of the stay. All this seems excessive for the medical care of a small boy in what is, after all, not a serious condition if properly nursed.

In any case why should not medical men co-operate and have their own nursing homes under their own management, where patients could be well looked after at fair charges. It should not be beyond the art of our professional brethren to organise a service of this kind, especially away from the neighbourhoods where rents are costly. At present the patient has often to pay so much for the nursing home that there is no money left for the medical attendant. It is the old story of everyone making money out of the patient except the man whose services are absolutely essential. It seems to me that the matter is one that might most advantageously be received in the columns of your valuable journal.

I am, Sir, yours truly,

R. Clark.

May 22nd, 1908.

THE POPULATION QUESTION.

To the Editor of The Medical Press and Circular.

Sir,—Your correspondent "A Student in Sociology" has once more broached a stupendous question. It would demand an essay to deal fully with it. It needs forcing upon the attention of the people and their leaders. It, unfortunately, cannot be discussed freely in public, on the platform, in the pulpit, or through the newspaper press, and you are conferring a benefit by generously opening your columns to it on this occasion. It is quite evident that the British Empire will not endure unless these islands possess an exuberant population of the highest physical and moral quality. We shall be in time swamped by weight of numbers if we do not increase with due rapidity; whilst it is to me tolerably evident that artificial restriction of fecundity as now practised must lead to degeneration. It is a system of artificial selection calculated to favour the survival of the unfit. This is the effect it is producing in France. It matters not how unfit, physically and mentally, the first-born children may be, the marriage of the one or two girls is ensured among the well-to-do and wealthy classes by provision of a fortune suitable to their rank. The boy in the same way is provided for, and he is enabled to marry in due course. If the family were numerous it is evident that those most fitted for matrimony would, as a rule, alone marry. No Frenchman marries "for love"; and without a fortune no girl can find a husband, however superior her physical and mental endowments. Then one would like to know what are the effects of these marital and marriage customs upon the indivudal parents and their offspring, and ultimately upon the race. The father remains without the stimulus to exertion which a larger family would impose upon him, and the mother has her maternal instincts suppressed to a great degree. The wealthy give themselves up to a life of pleasure, the pursuit of amusement; and for this Paris is the goal ardently striven for by all rich French people. Then the children of the very rich are almost invarably "spoilt," whilst among the less wealthy a position for the boy being found at home, all foreign enterprise, all movements of colonisation are rendered impossible. Discount it as one may, one cannot refuse to accept as an approximation to the truth the type of young man that the French novel writer depicts, and admires as his hero. Readers of French fiction from the pen of leading writers well know how constantly the hero is a sensual, cowardly, hysterical degenerate, devoid of all the qualities which have at any rate hitherto formed the ideal of manliness among our British folly.

I am, Sir, yours truly,

A Surrey Doctor.

May 22nd, 1908.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Operation for Acute Appendicitis.—Mr. Peyton Beale operated (on behalf of Mr. Carless) on a man, æt. about 35, who had been admitted with the following history: Three weeks ago he had pain in the abdomen, the onset of which appeared to be gradual and not localised to any particular spot; he described it as colicky. He then saw a doctor, who gave him aperients and fomented the abdomen. The pain became less until three days prior to admission, when he suffered sudden acute pain, which he referred to the left iliac region. On admission the man did not look acutely ill, he was able to walk, his temperature was about 100°. The abdomen was distended, but quite soft (it was reported to have been rigid until a day before his admission); it was tympanitic everywhere except in the right iliac region where there was obvious dulness. On turning the patient on to his left side, this dulness disappeared. There was slight pain on pressure over the right side of the abdomen. The patient had had no trouble in passing urine, his bowels had been opened several times by means of saline aperients, but an enema administered soon after admission was returned unaltered. The pupils were somewhat dilated. Mr. Beale stated that he believed the case to be one of acute appendicitis with general peritonitis, and a large quantity of pus and gas in the abdominal cavity. He said that this was not infrequently the last stage of an acute appendicitis, and the absence of what might be called acute abdominal symptoms was due to a great absorption of toxins from the peritoneal cavity into the blood stream leading to a condition of septic intoxication, so that the patient appeared not to be so ill as he really was. He had seen previously cases of the same kind in which the patient had walked a considerable distance (two miles), and the abdomen was full of pus; they might be termed cases of ambulatory acute appendicitis. The septic intoxication was so great that pain was practically absent, and the patient had an extraordinary appearance of general well being. If left alone sudden and violent collapse would supervene, and this was followed by delirium and rapid death. In the present case the patient was taken into the theatre at once and anæsthetised. The abdomen was opened in the right side as far back as possible, that is to say, at the junction of the right iliac and lumbar regions. On opening the peritoneum a large quantity of foul smelling gas and pus issued at very considerable pressure, all the coils of intestine which were visible were thickly coated with lymph, and the appendix could be felt adherent to the posterior abdominal wall. The peritoneal cavity was rapidly irrigated with a 1 in 20 solution of lysoform in hot water, and a large gauze drain inserted. Mr. Beale thought it inadvisable to attempt to remove the appendix, his experience of this particular class of case being that the best chance for the patient was to open the abdomen rapidly, to let out the pus, and to wash away that which was in the neighbourhood of the wound, and insert a large gauze plug, the whole of which proceedings would occupy not more than five minutes. If the patient recovered he would remove the appendix by the ordinary incision in the iliac region. He considered the posterior incision which he had made in this case to be very useful, in that it afforded perfect drainage, it was not liable to be afterwards the seat of a hernia, and it left the iliac region free for the subsequent removal of the remains of the appendix.

OBITUARY.

JOHN WILLIAM CARPENTER, M.D.St.And., M.R.C.S.

We learn with much regret of the sudden death of Dr. John William Carpenter, of Goudhurst, which occurred on May 14th, from apoplexy Dr. Carpenter, who was 79 years of age, practised for some years in the district, and his kindly actions towards the poor had won for him very high respect and esteem. At the inquest, held by Dr. Joyce, Margaret Jane Cork, deceased's housekeeper, stated that she was talking with him in the garden about a quarter to twelve when he suddenly fell back. He had been mowing, and was holding a scythe in his hand. She caught him as he fell, but he died immediately. Dr. W. E. Fielder on arrival found that Dr. Carpenter was dead. He had since made a post-mortem examination, and found the cause of death was an apoplectic fit. The jury returned a verdict of "Death from natural causes."

GEORGE ALOYSIUS WILSON, L.R.C.P.ED., L.F.P.S.GLASG.

WE regret to record the death, which took place on May 16th, at Blackburn, of Dr. George A. Wilson, the oldest medical practitioner in that town. The deceased gentleman, who was 72 years of age, was a native of Ribchester. He took up the study of medicine at Glasgow, and when about 35 years of age was awarded the Dr. James Watson gold medal and a purse of gold, and granted the licence of the Faculty of Physicians and Surgeons of Glasgow and of the Royal College of Physicians of Edinburgh. He qualified in 1872, and commenced practice in Blackburn, and continued there without interruption up to the time of his death. The late Dr. Wilson was of a retiring disposition, and never entered into public life, but was, nevertheless, well-known throughout the town, and there are many reminiscences of his unostentatious kindliness and generosity to those of his patients who were in adverse circumstances. In his day Dr. Wilson had an extensive practice in the town and district, and about 25 years ago he was a familiar figure on horseback in the Mellor and Balderstone neighbourhood.

SPECIAL ARTICLES.

THE ROYAL COLLEGE OF SURGEONS IN IRELAND AND THE UNIVERSITIES BILL.

WITHIN the next few days it will fall to the lot of the one-time champion of undenominational education—the Chief Secretary for Ireland—to decide whether or not his shall be the hand to destroy what would otherwise shortly become the only undenominational school of medicine in Ireland. The School of the Royal College of Surgeons in Ireland was founded shortly after 1784 as the after-result of a charter which stated that "the regulation of the profession of surgery is of the utmost importance to the public, and highly necessary for the welfare of mankind," and which empowered the College "to establish a reliable and extensive system of surgical education." We are unable to state what is the exact number of medical men who since that time have owed their education to this School, but some idea of their number may be gathered from the fact that at the present time there are 2,932 licentiates on the roll of the College. Thus it is obvious that, in one fundamental particular of its charter, the "reliable and extensive system of education" founded by the College has been successful. In another fundamental particular the College has been no less successful. The standard of medical ethics in Ireland is admittedly one of the highest, if not the highest, in the world, and it has been the fruit of the control exercised by this College and by the Royal College of Physicians. Therefore, if the College is to fall, it is not to fall because it has neglected its duty, but for some other entirely different reason. What is this reason, which is sufficiently powerful to make a great educational champion turn against his principles? Presumably we shall be told that it is "expediency." Expediency is notoriously a word of unreliable parentage, and never will it better justify its origin than in the present case. It is "expedient" for the sake of saving the Treasury a few thousand pounds annually to destroy the Colleges which are responsible for the control of the medical profession in Ireland and for the guidance of the State in affairs touching the public health. It is "expedient" for the sake of removing all competition from the way of a rival to destroy the only source of medical education which men of all creeds and politics can in the future regard as undenominational and purely professional. It is a well-known fact that for many decades the School of the College of Surgeons was the only one to which Catholics could resort without incurring ecclesiastical censure. Then, as now, it admitted all and sundry to its lectures, its degrees, its Council, and its Presidency, and then, as now, there was no taint of sectarianism. Is the abolition of such an institution in accordance with the spirit of the present age, and is the hand of Mr. Birrell an appropriate agency for effecting such an abolition? We are entirely ignorant of the identity of Mr. Birrell's "ecclesiastical scouts" or "medical advisers," and we cannot think that either the one or the other desire to lead him into the perpetration of what, in its stupidity, is worse than a crime. We therefore would fain think that the "expediency" of his policy was the result of Treasury influence alone.

It is an old adage that the foolish man begins to build his house before he has counted the cost, but, even if he does, he has the excuse that he must have a house. On the other hand, what defence can be brought forward for the man who begins to pull down his house before counting the cost? Yet, what else is Mr. Birrell doing? The destruction of the College School involves a severe loss to medical education, and to this we have already referred. It, however, involves something more, seeing that it cannot be accomplished without drawing in its train the destruction of both Royal Colleges. The cost of this must be borne by Ireland as a whole, and by the licentiates and fellows of the two Colleges; but the reputation of Mr. Birrell and of the present Government will also contribute to it, and once again an English statesman will be credited with the destruction of a successful institution in Ireland. Another member of the Cabinet gave Mr. Birrell good advice in the course of the second reading of the Universities Bill, by saying that the Government desired to create new institutions in Ireland and not to destroy existing ones. Will Mr. Birrell take this advice, supported as it is by practically the entire medical opinion of the United Kingdom, or will he, with a cheerful jest once again, let his good intentions get the better of his principles?

BURROUGHS WELLCOME'S HEMISINE.

ONE of the important organic drugs of recent years is undoubtedly that produced from the suprarenal gland. Like all products of organic origin its preparations are subject to changes which more or less impair their therapeutic value. That defect is overcome by the careful production of "Hemisine," the active principle of the medulla of the suprarenal gland, which is stable and active both in the fluid form and in the dry, from which a solution can be readily procured. Apart from its action as a local vaso-constrictor and anæsthetic. Hemisine has a wide and general action. It is given, for instance, in atonic conditions of circulation and of nervous system, asthma, purpura and dilated heart. Curiously, it has proved of little use in Addison's disease; while it is positively harmful in hæmorrhage from tubercular lungs. One great feature in Burroughs Wellcome's preparation is that it is standardised, an essential thing in dealing with so potent a drug. There are a number of convenient compound preparations issued in soloid and tabloid form, such as hemisine with atropine, cocaine, eucaine, and so on.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Fractures Complicating the Elbow-Joint.—S. Cole, in a paper (*Post-Graduate*, April, 1908) on fractures about the elbow-joint, deals briefly with the commoner forms of fracture, their diagnosis and treatment; then discusses more fully fracture at the upper end of the radius, and advises the following methods of treatment: In fractures of the head of the radius, treatment by plaster of Paris circular bandage, the forearm flexed to a right angle and carried just a little beyond mid-pronation in the direction of pronation, the elbow-joint having been first liberally surrounded by absorbent cotton wool held in place by a firm muslin bandage. Later, if sufficient interference be caused by any fixation, sufficient to justify operative measures, removal of the fragments and an effort to restore the function of the joint may be made. In cases where the neck of the radius is fractured, immediate removal of the fragments should be done, as fixation and loss of function must follow any other form of treatment. The same treatment is all the more imperatively demanded if fracture of the neck of the bone be complicated by fracture of the head as well. If the ulna has been fractured as well, avoid any open operative interference until a sufficiently long time has elapsed to show what permanent loss of function has been sustained, and what probable improvement can be obtained without operation. G.

Adipositas Dolorosa.—Sezary (*Revue de Médecine*, December, 1907) describes four cases of adipositas dolorosa, characterised by local or general deposition of fat, pain, asthenia, and psychic disturbances. The first patient, in whom one segment of the body was affected, also presented sensory disturbances, but there was a possible complication by alcoholic neuritis. While all of the cases occurred in women, there was no ætiological reason for assuming the hypothesis that the adipositas dolorosa was in any way connected with changes in the thyroid or in the ovaries. In two of the cases the disease developed soon after childbirth. In none was there any relation to the menopause. One of the patients suffered from syphilis, another from tuberculous disease, a third from glycosuria. Dr. Sezary mentions a fifth case of adipositas dolorosa which he had seen in a patient who also had aortic insufficiency and was probably syphilitic. The symptoms of this rare disease are by no means constant, or are only present to such a slight degree that they may be difficult to detect among other possibly obscuring symptoms. The obesity may be either diffuse or nodular, or it may affect only one segment of the body. The fatty tissue seems to be specially liable to develop after one of the attacks of asthenia, ; the tissue is extremely sensitive to pressure; ecchymoses are very readily produced; they are, in all probability, due to an instability of the vasomotor apparatus. The swellings at first, if examined, show the appearances of soft, rather œdematous tissue, and this later on is followed by the formation, deposition and gradual accumuation of fat. G.

Prostatic Hypertrophy.—After examining serial sections from 26 cases of prostatic hypertrophy, Dr. Raski (*Wien Rundschau*, No. 8, 1908) can only arrive at negative conclusions concerning the cause of the hypertrophy. He thinks that Ciechanovski is incorrect in thinking that the hypertrophy is caused by inflammatory narrowing of the ducts and consequent retention of the glandular contents; he is also unable to verify the intra-prostatic sphincter theory of Motz and Peronau. In 18 of his cases there were positive findings opposed to the teaching of Finger, who says that the hypertrophy follows as the result of chronic prostatitis. The author agrees with Bier that the hypertrophy is not the result of hyperæmia, but that both the hyperæmia and the hypertrophy are due to some unknown process or processes. He also holds that since there is such variation in the type of hypertrophy found in these cases of prostatic enlargement, in all probability the ætiology must also vary to a considerable extent. G.

Intra-Peritoneal Rupture of the Bladder.—O. Nordman (*Deutch. Med. Woch.*, April, 1908) thinks the most important symptoms in making a diagnosis are tenseness and rigidity of the abdominal muscles, and an unfulfilled desire to pass water. Strictly aseptic catheterism may be attempted, and, should this have no result, immediate laparotomy and suture of the bladder should be resorted to. If there is no purulent peritonitis, Nordman merely washes out the peritoneum with saline solution, then sutures the bladder, and completely closes the abdominal cavity, using in the bladder a retention catheter, keeping the patient sitting up in bed and giving urotropine or some similar drug by the mouth. He believes that it is never necessary to tampon or drain from the sutured bladder through the abdominal wall. The results he has obtained seem to justify this opinion. G.

Anatomy of the Pancreas in Relation to its Disease.—Mayo Robson (*Brit. Med. Journ.*, May 16th, 1908) points out that the relations of the pancreas to the aorta and vena cava, to cœliac plexus, the spleen, the left suprarenal and left kidney, the portal vein, the duodenum, stomach and colon, and even the uterus during pregnancy, render any attempt at even partial excision somewhat difficult. In disease invading the distal part or the tail, extirpation is practicable, and in certain cysts and tumours justifiable. Severe injuries of the pancreas not operated on terminate fatally in nearly every case. Surgical treatment gives much more favourable results. No hard-and-fast rule can be formulated as to the method of treatment. The injured part must be exposed, and either ligature of vessels or suture of surfaces adopted; but gauze tampons and drainage form important features in any of these operations. It is important to remember that the head of the pancreas sometimes overlaps and even embraces the second stage of the duodenum. Swelling of the head may lead to obstruction of the gut. An abnormal tail has caused acute obstruction of the third part of the duodenum. In cystic disease of the pancreas, the peritoneal relations, taken with the site of origin of the cyst, are responsible for various anatomical relations. Thus the cyst may be situated above or below the stomach, and may resemble a gall-bladder, right or left kidney, cæcal or mesenteric tumour. The retroperitoneal position of the organ is an important fact to notice. A collection of pus in some cases of suppurative pancreatitis may be reached from the loin, especially the left, by an incision in the costospinal angle. The variations in the ducts of the pancreas and its relations to the common bile-duct are significant. In a fatal case of acute pancreatitis a gall-stone was found reaching the bile papilla and converting the bile and pancreatic channels into a single duct. The author considers that the treatment of acute pancreatitis is no longer in doubt, and that many lives may be saved by abdominal section, incision of the inflamed gland, and free drainage, if operation has not been delayed too long. He believes that catarrhal jaundice is usually due to catarrh of the pancreas, the swollen head of the pancreas compressing the common bile duct. As regards the diagnosis of interstitial pancreatitis, the author says a correct opinion may be formed in a large majority of cases from the information obtained by the careful physical examination of the patient, a knowledge of the history of the case, and the result of chemical and microscopical examination of the urine and fæces. In discussing chronic pancreatitis in relation to diagnosis, it is pointed out that the original interstitial pancreatitis may pass on into the interacinar variety in which the islands of Langerhans become involved and glycosuria ensues, or the condition may pass on to complete cirrhosis with the same results. Glycosuria is by no means a common symptom of pancreatic disease. The author believes that cholecystoenterostomy to be the operation of choice for the treatment of interstitial pancreatitis, and only in case of absence or contraction of the gall-bladder, with great adhesion, should cholecystotomy or choledectotomy be done. S.

Arthroplasty and Ankylosis.—Whitacre (*Lancet Clinic*, April 18th, 1908) reports two cases in which joints were made in the knee for the treatment of bony ankylosis, which had taken place as the result of disease. The author's method of treatment follows the teaching of Murphy, of Chicago, and depends on the formation of a hygroma. The result is accomplished by interposing between and completely covering the bone ends by a flap of fat-bearing aponeurosis. The author points out that the operation can be done in the mandibular, hip, shoulder, elbow, and knee joints, and the prognosis as to the ultimate results is in this order: The operation gives the best results in the mandibular joint, and is least satisfactory in the knee. Case I.—Patient, a girl, æt. 22, suffered from acute arthritis of the knee, which, in spite of treatment, led to bony ankylosis. A lateral incision was made, beginning at the lower margin of the knee-joint and extending up the thigh a distance of about 10 inches. There was a similar incision on the inner side of the limb 6 inches long. No synovial membrane or articular cartilage could be found at the operation, and the crucial ligaments were gone. The capsule and restraining connective tissue was freely dissected away, and the lower end of the femur sawn off. A wide flap of fascia, with the subcutaneous fat, was removed from the outer aspect of the thigh, and drawn through the joint between the opposing bone ends in such a way as to cover the denuded end and sides of the femur completely. This flap was held in position by interrupted catgut sutures. The wound was closed and the limb put up in extension in plaster of Paris. In a month the plaster was removed, and passive movement commenced. In five weeks the patient was able to bear the weight of the body on the limb without pain. When discharged five weeks later the patient was able to walk without any support or assistance. Extension was almost complete, flexion within 10 degrees of a right angle without pain. At present, eight months after leaving hospital, there is no hyperextension or lateral movement. Active and passive flexion can be carried out to an angle of 90 degrees painlessly. The patella is movable, and the joint is not sensitive. The joint is not sufficiently strong to enable the patient to advance the leg in walking upstairs, but the author expects this power to be likewise regained. Case II. was similarly treated, but the results up to the present have not been so satisfactory. Nine months after the operation there is some lateral movement at the joint, and the patient requires a temporary brace with a hinge at the knee. S.

Fracture of the Patella Treated by Mobilising the Lower Fragment.—Lynn Thomas (*Brit. Med. Journ.*, May 16th, 1908) describes a case illustrating this method of treatment. The fracture of the patella was of 11 months' standing, and a gap of 1½ inches existed between the fragments. At the operation, as the fragments could not be got within half an inch of one another, it was decided to attempt to bring the lower fragment towards the upper by immobilising it. This was readily done by Kocher's curved external incision and chiselling off the tubercle of the tibia. Care was taken not to detach the tendinous and periosteal attachment along its inner edge. By forcible traction upon the lower fragment of the patella and its ligament, the fragments were soon brought into contact, and their bared surfaces were kept in apposition by means of two loops of silver wire. The tubercle of the tibia retained considerable strength of anchorage in its displaced position by means of the untorn fibrous attachments of the ligamentum patellæ on its inner side. The immediate result, and in time the functional result, was satisfactory. S.

Prolapse of the Inverted Bladder through the Urethra.—Leedham-Green (*Brit. Med. Journ.*, April 25th, 1908) reports the following case:—A girl, aged 18 months, was admitted to hospital with a small swelling which had recently appeared between the labia. A similar swelling had been noticed when the child was a month old, but had disappeared on bathing with hot water. On examination a red soft protrusion about the size of a walnut was seen between the labia. It was covered by mucous membrane. The small openings of the ureters were distinctly visible on either side of the prolapse, and from them urine was ejected in the characteristic manner. Under an anæsthetic the prolapse was easily reduced through the dilated urethra, which was large enough to admit the little finger. The child was otherwise healthy and normal. Cure was effected after some difficulty. Strapping the buttocks and thighs together with catheterisation was first tried, but failed. Packing the vagina with iodoform gauze for some time was also unsatisfactory. Finally, under an anæsthetic, a small amount of liquefied hard paraffin was injected into the periurethral tissue at the neck of the bladder. This method was perfectly successful, and when the patient was seen four months later she had perfect control over the bladder. S.

Serious Visual Defects in Responsible Marine and Railway Servants.—Dr. Galloway (Aberdeen), early last year, recorded the case of a captain of a Government cruiser suffering from tobacco amblyopia, a congenitally colour-blind trawl skipper, and a myopic express engine driver; and he now (*Ophthalmoscope*, May, 1908) records five more very similar cases:—(1) An engine driver, æt. 32, in railway service 14 years. Three years ago he was passed as a driver, having been examined by a lay inspector and superintendent. Vision of right eye = 6/24, left = 6/60; with correction both eyes = 6/6. (2) Another engine driver, æt. 45, who had passed eyesight tests 5 years and 1 year and 9 months previously. His vision was: right eye = 6/24; left eye = 6/18; and with + 2 both eyes = 6/6. Dr. Galloway ordered both these men glasses, and told them to wear them on the sly, as they are prohibited. (3) A trawl fisherman, æt. 26, who had been mate of his boat for two years, and had frequently kept a look-out. Vision: right eye = 6/36; left eye = 6/60; and with correction each eye = 6/6. (4) A trawl fisherman, æt. 28, had been nine years at sea, and for the past four years had been constantly in sole charge, and the only one on the look-out. With Holmgren's wools he was shown to be quite colour-blind. (5) Mate of a trawler, æt. 26, had been eight years at sea, and for four or five had been frequently in full charge of his boat. He obtained his mate's certificate because he had acted as mate for twelve months. There was no Board of Trade examination. As he was looking for skipper's certificate, he came to Dr. Galloway to be tested. With Holmgren's wools he matched bright green with the red skein. The author does not comment on the above cases. We suppose he does not deem it necessary. M.

A suspected case of cerebro-spinal meningitis has arisen in the Weaste district, and is under the observation of the Salford Medical Officer of Health. The patient is in a serious condition, and as there are complications it has not yet been possible to determine whether the case is really one of spotted fever.

An epidemic of recurrent typhoid has broken out at Moscow. The hospitals are overflowing, 2,000 patients being already under treatment, while 75 to 100 fresh cases occur daily. The municipality has asked the military authorities to transform the summer barracks into a typhoid hospital.

MEDICAL NEWS IN BRIEF

The Irish Universities Bill.

THE Committee of the Catholic Graduates' Association has drawn up an important memorandum on this Bill and on the draft charters of the proposed Colleges. The committee unhesitatingly accept the test Acts, and would open the emoluments of the new Universities to all-comers, but they wish to express the opinion that they regard as a serious defect the fact that there is to be no protection for the Catholic religion or for Christianity.

The new University, the memorandum declares, will set out under limitations strictly imposed on it by an outside Statutory Commission. The essential liberties of each College may be secured or be impaired to almost any extent by this Statutory Commission. As, therefore, the future usefulness or futility of the new institution depends on the constitution and the work of the Commission, we regard its composition as a matter of the utmost gravity.

The Commissioners should represent not only science, medicine, and law, but especially Irish studies, and philosophy embracing the social sciences and economics.

The Committee protest against the limitation of the autonomy of the University implied in Clauses 1 and 2 of Section 19 of the draft Charter of the University, and state that, however desirable it may be for the Senate to call in professors from other Universities to take part in its examinations either as assessors or as joint examiners, a University worthy of its own self-respect must feel it its duty to resent the form of coercion contemplated by those clauses which, if adopted, amounts to a vote of non-confidence in the capacity or the honesty of its own teaching staff. It is their strong opinion that the Senate should be allowed a discretion to call in extern examiners to assist their own professors in the examinations in a subordinate capacity.

An examination of the composition of the Senate of the University and the Governing Councils of the constituent Colleges shows that the autonomous ideal which was so strongly advocated in the report of the Robertson Commission has been completely displaced. In the scheme set out in the Irish Universities Bill the representatives of the professors and graduates—the men whose special knowledge and whose duty and interest all coincide in making the most apt instruments in the College administration—number only 11 out of 33. Under the Robertson scheme professors made up more than one-third of the Council; in the Bill they number less than one-fifth.

The Committee's opinion is that the management of all collegiate affairs, with the sole exception of the appointment of professors, should be placed in the hands of a College Council elected on purely academic lines.

They regard as a radical defect in the Bill the absence of any clause providing for life-tenure of the teaching officers of the University, and to the absence of any specific indication of what would be considered just grounds for dismissal—a bare provision is made authorising the dismissal of an officer. They believe it of vital importance that professors in the new University should hold office for life or good conduct.

On the question of endowment they declare that the proposed annual grant of £32,000 is manifestly insufficient.

Affiliation, by which the Committee mean recognition of professors in certain subjects, should be, they consider, strictly limited. The present affiliation clauses are too vague, and open the way to grave abuse.

Medical Sickness and Accident Society.

THE twenty-fifth annual general meeting of this Society was held on Thursday last, in the room of the Medical Society of London, when the report of the committee for the year 1907 was submitted and approved, an excellent position of the Society being shown in its increase of members and funds at its disposal.

During the year the membership had increased by 95, the total at the end of 1907 having reached 2,583, all male members of the medical profession or licentiates of dental surgery practising in the United Kingdom. Its funds now amount to £215,039, including an investment reserve of £11,031. The amount paid in sickness benefit was £12,700, being the largest yet disbursed in one year, whilst the annual sickness premium income amounted to £15,976. Great economy is shown in the management expenses, a large balance to the credit of the fund resulting thereby. Over £130,000 has been disbursed as sickness benefit since the Society started in 1884.

Medical Officers in Collieries.

IN pursuance of a suggestion that the South Wales Miners' Federation should, in conjunction with the British Medical Association, draft a scheme which would be satisfactory both to the workmen and the medical fraternity, whereby colliery doctors should in future be appointed and paid direct by miners' committees in the several districts, a joint meeting was held in Cardiff on May 15th, the attendance including Mr. W. Abraham (Mabon), M.P., Mr. Thomas Richards, M.P., Mr. A. Onions, Dr. Maclean (Cardiff), and Dr. Evan Jones (Aberdare). Arrangements were made for a further conference.

Anthrax Investigation Board.

A MEETING of the Anthrax Investigation Board was held on May 21st, at the offices of the Bradford Chamber of Commerce, the Lord Mayor, Chairman of the Board, presiding. It was decided to take steps to arrange, if possible, for the subject of anthrax to be raised and discussed at Glasgow in July. The question of the effectual saturation of bales of wool with a germicidal disinfectant was raised, especially with regard to the difficulty of thorough penetration without the bales being opened up and the wool or hair loosened.

Dr. Eurich reported that since the last meeting of the Board in March three cases of anthrax had occurred; one was fatal, one recovered, and the third was still under treatment. Further experiments as to the disinfection of bales had been carried out, but he was not yet in a position to report finally. During the same period he had examined 135 samples of wool, hair and dust. Of these 59 were bloodstained and represented 45 lots, and of these 59 he found anthrax in 8. He also found anthrax in a sample of shoddy blend. Dr. Eurich stated that so far as experience went, cases of anthrax arose with persons who had not been for a lengthened period engaged on the work in the exercise of which they had caught the infection. Discussion took place as to what was meant by "damaged fleeces" as referred to in the Home Office regulations.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have been granted the L.S.A. Diploma of the Society, entitling them to practise Medicine, Surgery, and Midwifery:—L. G. H. Furber, E. Lakovski, G. R. McCowen, and G. Rollason.

Royal College of Surgeons in Ireland.—Fellowship Examination.

THE following candidates, having passed the necessary examination, have been admitted Fellows of the College:—A. L. Fuller, M.R.C.S.Eng.; S. R. Godkin, L.R.C.S.I.; A. Greene, B.Ch.; M. R. J. Hayes, L.R.C.S.I.

The following have passed the Primary part of the examination:—K. Moinuddeen, L.A.H., L.R.C.S.I.; Miss M. M. S. Coghlan, M. Drummond, G. J. Fraser, H. M. E. H. M'Adoo, J. M'Mullin, H. H. Montgomery, Miss P. M. Powell, W. Prendiville, A. Stokes, and W. A. Swan.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

THE following candidates have passed the Final Examination, May, 1908:—S. Broderick, H. C. Burbidge, G. Collins, M. B. Dooley, E. Evans, F. N. Holden, G. S. Levis, F. W. Mathews, A. E. S. Martin, K. A. P. R. Murray, J. J. McGreal, D. O'Dwyer, M. Power, G. W. Stanley, J. F. Walsh.

NOTICES TO CORRESPONDENTS, &c.

☞ **CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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ENGLISH AS IT IS HEARD.

"What! Assistance towards appendicitis!" exclaimed the Acton magistrate to-day, when a man asked him something.

"Pedlar's licence" was what the applicant had mumbled.—*Star*.

CLINIC.—Test papers for carrying about in the pocket are obtainable. Albumin, sugar, and reaction can be tested for by them. They are certainly useful. The only ones we know are those put up by the Roborat Co., 8, Harp Lane, London, E.C.

DR. A. G. B.—The report reached us as we were "at press." Too late for present issue.

THE LEMCO PRIZES.

As medical men will probably be in a better position to know the value of the Lemco extract, the Liebig Extract of Meat Company ask us to announce an interesting competition, the object of which is to find out how many uses there are for Lemco. Over 200 cash prizes are to be awarded, the first being £50. Competitors have nothing to collect, and no expense is involved. All that is necessary is to make out a list of the different ways Lemco is found of service, and to send it with one Lemco buff wrapper to Lemco, 4, Lloyd's Avenue, London. E.C. The best lists get the prizes. The closing date of the competition is June 15th.

PORTSMOUTH.—The gentleman who appears to be most entitled to credit for the rationalisation of military drill is Lieut.-Col. J. A. Davy, R.A.M.C. He worked for years to show the physiological faults entailed by the "pouter pigeon" chest in the military attitude of "attention," and his views have lately been adopted in high quarters, we understand.

A CORONER'S GRIEVANCE.

A North Country coroner arrived at an inquest very much perturbed. He was late, as he explained, because he had been misdirected when in search of a well-known chapel by a "silly woman."

"I have no end of trouble in finding these churches and chapels and vestries," exclaimed the Coroner. "If I have any more trouble I will go back to the old public-houses. Every man, woman, and child in the parish knows where the public-house is, but there's not one in twenty knows where the chapel is!"

[We have to thank a Sheffield correspondent for the foregoing.—ED.]

GLOUCESTER.—There was a typhoid patient at the farm which the suspected milk came from in the Kelvinside (Glasgow) outbreak, but the cause of that case and of the rest of the milk cases, is believed to be a healthy woman who had had typhoid sixteen years ago and still harboured typhoid bacilli.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 27TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. P. Stewart: Lesions of the Optic Chiasma.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Skin (Dr. Meachen); Eye (Mr. Brooks).

THURSDAY, MAY 28TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Sir Malcolm Morris: Seborrhœa of the Scalp.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical (Mr. Carson); X-Ray. 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Demonstration of Clinical Methods of Estimating Blood Pressure (Dr. B. Price).

FRIDAY, MAY 29TH.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m.: Mr. E. Clarke: Clinique. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. J. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques: Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

Appointments.

BARBER, A., M.B., B.S.Lond., Clinical Assistant to the Samaritan Free Hospital.

EDWARDS, HENRY JAMES, M.D.Durh., L.R.C.P., L.R.C.S.Edin., D.P.H.Lond., District Medical Officer by the Barnstaple (Devon) Board of Guardians.

FINZI, N. S., M.B.Lond., Honorary Radiographer to the Hospital for Epilepsy and Paralysis, Maida Vale.

FOTHERGILL, W. E., M.A., B.Sc., M.D., Lecturer in Clinical Obstetrics and Gynæcology in the University of Manchester.

HAMILTON, R., M.B., C.M.Glasg., D.P.H., Police Surgeon and Medical Officer of Health to the Burgh of Coatbridge.

JAMISON, REGINALD, M B., B.Ch.Oxon., Clinical Assistant to the Samaritan Free Hospital.

KEYWORTH, W. D., B.Ch.Cantab., Clinical Assistant to the Samaritan Free Hospital.

LEAKEY, A. B., M.B., Ch.B.Edin., Clinical Assistant to the Samaritan Free Hospital.

MANUEL, ALEXANDER, M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Samaritan Free Hospital.

OVERSBY, EDITH, M.B., Ch.B.Glasg., Medical Inspector of Schools for the county of Worcester.

PROCTOR, JOHN, M.B., Ch.B.Aberd., Clinical Assistant to the Samaritan Free Hospital.

RIPPON, C. S. U., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Tintern District of the county of Monmouth.

TEMPLE, GEORGE HENRY, M.B., C.M.Edin., Honorary Medical Officer to the Weston-super-Mare Creche.

Vacancies.

Lincoln General Dispensary.—Resident Junior Male Medical Officer. Salary, £175 per annum, with furnished apartments, fire, and lighting. Applications to the Secretary, 2, Bank Street, Lincoln.

City of Liverpool.—Education Committee.—School Medical Officer. Salary, £300 per annum. Applications to the Office of the Committee, 14, Sir Thomas Street, Liverpool.

Infirmary of the City of London Union.—Assistant Medical Superintendent. Salary, £150 per annum, together with furnished apartments at the Infirmary, rations, and washing. Applications to Edward R. Woodward, Clerk to the Guardians, No. 61, Bartholomew Close.

Bethlem Hospital.—Two Resident House Physicians. Apartments, complete board, and washing being provided, and an honorarium at the rate of £25 each per quarter will be paid. Applications to the Treasurer, Bridewell Hospital, New Bridge Street, E.C. (See Advt.)

Leicestershire and Rutland Asylum.—Junior Medical Officer. Salary, £130 per annum, with board, lodging, and washing. Applications to W. J. Freer, Esq., 10, New Street, Leicester.

Lambeth Workhouse.—Assistant Medical Officer. Salary, £125 per annum, with board, apartments, and washing at Renfrew Road Workhouse. Applications to James L. Goldspink, Clerk, Guardians' Board Room and Offices, Brook Street, Kennington Road, S.E.

Joint Counties Lunatic Asylum, Carmarthen.—Second Assistant Medical Officer. Salary, £160 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent, Joint Counties Asylum, Carmarthen.

Burnley Union.—Resident Assistant Medical Officer. Salary, £120 per annum, with furnished apartments, rations, washing, and attendance. Applications to J. S. Horn, Clerk, Union Offices, Burnley.

Births.

BLACKWELL.—On May 19th, at Oxshott Lodge, Oxshott, Surrey, the wife of T. C. Blackwell, M.D., of a son.

BROCK.—On May 19th, the wife of J. H. E. Brock, M.D., F.R.C.S., of 77, Fellows Road, South Hampstead, London, of a daughter.

BURRIDGE.—On May 22nd, at 13, Mackenzie Street, Slough, Bucks, the wife of John H. Burridge, M.R.C.S.Eng., of a son.

SHARPLES.—On May 5th, at 102, Lansdowne Road, Clapham, the wife of M. W. Sharples, M.B., of twin sons.

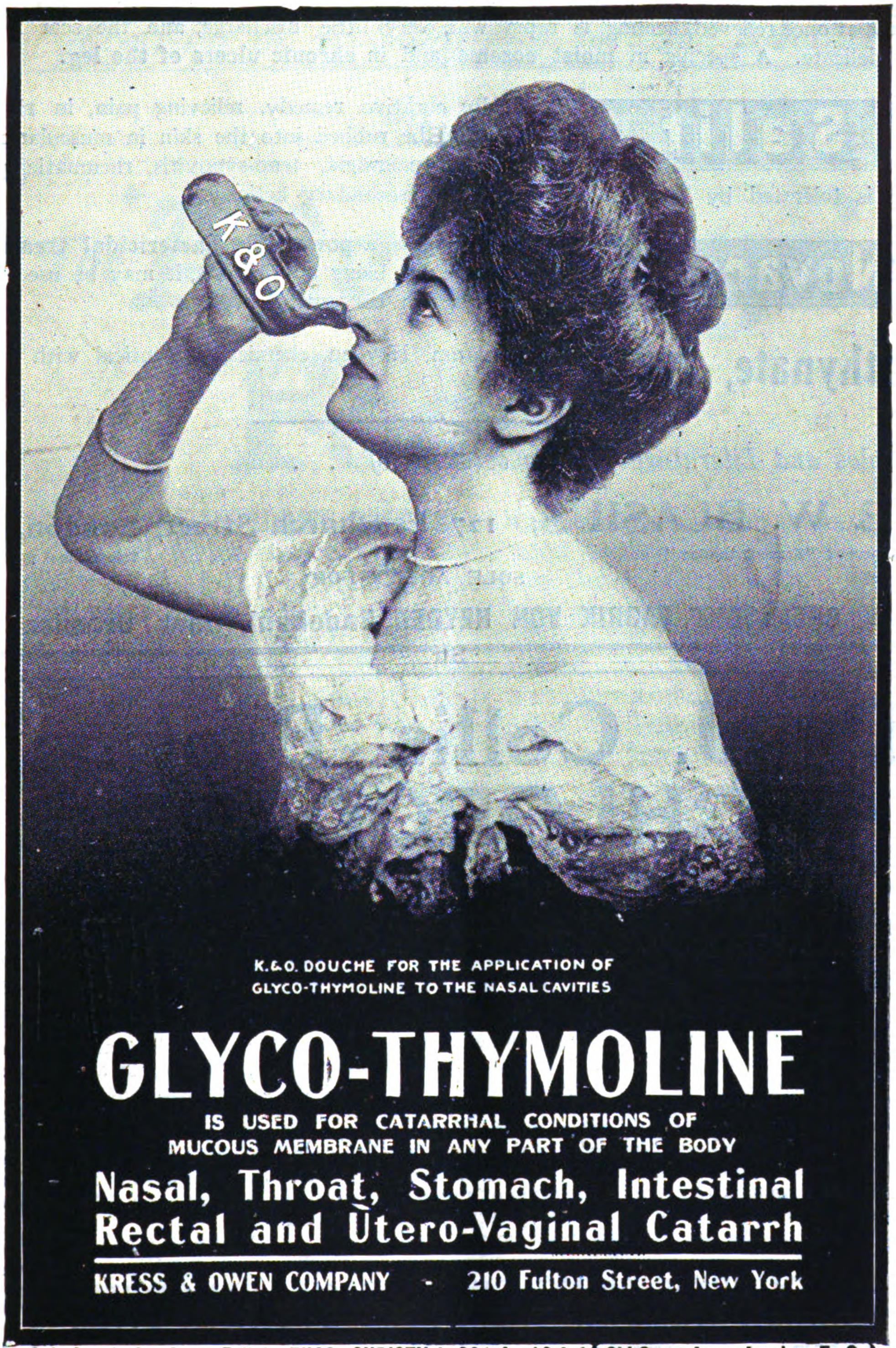
STAUNTON.—On May 19th, at Red Hill, Natal, the wife of G. P. Staunton, M.D. (*nee* Emily Jarrold)—a son.

Deaths.

DASHWOOD.—On May 19th, at Caistor Lodge, Bromley, Kent, Peyton Dashwood, aged 72, second son of the late Jarrett Dashwood, M.D., F.R.C.S.

MAY.—On May 21st, at 39, Oxford Gardens, London, W., Edward H. May, M.R.C.S., aged 73, late of 68, Pentonville Road, London.

VEALE.—On May 22nd, at Southern Hill, Reading, Deputy-Surgeon-General H. R. Veale, M.D., aged 76.



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Glasgow Medical Journal, June, 1905.

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New York Lancet, June, 1901.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JUNE 3, 1908. No. 23.

NOTES AND COMMENTS.

Habitual Criminals. THE Bill introduced by the Home Secretary in the House of Commons last week for the purpose of dealing with habitual criminals is one of the most noteworthy events of an eventful session. It marks a stage in the treatment of the criminal higher and more rational than any yet attained in this country, because it embodies for the first time the principle which has long been recognised by medical men that the habitual criminal is a mentally defective person, and must be treated as such. The levelling-up of prison conditions which has been in operation for the last twenty years has reached, or nearly reached, the maximum point to which it is safe to go; indeed, especially as regards dietary, we are not sure that the limits of wisdom have not been trespassed upon, as the diets provided for prisoners are now as good as those provided for paupers, and above the standard of living amongst the poorer members of the working classes. Now, although the reformatory effect of prison should be kept prominently in view, it is not safe nor prudent to lose sight of the deterrent effect, and if sentences are made too short and prison conditions too easy, there is no little danger that the wholesome dislike of incarceration which exists among the criminal classes will be much watered down. So long, at any rate, as the present Poor-law system prevails a substantial gulf should, and must, be fixed between the conditions of the workhouse and prison. Poverty is no crime, but if the surroundings of pauper life are much the same as those of prison life the temptation to avoid the former by risking the latter will make a strong appeal to the sporting instinct.

Permanent Detention. BUT Mr. Gladstone's new Bill makes a firm step away from the undue easing of the criminal's path, because it holds up before his eyes the prospect which he relishes least of all, namely, that of never being able to apply his skill and experience to their wonted uses, and leading perforce a virtuous existence. We fancy we are justified in saying that every atom of control of which he is capable will be exercised by the habitual criminal who recognises that a further transgression will lead to perpetual restraint from indulging in his wonted courses, and for those to whom crime is an instinct not to be resisted, the safeguarding of society and of themselves without undue rigour can only be the highest blessing. It is much to be hoped that the "humanitarians"—that is to say, those headstrong folk who oppose all disciplinary measures without regard to their merits—will not take into their heads to make trouble over this Bill. The habitual criminal, like the habitual inebriate, or the insane person, is not a responsible agent, and to deprive him of his liberty is just as much in his own interest as in that of society. The suggested safeguards against abuse seem to us to be adequate, and any aggrieved person should always be able to make a periodical appeal for reconsideration. The condition laid down is that the offences must be grave, and we trust that this will be interpreted to mean not poaching or petty pilfering, but chiefly grave offences against the person, especially sexual crimes. Persons convicted of unnatural offences of the latter order are very badly catered for at present, and this opportunity might be taken to make their restraint more equitable.

Medical Fees at Inquests. THE question of payments to medical men at Coroners' inquests has lately been before the Lancashire County Council, and that body has decided that the fee of a guinea for the post-mortem and a guinea for giving evidence is all that they are permitted to sanction for the medical witness, however long his journey may be, and however many times the inquest may be adjourned. As regards the latter point, their decision is unfortunately correct, but there is nothing to prevent the Council paying reasonable travelling expenses. There is no doubt that the whole of the procedure with regard to the Coroner and his court are antiquated in the extreme, and we should be very glad to see the whole subject taken up by the Government and put on a more modern basis. It is ridiculous that the guinea fee for the post-mortem should include all expenses with regard to analysis of the viscera, a long and complicated process, which alone should be paid for at ten times that figure. The omission specially to mention travelling expenses, is doubtless due to the fact that the Act enjoins that a neighbouring medical practitioner shall be called in, and it must press hardly on gentlemen who are so beloved of Coroners as to be frequently called from the North of London to the South to perform "expert" work which no one in South London is apparently capable of performing.

Merthyr School Children. THE Merthyr Education Authority and the good people of that district have been startled by the first report made to them by their recently-appointed medical inspector of schools. Dr. Askins, having examined the pupils, 283 in number, in three schools, found that 73 of them suffered from eye defects, 87 from diseases of the skin, 37 from diseases of the ear causing serious deafness; 57 from diseases of the throat and nose, 4 from diseases of the heart, 7 from mental deficiency, 3 from epilepsy, 4 from deformities, 1 from gastric ulcer, 7 from anæmia, 3 from diseases of the bladder, and 1 from rupture. Moreover, 95 per cent of the children had defective teeth, principally of the permanent set. These numbers are certainly very high, a good deal higher than those existing in most towns, and may well give cause for anxiety. The deafness especially, standing at 12 per cent, and being characterised as serious, is a grave factor. As these, the results of medical inspection begin to come in, there will doubtless be some confusion at first, especially as men and methods vary, but for purposes of comparison between the districts some more or less conventional standard will have to be fixed. But in any case we hope to hear that no districts are quite as bad as Merthyr.

Life Assurance and Fraud.

A point of much importance to medical men was before the Courts lately in an action brought by the executors of a lady against a well-known life assurance company to recover the amount, namely, £3,030, of a life policy issued by them. The lady had committed suicide, it appears, and the company denied liability on the ground that she had given a false answer to one of the medical examiner's questions. In answer to the interrogation, "Have you at any time had brain fever or any other disease of the brain?" she had replied, "No"; and after her death it came to the company's knowledge that she had suffered from acute mania seven years before she proposed to the office. She had not been certified, but had been a resident patient in a doctor's house, and it was said that the nature of her illness was never known to her. In the event the jury found that the lady had acted foolishly in not revealing the fact that she had consulted a medical man for what she believed to be a "nervous breakdown," but that she neither knew nor concealed the fact that she had been mentally deranged, and therefore there was no fraudulent concealment. Judgment was given for the defendants on condition that the premiums paid should be refunded. Medical examiners are aware how lightly many proposers for assurance reply to questions regarding their previous health and habits, knowing that as a rule it does not pay a company to refuse to honour a policy, and that the risk of any statement being disputed after death is extremely small. The result of this case should act as a healthy warning.

Licensing Dangers.

Objectors to the Government licensing proposals are bringing every imaginable species of argument to bear in opposition. Far be it from us to enter the thorny thicket of politics; all we have to say is that anything which reduces the amount of alcoholism in the country will, *ipso facto*, reduce enormously the amount of chronic disease. Whether the Government proposals will effect such reduction is a question for the individual judgment, but that there are grave auxiliary dangers to be faced if public drinking is curtailed is a matter of common knowledge among those who are acquainted with American medical literature. Hitherto this country has been happily free—or almost free—from one of the worst forms of quackery, namely, that of selling mixtures whose leading ingredient is alcohol, under the name of "Tonic medicines." By this dastardly trick the effect of temperance legislation is to a great extent thwarted and huge fortunes acquired by the vendors. The evil in America, especially in the prohibitionist States, has reached gigantic proportions, and the medical profession find it a most difficult one to tackle. This Government, therefore, will be well advised if they take this danger into account while there is time, and make adequate provision to meet it.

LEADING ARTICLES.

THE WAR AGAINST TUBERCULOSIS IN IRELAND.

The campaign against tuberculosis entered on a new phase last week with the opening of a depôt in Dublin for the sale of pasteurised milk. Our readers are aware of the strenuous work of Lady Aberdeen and her colleagues in the Women's National Health Association of Ireland, by which they have aroused in that conservative country a degree of interest never before felt in any sanitary question. The Tuberculosis Exhibition, first shown at the Irish International Exhibition in Dublin last autumn, has since visited practically every considerable town in the country, and everywhere it has gone it has attracted large numbers of intelligent spectators. The public lectures, given for the most part by medical men, have, in spite of some indiscretions, undoubtedly been of great value in educating the community to a knowledge, both of their responsibility and of their power with regard to the prevention of tubercular disease. That these efforts have not been without their result is shown by the large number of open windows one sees in the towns visited by the Exhibition, and by the greater activity shown by local bodies in exerting their powers of erecting sanatoria and otherwise dealing with the disease. Perhaps more significant than any other single fact is the activity displayed by the Local Government Board, the public department directly responsible for the control of sanitary administration in Ireland, and therefore for the neglect of public health in the past. In Dublin, not content with their educative efforts, the Health Association has entered on two definite lines of work. In conjunction with a committee of the physicians of the Dublin hospitals, they have inaugurated a scheme for visiting and assisting poor consumptive patients in their own homes. To consumptive patients presenting themselves for treatment at the out-patient departments of the hospitals cards are given. These cards, of which they may avail themselves if they choose, will obtain for them the visits and advice of a trained nurse employed by the Association. The duty of the nurse is to give advice as to the diet and mode of life of the patient, advice more definite and precise than can be given by the physician who does not see the patient in his own home. In cases where it seems required, sputum-flasks, clothing, and articles of food are supplied by the Association. Although only three months in operation, over one hundred patients have already come under the operation of the scheme. The other special task to which we have referred is the pasteurisation of milk. The entire expense of installation has been borne by Mr. Nathan Strauss, a wealthy American gentleman, who has made similar gifts to many other cities, and the plant has been erected under the supervision of Dr. Arthur Green, of New York, who has acted as the donor's expert adviser in similar undertakings elsewhere. The milk received in the depôt is drawn from a trustworthy dairy, in which the cows are subjected periodically to the tubercular test. The milk after pasteurisation is to be sold to the public. It will no doubt be a matter of satisfaction that the citizens of Dublin will find available a milk which will be above suspicion. Two things, however, will be necessary to render the depôt thoroughly useful—the sale of the milk at a low price, and such means of distribution as will bring it to the doors of the dwellers in the poorer quarters of the city. It is among them that milk-borne diseases are most rife, and it is for them that clean milk is most necessary. The schemes adopted by the Women's National Health Association seem to us well chosen, and we wish them every success. We confidently look for some reduction within the next few years of the appalling mortality from tubercle from which Ireland at present suffers.

SCARLET FEVER IN SURREY.

Dr. Seaton, Medical Officer of Health for the County of Surrey, has rendered good service to the branch of the profession he has made his own, by carrying out an inquiry into the incidence of scarlet fever during the last thirteen years in the district under his supervision. The results of the inquiry have been published in the form of a report. The question of the natural history of scarlet fever and the effect on it of compulsory notification and isolation, has been frequently brought forward by The Medical Press and Circular during the last four years, and although the lesson shown by articles in these columns—namely, that an enormous amount of money is being expended in hospital isolation with very little effect on the prevalence of the disease—was at one time scornfully rejected by authorities, it is now being appreciated. Dr. Seaton's report shows that 17,541 cases have occurred in the period under notice, but that the disease has been very mild and the mortality very small indeed, the number of deaths being less than those caused by measles. This paucity of deaths he attributes not to the decreased prevalence of scarlet fever, but to the benign form in which it now occurs. We do not follow Dr. Seaton in his deduction that this attenuation of virulence has been due to notification or isolation; first, because periods of benign scarlet fever always follow virulent outbursts; and, secondly, because, as he shows in his report, those districts which have not adopted hospital isolation have not suffered unduly in comparison with neighbouring areas where the plan is in force. Two of the faults which seem practically to nullify the influence of hospital isolation are shown to be "return" cases and late notification, and it seems rational to admit that if there were no return cases, and if early diagnosis could be made, *i.e.*, before the infective period, much good might, *primâ facie*, be expected from the system. The practical point is whether with these loopholes, which in the present state of our knowledge, it is impossible, or almost impossible, to close, it is worth while continuing to spend enormous sums in trying to "stamp out" a disease which causes so few deaths, when money cannot be found to deal with enormously important diseases like tuberculosis. In other words, would it not be a much better investment for the money available for disease isolation if it were expended on tuberculosis instead of on scarlet fever? We do not presume to say that the consumption sanatorium has been the success, or anything like the success, predicted for it, but to look at the matter from the humanitarian point of view alone, it seems to us that far more alleviation to human suffering would result from the hospital treatment of the consumptive who is very ill, and may even suffer terribly, than from cooping up for many weeks or months of numbers of healthy individuals who find the restraint irksome, and who seem to have little or no effect on the spread of scarlet fever. The only defence of the anomaly is that the scarlet fever isolation system is the established one, and possession is nine points of the law.

CURRENT TOPICS.

The Medical Defence Union.

The annual meeting at Liverpool last week of the Medical Defence Union registers the continued progress of its invaluable work. In face of the rapid growth of its membership from 400 in 1888 to over 7,000 in the present year, there is no need to insist upon the value of its protection to individual practitioners. As the President, Dr. Stamford Felce, pointed out, no class of the profession is exempt from the attacks of unscrupulous persons, and even consultants of the highest repute are occasionally obliged to defend themselves in actions for alleged negligence. We strongly advise any medical man who is not a member of one of the defence associations to write to Dr. Bateman, Trafalgar Square, London, for a copy of the last annual report. The record of the year's work forms the best testimony possible to the positive benefits conferred on members by this great professional organisation. As the oldest of these bodies, the Medical Defence Union has done pioneer work in establishing protective defence, and we are glad to see that now it is extending its operations againsts quacks and quackery. It is a sign of the times that at the Liverpool meeting a member formally called the attention of the Union to the prescribing and medical practice of chemists.

University Professors and Religious Tests.

We cannot forbear expressing our regret that Mr. Birrell, in defiance, as he admits, of his better judgment, has consented to insert a clause in the Irish Universities Bill, imposing tests on the professors of the colleges of the new university. The test will probably resemble that at present in force in the Queen's Colleges, namely, a declaration on the part of the professor that he will not teach anything contrary to the faith of his students. This declaration may lead to serious trouble in the future, since the tenure of office of the professors is to depend on the will of the governing body of the colleges. In the case of scientific teachers this concession of Mr. Birrell is not unlikely to hamper teaching in a disastrous fashion. We do not suggest that there is any fundamental hostility, or even incongruity between science and religion, since two truths cannot clash, but the ecclesiastical view of truth does not always agree with the scientific. If, as seems likely, the ecclesiastical element will be strong in the new governing bodies, it may go hard with men of science. Imagine the mercy shown to a Tyndall or a Huxley in the new universities! But our objection is based on broader grounds. Science and learning should be free and untrammelled. The teacher and the investigator must be left free to teach and to say, regardless of the opinions of others, the truth as he knows it, and any attempt to shut his mouth by the imposition of tests is alike immoral and unscientific.

The Council of the Royal College of Surgeons of England.

The annual election of members to the Council of the Royal College of Surgeons, England, takes place on the 2nd proximo, at which no fewer than four vacancies will be competed for. These are created by the resignation of Professor Howard Marsh, and Messrs. Harrison Cripps, J. Ward Cousins, and A. Pearce Gould. Professor Marsh, now the Master of Downing College, Cambridge, has resigned in consequence of the pursuance by the majority of the Council of a policy which does not meet with his acceptance. The other three councillors retire by rotation, and, presumably, they will offer themselves for re-election. There is one prominent representative of the surgical branch of our art, who, we believe, has never offered himself for election to the Council. We allude to Sir Victor Horsley, than whom, it might rightly be said, no one could be more fitted for the honour. Surely, despite all his professional and medico-political duties, Sir Victor might be prevailed upon to enter the Council —for it goes without saying that his election would be assured. If he agreed to this proposition, in time, undoubtedly, the high honour of being President of the College would naturally fall to him, which would only be some return for the progressive and original work which he has accomplished in surgical science and medical politics.

The Examinations of the Apothecaries' Hall, Dublin.

It will be seen in our report of the proceedings of the General Medical Council that the Executive Committee of the Council have recommended that the examiners appointed by the Council to examine in surgery at the qualifying examinations of the Apothecaries' Hall, should be instructed to supervise the medical and obstetrical portions of the examination, with the object of securing that at each qualifying examination the required standard of proficiency is maintained. The representative of the Apothecaries' Hall on the Council, Dr. Adye Curran, strongly objected to this proposal, and even called attention to the necessity, if it was adopted by the Council, of seeking a remedy elsewhere. Under the circumstances, therefore, we do not propose to comment on the necessity or otherwise for such an inspection, but we do desire to point out that even if the principle of supervision is accepted, surgical examiners are hardly the proper persons to supervise examinations in medicine and obstetrics. Supposing under such circumstances the Apothecaries' Hall carried out their threat of appealing to the Courts for protection, we fancy the General Medical Council would not improve their position by having to admit that they had appointed as supervisers of an examination in obstetrics, gentlemen who probably had not seen or attended a case of labour since their student days. It is obvious that if such supervision is necessary, the proper persons to supervise the medical and obstetrical portions of the examinations are men who devote their time to the practice of these branches of the profession.

The Irish Universities Bill.

The Irish Universities Bill is dragging along in the Committee stage, and at the present rate of progress is likely to continue so doing for a considerable time. At the end of last week the first clause had been passed, and the second clause was under discussion. In the meantime, an unforeseen cloud has arisen in the proposal by Mr. Birrell to affiliate Magee College to the Belfast University, and Maynooth College to the Dublin University. The effect of this is twofold. In the first place, it places in the power of extern students, resident and taught in ecclesiastical seminaries, and out of touch with University life, to swamp in Convocation the electoral power of graduates who genuinely belong to the University. In the next place, it obviously, and for all time, brands the University of Belfast as a Presbyterian institution and the new University in Dublin as a Roman Catholic institution, and thus at once sweeps away all suggestions that such is not the case. It is obvious that the first of these two consequences, at any rate, is a very serious matter, as when taken in conjunction with the excessive representation of local bodies on the Senates of the Universities, it goes far to destroy any prospect there was that the Universities should be governed by an academic body. Another sensation is to be found in a letter to the press by Mr. Campbell, the junior Member of Parliament for Dublin University, in which he points out that the University of Dublin is bound to suffer very severely under the provisions of the new Bill; that there is no really representative opinion in Ulster in favour of the establishment of a University in Belfast; and that, under the circumstances, the best thing that could happen would be the union with, or the affiliation of, the Queen's College, Belfast, to Dublin University. The terms of such a union, he thinks, would doubtless be difficult to adjust, but not impossible. If such a union were to take place it would only be an additional proof that in Ireland, as in Africa, the unexpected has a way of happening.

A Cingalese Quack at the Franco-British Exhibition.

The Franco-British Exhibition contains an excellent illustration of the modern quack, of the kind that figures largely in every modern scheme of civilisation. The gentleman in question is a diminutive Cingalese medicine-man, four feet in height, who is to be consulted in the Cingalese village. The fact that he does not speak English will probably not abate one jot the confidence of his clients in his medical skill. His great field is said to be in the cure of "sprains," a sphere of activity that is peculiarly inviting to the quacks of all nations and all climes. Gout and rheumatism he apparently claims to be able to treat, although it seems curious that a Cingalese should have acquired any close acquaintance with those home diseases. As to indigestion, he is said to possess many remedies of great value, and here, again, the claim is more than reminiscent of the shoal of quack advertisements of a thousand-and-one vaunted specifics for the cure of dyspepsia. It says little for the intelligence of mankind when a native of a remote Asiatic village is imported into the centre of the richest and most enlightened civilisation in the world in order to offer remedies for its disordered digestion. Nor does it say much for the preceding army of quacks who, despite their claims to omnipotence in that special branch of therapeutics, have left any uncured dyspeptics behind for the Cingalee to practice upon. The medicine-man, it is said, understands one English word, to wit, "stethoscope." Its mention within his hearing arouses, so we gather, a sort of fury, on the ground that "plants and herbs" cure more than stethoscopes. His practice appears to be no better and no worse than that of the myriad quacks who batten upon the credulity of mankind in all parts of the world, civilised and uncivilised. The present writer has seen a quack advertisement pasted on the walls of a Chinese town!

Medical Euphemisms.

The exigencies of medical practice oblige one to resort to various verbal subterfuges in order that the truth may not be brought too clearly home to the patient on the one hand, yet may convey an unmistakable meaning to the ears for which they are intended. The use of the word "specific" is a very good example of the kind, and "neoplasm" is another. Of late a tendency has manifested itself to discuss certain medico-social questions more openly than was formerly held to be admissible, and a new vocabulary has become necessary in order to avoid shocking the feelings of ladies bent on reform, who while willing, nay, anxious, to discuss the social questions still squirm at the descriptive term. In France, Brieux's celebrated play, "Les Avariés," *e.g.*, "the Damaged Ones," has called public attention to the immense amount of evil that is inflicted on a defenceless section of the public by unscruplous, careless, or ignorant men, and parents are now beginning to inquire closely into the medical history of the candidate sons-in-law in order not to ally themselves with an *avarié*. In order to permit the subject being discussed in the bosoms of families, the quasi-medical terms, "avariosos" and "neisserosis" have been introduced to designate syphilis and gonorrhœa, and bid fair to become acclimatised.

PERSONAL.

The Earl of Lytton presided on May 26th at the annual meeting of the State Children's Association.

The French Hospital, in Shaftesbury Avenue, was visited last week by M. Fallières.

Dr. G. Nixon Biggs has been appointed Assistant Surgeon to the Ear, Nose, and Throat Department of the Dreadnought Hospital, Greenwich.

Lord Cromer will take the chair at the first meeting of the Research Defence Society, to be held at 20, Hanover Square, on June 19th, at 5 p.m.

Dr. Samuel Rotmann, who, although a Jew, has spent twenty-eight years as a surgeon in the Russian Army, has now retired from active service.

Dr. J. B. H. Davson, Medical Officer, Sierra Leone, has been transferred to the Gold Coast Colony on promotion, as Senior Medical Officer of that Colony.

Dr. Raymond, the well-known French neurologist, will deliver an address at the Royal College of Physicians of London, on June 22nd, at 5 p.m. His subject will be: "Les Maladies dites Familiales."

Dr. J. B. Addison who, since the transfer of Dr. R. Denman to the Federated Malay States, has been acting as Chief Medical Officer, Seychelles, has been confirmed in that office.

A statue to Queen Alexandra has recently been erected in the grounds of the London Hospital. It is executed in bronze by Mr. George Wade, R.A., and shows her Majesty in Coronation robes.

Dr. Comyns Berkeley, B.A., M.B. Cantab., M.R.C.P., has been elected Obstetric Physician, and Dr. W. F. Victor Bonney, M.S., B.Sc., F.R.C.S., Assistant Obstetric Physician, to the Middlesex Hospital.

At the General Hospital, Stratford-upon-Avon, on May 20th, Dr. H. Lupton's long and valuable services to the institution were recognised by the presentation to him of a handsome silver tea and coffee service and silver salver.

Earl Cawdor, the treasurer of the London Homœopathic Hospital, Great Ormond Street, W.C., has received the sum of 1,000 guineas for the endowment of a bed in the new extension, in memory of Dr. George Napoleon Epps, from his daughters and sons.

Dr. M. Armand Ruffer, C.M.G., M.D.Oxon., President of the Maritime, Sanitary, and Quarantine Council of Egypt, has been granted the Royal permission to wear the insignia of Commander of the Order of the Crown of Italy, conferred on him for his valuable services by H.M. the King of Italy.

After a considerable period of ill-health, the secretary of University College Hospital, Mr. Newton H. Nixon, has found himself unable to resume the duties of his post, and has in consequence retired. He has been granted a substantial pension by the hospital authorities.

The Clarence Wing fête, held at St. Mary's Hospital last week, has enriched the opening fund to the extent of some £2,000. This sum resulted from the sales alone, and it is hoped that the subscription list in conection with the fête will be considerably more productive.

At the Samaritan Free Hospital Mr. Butler-Smythe, F.R.C.S.Ed., and Dr. Corrie Keep, M.D., have been promoted from the out-patient department to be surgeons to in-patients. The vacancy on the junior staff has been filled by the appointment of Dr. R. D. Maxwell, M.D., F.R.C.S., to be surgeon to the out-patient department.

Mr. W. P. H. Montgomery, honorary assistant surgeon to the Manchester Royal Infirmary, who has been in close association with the Infirmary for about 20 years, has written from Bournemouth regretting that, owing to ill-health, the time had come for him to resign his position.

A CLINICAL LECTURE

ON

INFANTILE MARASMUS. (a)

By G. F. STILL, M.A., M.D., F.R.C.P.,

Professor of Diseases of Children, King's College, London; Physician for Diseases of Children, King's College Hospital; Physician to Out-Patients, Hospital for Sick Children, Great Ormond Street.

GENTLEMEN,—Marasmus, or wasting, is a symptom rather than a disease, and, like most symptoms, may have many different causes. I mention this at the outset because I think there is a tendency to jump to the conclusion that whenever an infant is wasting, there must be something wrong in the food, and that all that is required is to change the food, and keep on changing it until the weight begins to rise. Undoubtedly digestive trouble from unsuitable feeding is the commonest cause of wasting in infancy, but even so, it does not follow that the food requires changing; it may be that the fault is not in the food, but in the manner of feeding, particularly as to the frequency or the bulk of feeds; moreover, there are cases in which the wasting is not due to any fault in the food or manner of feeding, but to some cause in the infant, such as chronic constipation or congenital syphilis.

Unsuitable food—to deal with the commonest cause first—is not necessarily, or even usually, grossly improper food; it is unsuitable usually through some slight excess or deficiency in one or other of the constituents of an ordinary milk mixture.

Faults in the Food.—Insufficient dilution is a common fault. An infant who is fed with equal parts of milk and water at a month old, or with two parts of milk to one of water at three months, is likely to have a disordered digestion and waste; it is perfectly true that there are infants who will thrive on undiluted milk almost from birth, but in my experience this has been the exception, not the rule. One may accept as a sort of working standard the following proportions:—

Three months, milk and water equal parts.
Six months, milk 2 parts, water 1 part.
Nine months, milk 3 parts, water 1 part.

Any considerable departure from these proportions is likely to result in failure of nutrition, except in cases where cream is added, and where, therefore, the dilution may be much greater without harm.

An excessive proportion of cream is often responsible for nutritional disturbance. An infant may tolerate an average proportion of 4 per cent. of fat in human milk, but my own clinical observation has convinced me that the cream from cow's milk is less easily tolerated, and that it is seldom wise to exceed 3.5 per cent. of fat in the mixture, whilst there are many infants who cannot digest a mixture containing more than 3 per cent. of fat. Often I find that a wasted infant has been given two tablespoonsful of cream in a feed of three ounces, consisting of equal parts of milk and water; no attempt has been made to ascertain the strength of the cream, which proves to be the ordinary 48 per cent. cream as usually sold in London. The percentage of the fat in the mixture is therefore 5-6 per cent., and after gaining weight rapidly for a time on this mixture the infant has begun to waste. Herein lies the importance of a practical working knowledge of the composition of milk and of the ordinary foods in common use for infant feeding. Percentage analysis may be, and often is, a very incomplete guide to the choice of a food, but it gives, at any rate, one means by which we may compare any food with the ideal standard, human milk, and with the standards of artificial feeding which experience has shown to be most generally successful. Nature is lenient in her requirements, exacting no slavish adherence to decimal points of percentage, as some would have us believe, yet there are fairly-defined limits of variation which must be observed if an infant is to thrive. To give an infant a food which contains less than 2 per cent. of fat for any considerable length of time after the age of three months is to incur the risk of rickets; on the other hand, to give a food containing 5 per cent. of fat or more is to expose the infant to risk of gradual failure of assimilation, if not to acute digestive disorder.

So, too, with the sugar—any excess is likely sooner or later to bring flatulence and discomfort, with loose, slimy stools and wasting. It is remarkable how little sugar seems to be necessary, but nutrition is likely to be poor when the sugar percentage falls far below 5 per cent., while, on the other hand, sugar above 8 or 9 per cent. is very apt to cause digestive disturbance. In the proportion of sugar is to be included any other carbohydrate present, whether insoluble as starch, or soluble. In my opinion, starch should not enter at all into the diet of an infant under nine months of age; even the small proportion present when barley-water is used as a diluent—that is, .5-1 per cent. of starch at most, will sometimes cause definite disturbance of digestion.

Condensed milk is responsible for much infantile marasmus in hospital practice; and this is usually not due to any excess of sugar, but to excessive dilution. An extreme instance was that of a wasted baby to whom Nestlé's milk was being given in the proportion of four teaspoonsful to two pints of water, which would yield a mixture containing at most: proteid .5 per cent., fat .7 per cent, sugar 2.75 per cent; in other words, practically nothing more than a weak solution of sugar. Even when diluted most carefully so that the proportions become: proteid 1.1 per cent., fat 1.2 per cent., sugar 6.7 per cent, it is so deficient in fat that it is quite unsuitable for prolonged use in infant feeding.

Fresh cow's milk, it is to be remembered, can be made almost as unsuitable as condensed milk if it is diluted too much. I see infants sometimes who, at the age of six or eight months, are having equal parts of milk and water, or, as more often happens, barley-water, with no addition of cream. The result is poor nutrition and rickets.

Faults in the Manner of Feeding.—The manner of feeding is often more responsible than the food for wasting in infancy. Even with breast-feeding, irregularity in the intervals may be sufficient to disturb digestion and produce wasting; so, too, does feeding "whenever he cries," which generally means that the infant is taking milk almost every hour. It is always a wonder to me how mothers who know well enough that if they themselves took meals at short and long intervals quite haphazard they would suffer very quickly with indigestion, expect their babies, whose digestion is so much more easily upset, to digest and thrive when they are fed in this irregular manner.

(a) A Lecture delivered at the Medical Graduates' College and Polyclinic, London, May 12th, 1908.

Even with regularity, the intervals may be wrong; the infant is rarely fed too seldom, usually feeding is too frequent; to feed an infant at three months with three or four ounces every two hours is to overtax digestion and induce marasmus.

Another cause of marasmus upon which I wish to lay some stress—for it is, I think, not generally recognised—is the use of feeds too large for the age. An infant is given two ounces when he is a fortnight old, and perhaps five or six ounces when he is three months old. Now, what happens? At first he gains weight rapidly, and at three or four months old he is a theme of admiration, his weight is considerably above the average, and everything seems *couleur de rose*. Then comes a pause, the weight begins to fall, and soon the infant is in a state of marasmus, from which it is exceedingly difficult to extricate him. I regard these cases of marasmus from too large feeds as some of the most difficult to treat.

Causes in the Infant.—If ever marasmus can be called a disease rather than a symptom it is in a certain group of cases in which, in spite of the best of feeding—it may be breast-feeding—the infant begins to waste and goes steadily downhill, with no evidence of digestive disturbance. Such a condition sometimes occurs in successive children in the same family.

For these cases we have no satisfactory explanation; it seems, indeed, as if, like "the wonderful one-hoss shay," the assimilation in these infants comes to the end of its term of activity before the rest of the functions of the body; it is endowed *ab initio* with less than the ordinary share of durability.

Possibly the fact that some infants manifest from the beginning an extraordinary idiosyncrasy in the digestion of one or other food constituent, so that one infant can digest only the minutest proportion of fat, another only a very low percentage of sugar, and another very little proteid, may explain some of these cases of marasmus starting from birth, for it is evident that if the idiosyncrasy included any two of the constituents, nutrition would be extremely difficult, if not impossible.

A very common group of cases is that in which marasmus follows some acute gastro-intestinal disturbance, especially diarrhœa. Some of these cases resist all treatment, and possibly the theory that fibrotic changes in the mucosa have destroyed the absorptive surface or large areas in the intestine may account for the difficulty in improving nutrition; but probably in many there is nothing more than a disorder of function—an intestinal dyspepsia.

Congenital syphilis is a more easily overlooked cause of marasmus than might be imagined. The marasmus may occur before any other manifestations of the disease are present, so that a diagnosis of the cause may be impossible unless the parents are able to supply the necessary information; and it is very important that they should, for although some of these cases do not respond at all to antisyphilitic treatment, in others mercury at once improves nutrition and saves the infant's life.

There is one cause of marasmus to which I wish to draw special attention, for it is often ignored, namely, chronic constipation. It may be quite useless—nay, worse than useless—to try food after food in the hope of hitting upon the food which will "suit the child," when the one thing needful is regular administration of some laxative drug. Even when the feeding is at fault, constipation will aggravate the difficulty of nutrition; and a regular dose of grey-powder twice or three times daily will often secure a good result from changes in the feed, which otherwise might be made in vain.

Another condition which profoundly affects the nutrition of an infant is congenital heart disease. The blue child, with its clubbed fingers and cyanotic cheeks, excites no surprise when it fails to gain weight; but, remember that congenital heart disease is often associated with no cyanosis whatever, and that in these cases, where there is nothing to draw attention specially to the heart, failure to gain weight or actual loss of weight is a frequent manifestation. I have seen many such cases in which the infant had been under treatment for wasting; there was nothing to call attention to the heart, and it had been assumed that the food was at fault; first one food was tried and then another, but still the infant failed to thrive. Examination showed signs of congenital heart disease. Unfortunately, the recognition of this does not help us in therapeutics, but it does help us I think, in other ways. In the first place, it is no small thing to know the cause of any symptom that we are called upon to treat; such knowledge gives confidence to the doctor, and the knowledge that the doctor knows what he is dealing with gives confidence to the parents. It is far more satisfactory to be able to say to the parents, "The wasting in your baby is not due merely to indigestion or to lack of suitable food; it depends largely upon the deformity of the heart," than to try food after food with unexplained failure, while the parents are disappointed and dissatisfied at what they suppose to be the doctor's lack of skill in "hitting off" the particular food required. In the second place, recognition of congenital heart disease as a cause of marasmus will prevent the hasty assumption that because an infant is not thriving the food must at once be changed. I have known an infant weaned by the unskilled advice of a nurse, when its poor nutrition was in reality due, not to unsuitability of the breast milk, but to congenital heart disease. I suppose that weaning in such a case was the worst possible step which could have been taken. I have not mentioned tuberculosis hitherto, because it must occupy a place in the background of the clinical picture of infantile marasmus. Tuberculosis is extremely rare under three months, rare under six months, and only begins to be common towards the end of the first year. The sooner the term "consumptive bowels" is dropped the better, for it too often confers upon the results of improper or careless feeding the dignity of a dispensation of Providence.

Treatment.—The treatment of infantile marasmus embraces the whole subject of infantile feeding, upon which I cannot enter now, but I will say generally that where marasmus is due to digestive disorder, a weak food is commonly the right food; it is often wise to start afresh with veal broth only or chicken broth, to which milk-sugar may be added in the proportion of a teaspoonful to every 3 ounces. After a day or two milk, freely diluted and peptonised, may be substituted for the broth at alternate feeds; a more readily-assimilable food where even weak peptonised cow's milk cannot be assimiliated is asses' milk; it is often remarkable how well a feeble marasmic infant will thrive for a time on asses' milk. Where asses' milk is impracticable on account of expense, one of the various brands of desiccated milk often succeeds, and in any case may be useful as a temporary food when it is decided to try something a little stronger than asses' milk or much-diluted cow's milk. Where fresh cow's milk in various dilutions has already failed, it is often best to proceed at once to fully-peptonised milk.

Fats are very commonly ill-tolerated by the marasmic infant; the addition of cream is, therefore, often best avoided altogether, and, if used, it should be given in very small quantities. For the same reason cod-liver oil is often quite unsuitable for a wasted infant; it retards digestion and aggravates the trouble.

Lastly, in connection with the diet, I would insist upon the need for slowness in increasing the strength of the food. Again and again the medical man is over-persuaded by an anxious mother into increasing the food or the strength of the milk-mixture, and the result is a most disheartening loss of weight instead of improvement of nutrition.

In treating these infants, remember that for a feeble, wasted infant *warmth* is of the greatest importance. In these days when open-air treatment is the fashion, it is necessary to point out that warmth is far more important to an infant than open-air. By all means let the infant have plenty of fresh air, but see that it is warm fresh air if the infant is in a puny, marasmic state; the excellent results of the incubator, with its temperature of 80°-90° and its meagre supply of fresh air, demonstrate sufficiently the importance of warmth.

With regard to drugs, malt is far more useful for these wasting infants than cod-liver oil; sometimes by using malt instead of ordinary sugar to sweeten the food a distinct improvement in weight is obtained.

Some very interesting observations have recently been made by Dr. Simpson, of Edinburgh, upon the effect of thyroid extract on infantile marasmus. He found that the administration of doses of $\frac{1}{3}$-$\frac{1}{2}$ grain of this drug (Burroughs Wellcome's tabloids were used) three times a day was sometimes followed by more or less steady rise of weight.

I have had some cases under my care at hospital in which it certainly seemed as if a gain of weight was started by the administration of thyroid. I have used the Thyroideum siccum of the British Pharmacopœia in doses of 1-15th to 1-10th grain once or twice daily.

Lastly, I should like to refer to inunction of oil, which is an old-fashioned practice, and, as far as I know, not open to any objection, apart from its "messiness" and unpleasant smell, which, however, may be overcome to some extent by using neat's-foot oil instead of cod-liver oil. I have never been able to satisfy myself that any oil is absorbed through the skin in these cases, but I doubt not that it helps to maintain the warmth of the infant, and in this way may be of value.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Wm. St. Clair Symmers, M.B., C.M. Aberd., Professor of Pathology, Queen's College, Belfast. Subject: "Some Landmarks in the Study of Tuberculosis."*

ORIGINAL PAPERS.

THE MILK PROBLEM,
OR THE
PRODUCTION AND DISTRIBUTION OF PURE, CLEAN MILK. (a)

By JOHN C. THRESH, D.Sc.Lond., M.D., D.P.H. Camb.,

Lecturer on Public Health, London Hospital; Examiner in Hygiene, University of London.

One of the most important—or, I may venture to say, *the* most important article of diet for children (and for invalids) is milk, and for this reason no apology is necessary for my selecting it as the subject of a popular address.

Why milk takes this high rank as an article of food is well known to most of you. It must suffice, therefore, if I merely state that it is the one natural article of diet which contains all the necessary constituents for growth and nutrition, and for the formation of blood, bone and muscle. Not only so, but it contains these in such a proportion that, by slight modification, it may be made suitable for children of any age. Mothers' milk is the natural food for the infant until it is some months old, and, whenever possible, this should be its only food. The milk of no animal can be modified so as to make it identical with mothers' milk, and a mother who can suckle her child and refuses to do so fails in her duty to her offspring, and in her duty to the community, and the sin of omission on the part of the parent is often visited upon her children for more than one generation.

Milk is a product of living tissues, a vital fluid, which, the chemist tells us, contains proteids or flesh-forming matters, sugars, fats, etc., all forming an emulsion in water; but the physiologist tells us that it contains other constituents of great importance, substances of such complex constitution that the application of heat or the addition of chemicals easily destroy them and diminish the value of the milk as a food.

Containing all the necessary elements of nutrition constitutes its great value as a food, and at the same time constitutes its great danger if it is not pure. It is not only the ideal food for animals, but it is the ideal food for bacteria, those very lowest forms of life, some of which are the scourge of the human race.

Put a few bacteria into a little warm milk, and in a few hours they will have increased to millions. Some of those which thrive well are, unfortunately, those which can produce disease when introduced into the human system. The case is very different with water. When the disease-producing bacteria are introduced into water, they die out with greater or less rapidity, they rarely, if ever, multiply. Hence the great importance of keeping them out of the milk. If any water contained in one gallon as many bacteria as may be contained in one or two drops of dirty milk, it would be condemned as utterly unfit for drinking purposes. Yet we have systematic bacteriological examinations made of our water supplies, but we rarely hear of such examinations being made of our milk supplies.

Milk taken in the most careful manner and under the best conditions contains a considerable number of bacteria; but if the milk is properly cooled (to about 40° F.) it will keep for 48 hours with but little change. At 50° F. there will be a most marked increase in 48 hours, but at 70° F. the bacteria will have increased so enormously that a single drop will contain as many bacteria as there are human beings on the globe.

Fresh Milk.		Milk after keeping 48 hours.		
Bacteria per c.c.	...	at 40° F.	at 50° F.	at 70° F.
2,400		3,600	540,000	25,000,000,000

Very fortunately for us, nearly all these bacteria are harmless, if they are not present in such number as to have altered the character of the milk; and fortunate again is the fact that fresh milk has a marked germicidal action.

How do these bacteria get into the milk? As I have stated, some are present in the most carefully drawn milk. Probably these come from the teats, the milkers' hands, the dust from the cows' hide, and the dust in the air. But in milk from unhealthy cows they may come from the milk glands themselves, and in milk, as usually produced, they come chiefly from the manure which coats the flank of the cows, and which all too often is found on the udders also. Sometimes they are also derived from impure water used in washing the utensils, and from the hands or throat of a milkman who may possibly be suffering from an infectious disease.

The bacteria we have most to dread are those producing diarrhœa (possibly the bacillus enteritidis of Gaertner), the bacillus of tuberculosis, causing the various forms of consumption; the bacillus of typhoid fever and bacillus of diphtheria, and the still smaller organisms which cause scarlet fever and epidemics of sore throat.

(a) Abstract of paper read before the Birmingham Branch of the Incorporated Institute of Hygiene, March 30th, 1908.

I have recently had to examine a good many samples of milk, and I have made sketches of the various kinds of dirt, etc., which I found in some of them. These sketches I will pass round for you to examine. Bacteria you will find in all, sometimes in masses of millions, and in all you will find *débris* which could only have been derived from manure. In clean milk the amount of deposit obtained from one pint is exceedingly small in amount, and of a pale fawn colour. In dirty milk it is much more abundant, and of a dirty brown colour. The centrifugalised deposit from pure milk, when injected into a guinea-pig, has little, if any, effect upon it, but the residue from a dirty milk causes the death of the animal.

My experience is no unusual one. The Medical Officer of Health for the City of London caused a number of samples of milk to be examined annually, and the following results are taken from his report:—

	1904	1905	1906	1907
Fairly clean and pure	48·8	68·2	80	54·2
Unclean	43·6	22·7	12	37·5
Tuberculous	7·7	9·1	6	8·3

In this city (Birmingham) last year it was found that 14 per cent. of the samples of milk which came into the city from outside contained tubercle bacilli, and in Liverpool the average for the last six years was 14.5 per cent. Similar results have been obtained in Manchester and elsewhere. We may take it, therefore, that fully 10 per cent. of the milk used at the present time is tuberculous, and capable of producing tubercular disease in children, if not in adults, and that another 30 to 40 per cent. is so unclean as to be dangerous to health, especially in summer time, when the bacteria increase most rapidly.

To enable us to realise the importance of the milk problem, we must first consider to what extent the impurities in milk affect the health.

Tuberculosis of the lungs is a cause of death which is steadily and continuously declining, and to a far greater extent than other forms of tuberculosis which chiefly affect children. Milk may not be the sole cause of these forms of tuberculosis, but we have two very significant facts which, taken together, tend to show that there is some connection between them:—(1) Cows' milk is the most important food of young children. (2) Cows' milk frequently contains the germs of tuberculosis. The results of the researches of the Departmental Committee which issued a report last year lead the members of the Committee to report as follows:—

"There can be no doubt that a certain number of cases of tuberculosis occurring in the human subject, especially in children, is the direct result of the introduction into the human body of the bacillus of bovine tuberculosis, and there can also be no doubt that in the majority of these cases the bacillus is introduced through cows' milk. Cows' milk containing bovine tubercle bacilli is clearly a cause of tuberculosis and of fatal tuberculosis in man."

Whilst referring to this report, I may make one other quotation:—"A very considerable amount of disease and loss of life, especially among the young, must be attributed to the consumption of cows' milk containing tubercle bacilli. The milk coming from such a cow (*i.e.*, one suffering from tuberculosis, and which may be yielding tuberculous milk), ought not to be used as food at all."

Other forms of tubercular disease (general tuberculosis, scrofula, lupus and tuberculous affections of the bones, joints, and other parts of the body not especially specified), the Registrar-General states, cause an average mortality of 186 per million population, or over 5,000 per year in England. "The mortality from these diseases differs from that of the other specified forms of this infection, in that it has risen considerably in the course of the last 40 years, more especially among children under five, whose mortality has increased since 1871-80 by 81 per cent."

That illness may be caused by milk injected with the germs of typhoid fever, diphtheria, and scarlet fever is well known to every medical man. Besides these, many outbreaks have occurred of anomalous illness, sometimes fatal in character, and usually characterised by feverishness and sore throat, due to milk infected with purulent matter from the udders of diseased cows.

Every year epidemics of infectious disease of a more or less serious character, and due to milk, are recorded, and many more, judging from my own experience, pass unrecorded, or are only referred to in the reports of Medical Officers of Health, and there are good reasons for believing that infantile diarrhœa is in some way related to the milk supply.

Dr. Savage, the Medical Officer of Health for Colchester, found that only 26 per cent. of the infants of the borough were hand-fed; yet, amongst these children, 82 per cent. of the fatal cases of diarrhœa occurred.

At East Ham Dr. Sowden found that 80 per cent. of the children were breast-fed; yet only 5 per cent. of the diarrhœal deaths occurred amongst such children. Fresh cows' milk formed the diet of 38 per cent., and condensed milk of 39 per cent. of the children who died from diarrhœa.

That these are not unusual results may be gathered from the fact that Dr. Hope has stated that in Liverpool the deaths from diarrhœa in children under six months of age were in the following proportion:—Breast-fed, 1; partly breast-fed, 15; no breast feeding, 22.

That milk forms the chief vehicle of infection there can be no doubt, and if we assume that in some cases the infection may occur in the houses of the people, it is not unreasonable to assume that the excremental matter which gets into the milk at its source is the cause of the majority of cases.

The remarkable decrease of mortality amongst the infants at the New York Foundling Asylum after the introduction of clean milk and of a milk sterilisation plant is a further proof of the deleterious nature of the bacteria found in milk, and the results obtained in many other institutions and towns with municipal milk supplies corroborate it.

To quote Sir J. Crighton Browne, "measures must be taken to secure a supply for our infants, our children, our invalids, for all classes, of uncontaminated milk of proper nutritive standard. We must have pure milk."

Infantile tuberculosis and infantile diarrhœa show little, if any, signs of diminishing. All our sanitary improvements have had little or no effect because they have not reached the cause of the evil, the impure milk supply.

By improving our water supplies we have reduced the mortality from typhoid fever to an enormous extent; by improving the houses of the working classes and improving the conditions of labour, typhus fever has become almost unknown, consumption of the lungs has decreased continuously, and many other diseases have become far less prevalent and fatal.

Tuberculosis in children and infantile diarrhœa are just as preventible diseases as any of those mentioned, if we set about preventing them in the way indicated by modern science.

The evidence which I have deduced shows that there can no longer be any doubt that impure milk is one of the chief causes of the excessive and continued mortality from these diseases. Hence the great importance of insuring a pure milk supply. Incidentally it may be mentioned that, besides diminishing infantile mortality, a pure milk supply would be a great aid to temperance. Only those who have quaffed pure cold milk in summer know how delicious it is. Those whose only acquaintance with milk as a beverage is derived from drinking it as supplied at refreshment-rooms and bun shops have no idea of what milk should be. I very rarely taste milk, yet I know no beverage in summer to equal cold pure milk, and if I could be sure of obtaining it, I should greatly prefer it to the beverages I am compelled to select. The amount of milk consumed at the present time is only a portion of what it would be if public confidence were gained, and this greatly increased demand would benefit the very persons whom we are urging to supply us with what we want.

First and foremost, we demand that it should be a criminal offence for anyone to sell milk taken from a cow obviously suffering from disease unless a veterinary surgeon has certified that such disease will not affect the milk. No one would knowingly drink milk from a diseased cow, and the public should be protected from having to do so unknowingly. This, no doubt, would imply frequent veterinary inspection, but veterinary inspections now take place when anthrax and certain other diseases are suspected, and this merely to prevent disease spreading amongst cattle. Surely one human being is worth a good many cattle, and the prevention of the spread of disease from cattle to man is infinitely more important than the spread of disease amongst a herd of cows or a lot of swine.

But this question of veterinary inspection I need not labour, as I feel that I have said enough to convince the most sceptical that proper veterinary inspection of the milk cows is imperative.

Our next demand is the more thorough inspection of the cowsheds and dairies and increased supervision over the conditions under which the milk is produced.

Every sanitary authority has power to make regulations for enforcing the provision of sufficient air space for the cows, for securing proper drainage and water supply, and for securing cleanliness generally. Unfortunately, many authorities have not adopted such regulations; but, still more unfortunately, the majority of those who have either do not properly enforce them or say that they are powerless to enforce them.

From a wide experience I have no hesitation in saying that at the present time the majority of the places at which milk is produced are unsatisfactory. In very many there is no proper water supply, more or less polluted water being used for dairy purposes. Enormous accumulations of manure lie in the immediate vicinity of the cowsheds, often in the cow-yard into which the cows are turned in the winter for an airing.

The cowsheds are filthy, the walls and floors being plastered with manure. The ventilation and lighting are defective. Proper lighting is especially neglected.

The excuse given by dairymen for the existence of bad dairy conditions is that he cannot afford the time necessary to produce clean milk and that he cannot get his men to carry out his instructions. One man informed me that if he were to insist upon his men carrying out all the reforms I required, especially those referring to the cleansing of the cows and to the personal cleanliness of the men themselves, that they would leave in a body.

I do not believe this, for I have experience to the contrary. I know many dairy farms where all the cows are groomed daily, where washing utensils are provided in every cowshed, and overalls and caps are worn by every milkman. The managers see that everything is kept clean. One farmer informed me that he had at first some trouble in getting the men to carry out his instructions, but when they saw that he was in earnest and meant to have them carried out they were and are carried out, and he has not had to engage a single additional hand. It costs him no more to produce his milk under cleanly circumstances than it did previously under the unclean conditions. It is useless a master giving instructions or hanging up printed instructions in his cowsheds if he does not himself rise early and see that they are obeyed. One sanitary authority issued large cards of printed instructions to milkers and had them distributed. I found some of these prominently displayed in cowsheds where every instruction was ignored and where the cows were in a disgustingly filthy condition. There they are, said the cowkeeper, I cannot make the men carry them out.

It is perfectly certain that until the public bodies now entrusted with authority have additional powers and are compelled to assert their authority, or until the powers now, or to be, conferred upon them are delegated to some other bodies which will either themselves enforce them, or see that the sanitary authorities enforce them, very little progress will be made. Meanwhile we must continue to use dirty milk or be driven to use such substitutes as tinned milk or dried milk, or sterilised, or pasteurised milk, or we must go without milk.

It may be difficult and an expensive matter in some cases to obtain a good and copious water supply, but a farm should not be used as a dairy farm unless it has such a supply.

If clean milk is to be supplied it must be clean from the beginning; I have no faith in filters and strainers. This is a case in which "Prevention is better than cure." Keep out the polluting matter, it is easier and cheaper and infinitely preferable to keep out the filth than to remove it afterwards by any process whatever.

(To be continued.)

IONIC MEDICATION
IN THE TREATMENT OF SOME OBSTINATE CASES OF
PELVIC DISEASE IN WOMEN. (a)

By SAMUEL SLOAN, M.D., C.M. GLASG., F.F.P.S.,

Consulting Physician to the Glasgow Maternity Hospital, and to the Glasgow Hospital for Diseases of Women.

THE author explained that ionic medication was the application of electro-chemistry to therapeutics. He showed diagrammatically the probable position and behaviour of the ions—molecules and atoms—in the case of water: first, when not influenced by any electro-motive force; secondly, when an E.M.F. of 1 volt is applied; and thirdly, under at least 2 volts, when decomposition of the water takes place. He next demonstrated the existence of free ions in a solution of common salt, by showing that a current could be set up by the mere insertion of two carbon electrodes into the solution, giving evidence at the same time that these electrodes did not differ in potential. He explained that, whereas in the case of simple electrolysis the changes took place at the poles only, in the case of ionic medication, on the other hand, the changes took place from the active pole into the tissues in the direction of the neutral pole; iodine, etc., from the negative pole; copper, etc., from the positive pole; these being the two substances which he had used in this treatment.

He quoted from Prof. Howard A. Kelly's new book on "Medical Gynæcology," to prove how obstinate were most of the cases of sepsis of the genital tract in women, and then proceeded to refer to some cases of obstinate septic disease accompanied with purulent discharge, which he had treated by ionic medication. The success had, in his hands, been most gratifying, a cure having practically resulted in nearly all his cases, after a short term of treatment. The same may be said of his treatment of cases of hæmorrhage.

The solution he employed was, in the case of copper, 1 per cent. of the cupric chloride. The vulva is first treated by being carefully packed with cotton-wool soaked in the solution; then the medication is applied to the vagina in a specially-made glass speculum containing a spiral of copper wire, and filled with the copper solution. When vulva and vagina have been rendered aseptic, a specially-constructed cervical electrode is passed through the speculum as far as the inner os. A few applications, say, three or four, at intervals of three or four days, usually suffice to render this cavity normal. The endometrium is next treated by means of a long, curved and grooved copper electrode passed up to the fundus. The patient during the applications is placed on her back with a bed-slipper under the pelvis. When the affection partakes of a sub-acute nature he prefers to use iodine as the ionic agent, the solution employed being a 2 per cent. one of iodide of potassium combined with 0.2 per cent. solution of liquor iodi.

His electrode holder is kept in position by a bag of shot which rests on the broad end of the holder on the couch, this holder serving to keep the speculum in position. The current he employs is from a battery of Leclanché cells of good size, and about twenty in number, the amount of current varying from 10 to 20 m.a. for 15 to 20 minutes.

(a) Abstract of paper read at the meeting in Glasgow of the Electro-Therapeutic Section of the Royal Society of Medicine, May 22nd, 1908.

The neutral electrode, he advises, is one made of copper gauze covered with wet sculptor's clay, on which the patient's hands rest.

Since he began this form of treatment he has seldom required to employ curettage in the treatment of septic endometritis, and he believes that no other form of treatment will give results in any way approaching those to be obtained from ionic medication.

THE CURE CRAZE OF TO-DAY. (a)

By R. MURRAY LESLIE, M.D., M.R.C.P. Lond.,

Physician to the Prince of Wales Hospital, Physician to the Royal Hospital for Diseases of the Chest, &c.

"Cures" of all kinds, it is hardly needful to point out, are as ancient as history itself. Homer refers to the cure of Hercules by Minerva at the springs of Thermopylæ—cures by hot air baths and hot springs were well known to the ancient Greeks—and Hippocrates himself recommended them to his patients. Hydropathic cures were largely practised by the Romans. Julius Cæsar had his health restored by the sulphur springs of Cauterets; Nero regularly visited the vapour baths of Pozzioli; while the wonderful remains of the Roman thermæ at Pompeii, Pragnieres, Bath, and countless other places, show how universal was the custom amongst the Romans of taking the cure.

It would be impossible to refer to all the cures in vogue at the present day. There is the rest cure, the open-air cure, the hydropathic cure, the various bath and thermal cures, the mud cure, the massage cure, the sun cure, the light cure, the Weir-Mitchell cure, the Salisbury cure, the Chittenden cure, not to speak of the multitude of cures associated with individual health resorts, such as the Plombieres cure, the Nauheim cure, the Aix cure, the Vichy cure, the Marienbad cure. There are cures for making people fat, and still more numerous ones for making them thin, while in addition to these more or less legitimate cures there are hundreds of quack cures, whose devotees or victims may be numbered by thousands, and there are religious and ostensibly religious cures, such as the Lourdes cure and the Christian Science cure.

The existence of all these cures is no doubt partly a question of demand and supply, and partly one of obedience to the dictates of fashion. The demand is the outcome of the strain, stress, and hustle of modern life. Competition is so keen that the business man drains his mental and physical energy. He is constantly on the rack, with insufficient leisure to recruit his energies, and even his spare time is fully occupied with his social or other duties, or it may be with his pleasures and dissipations. He eats too much, sometimes drinks too much, and sleeps too little. The professional man works, if possible, still harder. The growing army of women engaged in business and professional pursuits often work far beyond their strength, regardless of ill-health and of natural and acquired ailments. The fashionable woman has to work still harder. She has her ceaseless round of social duties and pleasures—her shopping, her dressing, her lunch parties, her bazaars, her afternoon calls and "at homes," her dinners, bridge parties and dances, and then snatches a few hours' sleep before re-commencing her next day's round. In her sane intervals she has to acquire a smattering of the current political and other topics of the day for conversational purposes. In fact, on all hands the candle is being burnt at both ends, and the bodily system is taxed and racked beyond its limits of endurance. The result is nervous breakdown, brain fag, physical exhaustion, and disordered functions of the bodily organs, with their thousand-and-one manifestations.

Desperate illnesses require desperate remedies, hence the necessity of cures planned to suit the different needs of the individual. There is, however, another factor at work which must not be ignored. There has arisen an almost morbid interest in all questions relating to personal ailments. Appendicitis is quite as common a topic of conversation as the merits or demerits of the Directoire costume, and such matters are probably the commonest subjects of conversation at the present day. What a boon it would be if there were similar eagerness to discuss the necessity and practice the art of living a natural hygienic life which would avoid the many evils that the different cures are designed to treat, and it is one of the main objects of this Institute to inculcate these elementary principles of hygiene among the younger women of England and the future mothers of our race.

The factors more or less common to all cures are rest, fresh air, sunlight, change, regulation of diet, daily exercise, and faith, most of which are comparatively easy of attainment by the well-to-do.

(a) Summary of Address delivered at the Institute of Hygiene, May 26th, 1908.

CLINICAL RECORDS.

CASE OF ANEURYSM OF THE DESCENDING AORTA.

By R. O. MOON, M.D.

H. C., a carman, æt. 37, came up to my out-patient department at the Heart Hospital, in January, 1908, complaining of pain in the left lumbar region for the last 18 months, which was gradually becoming worse.

Family History.—Father died of rheumatism, and mother of apoplexy.

Previous History.—At the age of 18 he had syphilis, for which, apparently, he did not undergo any lengthy course of treatment. Since then he had enjoyed good health till 1½ years ago, when he describes himself as having been caught somewhat suddenly by pain in the left side. For about a fortnight he was quite unable to move. After that he was able to get about, but was obliged to give up his work entirely, and was never entirely free from pain. For the past six months he had had dyspnœa and palpitation of the heart on exertion.

The examination of the heart showed the apex beat to be within the nipple line, the impulse heaving, and a soft systolic murmur traceable into the axilla. Examination of the lungs, however, presented complete dulness over the left lung posteriorly from the base to the spine of the scapula and in the axilla; the TVF was much diminished; on the other hand, the air entered well.

The pain was very definitely localised to the left lumbar region, which was tender on pressure. At times the pain, which was of a continuous gnawing character, extended to the epigastrium, but there was no pain on percussion of the vertebræ. A diagnosis was made of aneurysm of the descending aorta. The possibility of a mediastinal growth was ruled out partly on account of the age of the patient, and also because a growth would almost certainly have proved fatal in 18 months. Then, too, there was the history of syphilis, which, of course, pointed to aneurysm. The X-rays showed a large tumour in the left chest, but were not helpful as to its nature.

While in hospital he did not get much relief from iodide of potassium, but fortunately the pain was by no means so severe as is often the case with aneurysm, and only once did he require morphia. He went out of the hospital at his own request after six weeks, and a week later suddenly became faint, fell to the ground, and died a few minutes after the arrival of the doctor who had been summoned. As the latter knew nothing of the case, an inquest was held, and I heard later that a large sacculated aneurysm of the descending aorta, some 5 inches from the diaphragm was found, which had thus suddenly ruptured.

The case seems to be of some interest from the suddenness of the initial onset of the pain, and from the fact that the pain, though continuous, was never very severe, and remained the only symptom of the disease till the final rupture of the aneurysm.

OPERATING THEATRES.

GUY'S HOSPITAL.

Laparotomy for Cancerous Growth. — Mr. Arbuthnot Lane operated on a woman, æt. 34, who was suffering from a cancerous growth of the rectum involving the posterior surface of the uterus. He opened the abdomen by a vertical incision ¾ inch to the left of the middle line and extending from the umbilicus to the symphysis pubes. The sigmoid was separated from the iliac fossa to which it was fixed as is usual when distal obstruction exists by firm adhesions. In the same way the left ovary and tube had become involved in the peritoneal bands. The growth in the rectum was then defined, when it was found that the infection of the uterus was limited to the junction of the body and cervix. The uterus was removed together with the entire rectum and meso-rectum, with a portion of the meso-sigmoid, the bowel being brought out through the abdominal incision. Then it was divided, and sufficient length only being left to connect up with the special arrangement of tube and bag which Mr. Lane employs in these cases, and which is so efficient for the purpose of cleanly drainage. He then closed off the true pelvis by suturing the peritoneum covering the bladder and broad ligaments to the peritoneum covering the posterior margin of the pelvic inlet. A piece of gauze was then placed in the pelvis below this artificial peritoneal diaphragm, which separated the true pelvis from the remainder of the peritoneal cavity. During the greater part of the operation a quantity of saline solution was passing into the subcutaneous tissue of the axillæ. This was continued for several days. The patient was doing exceedingly well five days after the operation.

On the same day Mr. Arbuthnot Lane operated on a man who had a cancerous mass in the sigmoid which produced marked obstruction. The abdomen was opened in a manner similar to the last. The growth was found to involve the sigmoid for an area of three inches. It had dropped into the case of the pelvis, where it lay to the left of the middle line fixed to the bladder, which was involved in the growth over an area of one and a half inches square. The growth, with the peritoneal and muscular coat of the bladder to which it was attached, was removed from the pelvis, and brought out through the abdominal incision. It was then freely excised with the area of meso-sigmoid corresponding to it. Continuity of the sigmoid was then effected by an end-to-end junction. The damage sustained by the bladder was met by the accurate approximation of the incised peritoneal margins. The progress of the case was excellent.

Operation for Fractured Femur in a Child.—Mr. Arbuthnot Lane also operated on a young child who had been struck by a motor-car, and who had sustained a somewhat irregular transverse fracture of the femur at the level of the trochanter; the upper extremity of the shaft was displaced upwards and inwards upon the upper fragment, and this displacement was only exaggerated by traction and manipulation. The seat of fracture was exposed by a vertical external incision when an attempt was made to replace the fragments in apposition by traction on the limb. It was then seen that the traction on the shaft caused the upper fragment to rotate around an axis running antero-posteriorly through the head of the femur, and so render replacement impossible. It was attempted to control this rotation of the upper fragment first by traction in an upward direction in the trochanter, but this resulted only in damage to this structure, which was very fragile. A similar result followed an attempt at reduction by the introduction of an elevator between the fragments, the exercise of any leverage being followed by some scrunching of the broken surfaces. Finally, by adducting the thigh very forcibly the upper end of the shaft was protruded outwards through the incision, and accurate apposition was at last obtained. The replacement was very difficult and prolonged. Mr. Arbuthnot Lane pointed out that in his experience this fracture occurring in young life was the most difficult he knew to deal with, and after it he would put a similar fracture of the humerus at the same period of life. The difficulties in the way of replacement were the mobility and fragility of the upper fragments. When the fragments of the femur were accurately apposed they were retained in position by a dumb-bell shaped steel plate with three screws, two of which received the shaft, one the upper fragments. The screws employed were those he had chosen for fractures of the patella, and such fractures in which only a proximal compact tissue could be easily dealt with. They were half-inch screws threaded up to the head, the smooth barrel being absent. This form of screws in the peculiar circumstances offers special advantages. The absence of the barrel is not material to the functioning of the screw, since friction and not approximation are required of it. The child is making the uninterrupted recovery which is universal in this class of case.

SPECIAL REPORTS.

GENERAL MEDICAL COUNCIL.

EIGHTY-SEVENTH SESSION.

FIRST DAY.—Tuesday, May 26th, 1908.

The President, Dr. MacAlister, in the Chair.

The President read his address. He began by referring in a few well-chosen words to the regretted deaths since the last session of Sir Thomas McCall Anderson, of Sir Patrick Heron Watson, and of Dr. James Bell Pettigrew. He then stated that the University of Glasgow had done him the honour of appointing him, as from May 27th, to be its representative on the Council. He therefore proposed to resign on the morrow the seat to which he was elected some nineteen years ago by his fellow-graduates of the University of Cambridge. This would necessitate his vacating the Presidential chair. He pointed out that in the direction of finance the Council could look back with satisfaction, the surplus in 1907 being £1,095, even after £415 had been paid towards the expense of enlarging the Council chamber and of improvements, one of the most important being the erection of a light gallery specially reserved for representatives of the Press. The President next referred to the recognition of the degree of Doctor of Medicine of the McGill University of Montreal and the Laval University of Quebec; also to the question of restraining medical practice by unqualified persons. After mentioning the medical faculty of the University of Wales, and speaking of the work performed by the various committees of the General Medical Council, Dr. MacAlister finished his address with the following words:—"In conclusion, I would remind the Council that its first meeting was held on November 23rd, 1858, pursuant to a summons by the Secretary of State at the Royal College of Physicians of London, and under the Presidency of Sir Benjamin Brodie. Our next session in the ordinary course will begin on November 24th, 1908, and the Council will just have completed the first fifty years of its existence. . . . I suggest that we should celebrate our jubilee by a friendly reunion, to which all who survive of the past members of the Council should be invited. . . ."

Moved by Dr. LITTLE, seconded by Dr. NORMAN MOORE, and carried by acclamation:—"That the President be thanked for his address, and requested to let it be printed in the minutes."

On motion from the CHAIR, it was agreed:—"That the following constitute the Business Committee:—Dr. Norman Moore, Chairman; Mr. Young, The President, Sir Christopher Nixon.

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to:—"That the Council do adjourn after 4 p.m. to enable certain committees to meet for the completion of their reports."

Moved by Dr. NORMAN MOORE, seconded by Sir JOHN MOORE, and agreed to:—"That the following yearly tables be received and entered in the minutes":—

(*a*) I. and II. Tables showing Results of Professional Medical Examinations during 1907.

(*b*) Table showing Results of Professional Examinations for Qualifications in Sanitary Science, Public Health, or State Medicine during 1907.

(*c*) Table showing Results of Professional Dental Examinations during 1907.

(*d*) Table showing Results of Preliminary Examinations during 1907.

(*e*) Answers sent by the Medical Authorities as to the exemptions granted by them in any part of their Examinations during the year 1907

(*f*) Table showing Results of Competition held on May 4th, 1908, for Commissions in the Medical Staff of the Royal Navy.

(*g*) Table showing Results of Competition held in January, 1908, for Commissions in the Indian Medical Service.

Moved by Dr. MCVAIL, seconded by Sir CHRISTOPHER NIXON, and agreed to:—"That the thanks of the Council be conveyed to the Director-General of the Medical Department of the Royal Navy, and the Under-Secretary of State for India respectively, for the returns which they have again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council."

Moved by Dr. SAUNDBY, seconded by Sir CHRISTOPHER NIXON, and agreed to:—"That in future such regulations of the General Medical Council as have been passed from time to time relating to the conduct of members of the medical profession shall be included in the matter published in the *Medical Register*."

Moved by Dr. SAUNDBY, seconded by Sir CHRISTOPHER NIXON, and agreed to:—"That in future such regulations of the General Medical Council as have been passed from time to time relating to the conduct of members of the dental profession shall be included in the matter published in the *Dentist's Register*."

Moved by Sir HUGH BEEVOR, seconded by Mr. MORRIS, and agreed to:—"That Mr. Peyton Todd Bowman Beale, F.R.C.S.Eng., L.S.A., be appointed Assistant Examiner in Surgery to the Apothecaries' Society of London vice Mr. Stonham, who retires by rotation."

Dr. ADYE-CURRAN asked whether the Assistant Examiners in Surgery to the Apothecaries' Society of London would be directed to report on the other two subjects of the Final Examination.

The PRESIDENT answered that the Council might so direct it if it saw fit.

Read:—A report by the Executive Committee pursuant to the following standing order:—"The Executive Committee shall be empowered to take the necessary steps for carrying into effect the clauses of the Medical Act (1886) relating to the registration of the diplomas of colonial and foreign practitioners, and shall report to the Council, from time to time, their proceedings thereon.—(1887, XXIV., 270)."

REPORT.

The Executive Committee report that Part II. of the Medical Act (1886) having been extended by an Order in Council to the Province of Quebec, they have considered the conditions under which certain medical qualifications granted in the Province shall be recognised for registration in the Colonial List of the *Medical Register* of the United Kingdom, and on May 25th, 1908, adopted the following resolution:—

"That any person who holds—(1) The Degrees of Doctor of Medicine and Master of Surgery of McGill University, Montreal, together with the Licence to practise in the Province of Quebec; or (2) The Degree of Doctor of Medicine of Laval University, Quebec, together with the aforesaid Licence to practise, shall be entitled to be registered in the Colonial List of the *Medical Register*, provided he satisfies the Registrar of the General Medical Council regarding the other particulars set forth in Part II. of the Medical Act, 1886."

On motion from the CHAIR it was agreed unanimously:—"That this report of the Executive Committee be received and entered on the minutes; that the Registrar be directed to give effect to the resolution therein contained, and that the Council record its satisfaction at the establishment of reciprocal relations with the Province of Quebec, and its desire that similar relations may soon be established with the other Provinces of the Dominion of Canada."

On motion from the CHAIR, and agreed to:—"That the report of the Executive Committee on the question of the duties of Assistant Examiners of the Apothecaries Hall, Dublin, be received and entered on the minutes." The report contained recommendations that the Assistant Examiners be instructed to conduct the surgical portion of these examinations, and, in addition, to supervise the medical and obstetrical portions. . . . Also that the Examiners be instructed to report fully for the information of the Council as to the methods and standards actually adopted at each qualifying examination, and as to the steps they have taken in fulfilment of the duties imposed upon them by Section 5 of the Medical Act, 1886."

It was subsequently agreed to, on the motion of Mr. MORRIS, seconded by Dr. LINDSAY STEVEN:—"That the further consideration of the report be adjourned to a later period of the session in order that Mr. Lushington may be present."

Strangers having withdrawn, the Council deliberated *in camerâ*, and, on their re-admission, the PRESIDENT announced that the name of Dr. John Shaw had, at his own request, been removed from the *Medical Register*.

The Council then adjourned.

SECOND DAY.—WEDNESDAY, MAY 27TH, 1908.

The President, Dr. MACALISTER, in the Chair.

The official notification of the appointment of Dr. Donald MacAlister as representative of the University of Glasgow for five years from May 27th, 1908, having been read, Dr. MacAlister vacated the chair, which was taken by Mr. Tomes as Senior Treasurer. Dr. MacAlister having been introduced to the Council as representative of the University of Glasgow by Sir John Batty Tuke, it was proposed by Dr. LITTLE, seconded by Dr. MCVAIL, and agreed to unanimously, "That Dr. Donald MacAlister be elected President of the General Medical Council." He thereupon took the chair.

After it had been agreed to unanimously that the President, Treasurers, and Chairman of the Business Committee be appointed a Committee to make arrangements for the celebration of the Council's Jubilee in November, 1908, the Council resumed the consideration, adjourned from November 27th, 1907, of the case of Duncan Shaw Morrison, M.B., M.S.Edin., who had been summoned before the Council on account of having been convicted on three different occasions at the Lochgilphead Police Court for breaches of the peace and contravention of the Licensing Act, Scotland.

Mr. Morrison was called, but did not answer to his notice. On the re-admission of strangers after the Council had deliberated *in camerâ*, the President announced that the Registrar had been directed to erase from the *Medical Register* the name of Mr. Duncan Shaw Morrison.

The Council proceeded to the consideration, adjourned from November 29th, 1907, of the case of William Henry Roberts, L.R.C.P. and S.Edin., who had been summoned before the Council on the charge of having assisted unregistered dentists.

Mr. Roberts attended, and the British Dental Association was represented by Mr. Hart. On the re-admission of strangers after the Council had deliberated *in camerâ*, the President announced that the Council, having further considered the facts, does not judge Mr. Roberts guilty of infamous conduct in a professional respect.

In the adjourned case from November 29th, 1907, of Morgan Watkin Williams, M.B., B.S.Glasg., who had been summoned before the Council on the charge of enabling an unqualified and unregistered person, Mr. Frank Hannah, to engage in medical practice, the President, on re-admission of strangers, announced a similar result.

The consideration of the case of Christopher Richard Kempster, M.R.C.S.Eng., L.R.C.P.Lond., of Melbourne, charged with advertising himself and associating himself with the Freeman and Wallace Electro-Medical Institute of Melbourne and Sydney, was adjourned to the November session.

The Council next considered the case of James Brookes, Birmingham, L.R.C.P.Edin., L.F.P.S.Glasg., who had been summoned before the Council on the charge of having allowed an unqualified and unregistered person, J. W. Austin Brookes, to attend patients, prescribe for them, and sign certificates on his (James Brookes') behalf. The matter was brought before the Council by the Education Committee of the City of Birmingham.

Mr. Brookes was accompanied by his solicitor, Mr. John Pritchard, of Birmingham. The solicitor of the Council, after witnesses in the case had withdrawn, read the notice and several statutory declarations, amongst others those of Mr. Stevenson, Chief Superintendent of the School Attendance Officers, and Mr. Peter Banks, Chief School Attendance Officer, who were both called as witnesses, being examined and cross-examined, and answering questions from the Chair, the legal assessor and members of the Council. Several other witnesses were examined; amongst them was a child of 10 and a girl of 14, also a blind man. After addressing the Council, Mr. Pritchard called Mr. James Brookes, and also Mr. J. W. Austin Brookes. Both were examined and cross-examined.

It was then moved by Sir Christopher Nixon, seconded by Dr. McVail, and agreed to:—"That the Council do adjourn its decision in the case until the following day"

The Council then adjourned.

THIRD DAY.—Thursday, May 28th, 1908.

The President, Dr. MacAlister, in the Chair.

The Council resumed the consideration, adjourned from Wednesday, May 27th, of the case of James Brookes.

When strangers were re-admitted after the Council had deliberated *in camerâ*, the President, addressing Mr. Brookes, said:—"Mr. James Brookes, I have to announce to you that the Council, having carefully considered the facts proved against you, have directed the Registrar to erase your name from the *Medical Register*."

The Council proceeded to the consideration, adjourned from November 27th, 1907, of the case of John P. Rafter, L.A.H. Dublin, L.K.Q.C.P. Ireland, L.Midw.R.C.S. Ireland, registered as of 338, Stanley Road, Bootle, Liverpool, who had been summoned on the charge of having systematically sought to attract patients in Great Crosby and Waterloo, Lancashire, by the distribution of cards from house to house and in the street.

The complainants were the Medical Defence Union, which was represented by Dr. Bateman. Mr. Rafter attended in answer to his notice, and put in several certificates as to character, both from medical men and civic functionaries. He addressed the Council on his own behalf.

When strangers were re-admitted after the Council had deliberated *in camerâ*, the President, addressing Mr. Rafter, said:—"Mr. Rafter, I have to inform you that the Council, having further considered the facts proved against you, do not judge you guilty of infamous conduct in a professional aspect."

The Council considered the case of Frederick Aubin Monks, registered as of Woodcliffe House, Burgess Hill, Hampstead, N.W., L.S.A. Lond., 1871; M.R.C.S. Eng., 1871; L.R.C.P. Edin., 1873, who had been summoned to appear before the Council on the following charge:—"That you abused your position as a medical man by having sexual intercourse with a patient, namely, Annie Rose Le Farre (or Ely), whom you were attending professionally at your surgery, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the Medical Defence Union.

Mr. Monks attended in answer to his notice with Mr. C. F. Gill, K.C., his counsel, instructed by Mr. Freake Palmer, his solicitor.

Dr. Bateman appeared on behalf of the Medical Defence Union.

The Solicitor having read the notice to attend, Dr. Bateman read the declaration which had been made by himself and an extract from the depositions taken at the Police Court when a charge was preferred against Mr. Monks.

Mr. C. F. Gill, K.C., then addressed the Council on behalf of Mr. Monks. This discourse tended to show that Rose Ely had not been Mr. Monk's patient at the time of the intercourse, and also opened up her past life. He read a letter which had been written by Mrs. Annie Rose Ely, in answer to an advertisement in *The People* newspaper, and tendered Mr. Monks as a witness.

The Solicitor read a letter of explanation which Mr. Monks had written to the Registrar.

Mr. Monks was cross-examined as to some letters written by him to Mrs. Ely. Mr. Monks was re-examined by Mr. Gill, and answered questions put to him by the Legal Assessor, and by members of the Council through the chair.

This closed the case for Mr. Monks.

Mr. Monks and strangers having been re-admitted after the Council had deliberated *in camerâ*, the President announced the judgment of the Council as follows:—"Mr. Monks, I have to tell you that the Council have come to the conclusion that the facts alleged against you in the notice of inquiry have not been proved to the satisfaction of the Council."

The Council considered the case of Stanley Southam, registered as of 512, Rochdale Road, Manchester, L.S.A. Lond., 1900, who had been summoned to appear before the Council on the following charge:—"That you acted as 'cover' to an unregistered dentist, namely, Mr. Sydney Smith, of 163, Conran Street, Harpurhey, Manchester, by systematically acting for him in your own surgery in respect of the treatment of patients sent to you by him for dental operations requiring an anæsthetic, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the Medical Defence Union.

Mr. Southam attended in answer to his notice, accompanied by Mr. William Vickers Hamilton, his solicitor.

Dr. Bateman attended on behalf of the Medical Defence Union.

The Solicitor having read the notice, Dr. Bateman opened the case for the complainants. He read declarations which had been made by Mrs. Emma Marshall, Miss Clara Furlong, Mr. Roland Salt, Miss Nellie Haxby, and Miss Florence Ada Quinn.

Mr. Hamilton then opened the case for Mr. Southam. He read a declaration which had been made by Mr. Southam on April 7th, 1908. He tendered Mr. Southam, and examined him as to the accuracy of a further declaration which he had made, and which he put in. Mr. Southam was cross-examined, and answered questions put to him by the Legal Assessor and by members of the Council.

Strangers having been re-admitted after the Council had deliberated *in camerâ*, the **PRESIDENT**, addressing Mr. Southam, said :—" Mr. Southam, I have to inform you that the Council having considered the facts alleged against you have come to the conclusion that the facts have not been proved to their satisfaction."

The Council considered the report of the Dental Committee on the charge against Arthur Ward (in practice before July 22nd, 1878), the British Dental Association being the complainants. The Committee had found the following facts to be established by the evidence :—" He has issued and circulated a pamphlet containing statements of an objectionable character, viz., laudatory statements as to his own skill and methods, and depreciatory statements as to the work of other practitioners and claims of superiority over other practitioners. After receiving notice of the charge in this case he withdrew the pamphlet and issued another which omits certain depreciatory statements as to the work of other practitioners, but contains certain laudatory statements as to his own skill and methods. He expressed his willingness to undertake to withdraw the pamphlet altogether, and not to issue any similar advertisements in future."

Mr. Ward attended, accompanied by Mr. Coley, his solicitor.

Mr. **HART**, representing the British Dental Association, addressed the Council, and Mr. **COLEY** replied.

After the Council had deliberated *in camerâ*, the **PRESIDENT**, on strangers being re-admitted, said that the Council had adjourned the further consideration of the case till November.

The Council considered the report of the Dental Committee on the charge against William John Watson.

The Committee find that the following facts were established by the evidence :—

William John Watson was registered in the *Dentists' Register* on December 31st, 1878, as in practice before July 22nd, 1878, and his address in the *Register* for the current year is 8, New Street, Birmingham. In the year 1881 the qualification of Licentiate in Dental Surgery of the Royal College of Surgeons, Edinburgh, was added to his name in the *Dentists' Register*. He was, however, deprived of that diploma by the College in the year 1891 for advertising contrary to the declaration signed by him on admission. In the year 1901 the said William John Watson caused to be printed, issued, and circulated a pamphlet containing statements of an objectionable character—viz., laudatory statements as to his own skill and methods, and depreciatory statements as to the work of other practitioners and claims of superiority over other practitioners. This pamphlet contains a statement that the said William Watson had obtained the above-mentioned diploma by examination. Testimonials are also printed in the pamphlet which state that the said William John Watson possesses the said diploma. These testimonials are not dated, but they were, in fact, given before 1891 (when the said William John Watson was deprived of the said diploma) to assist him in obtaining an appointment he was then proposing to apply for. In the year 1903 or in the year 1906 (the evidence was not clear as to which date) the said William John Watson instructed his printer to destroy the remaining stock of these pamphlets, and the bulk of them were then destroyed, but one parcel was not destroyed, and some of these were recently distributed. The said William John Watson stated that these copies were accidentally discovered, and that they were distributed inadvertently, and that the remainder have since been destroyed. He undertook in future not to issue the same or any other similar pamphlet, and to discontinue all advertisements.

Mr. Watson attended, accompanied by Mr. A. C. Hayes, his solicitor, who addressed the Council on behalf of his client.

After the Council had deliberated *in camerâ*, the **PRESIDENT**, on strangers being re-admitted, said that the Council had deferred the further consideration of the report till November, when Mr. Watson would require to be present and present satisfactory evidence as to his conduct in the interval.

The Council then adjourned.

FOURTH DAY.—FRIDAY, MAY 29TH, 1908.

The President, Dr. **MACALISTER**, in the Chair.

The Council first received a communication *in camerâ*.

The whole time of the meeting was then occupied by the consideration, adjourned from November 29th, 1907, of the case of John Papa Nicolas, registered as of 87, Dowanhill Road, Catford, S.E., M.R.C.S.Eng., L.R.C.P.Lond., who had been summoned on the following charge :—"That you have systematically canvassed in Catford for patients by personal visits to patients of Mr. Thomas William Atkinson and others, both while you were in the employment of the said T. W. Atkinson and subsequently, and that in the course of such canvass you disparaged the qualifications and skill of the said T. W. Atkinson, and extolled your own, and that in relation thereto you have been guilty of infamous conduct in a professional respect."

The complainants were the London and Counties Medical Protection Society.

Mr. J. P. Nicolas attended in answer to his notice, accompanied by Mr. H. L. Randolph Hemming, his solicitor.

The London and Counties Medical Protection Society were represented by Mr. Alec Neilsen, counsel, and Dr. Hugh Woods, Secretary to the Society.

Mr. **HEMMING** read a statement which he had prepared taking exception to the right of the Council to proceed with this case, and urging that the Council had no jurisdiction under Section 29 of the Medical Act, 1858, to try Mr. P. Nicolas on a charge of infamous conduct in a professional respect.

The **LEGAL ASSESSOR** directed him to hand in his objection, which, he stated, could not be entertained.

Mr. **HEMMING** took a further objection to the Council dealing with the case on the grounds of prejudicial and oppressive irregularities, and the alleged breach of Standing Order, Chapter XIV., 3 (c).—The **LEGAL ASSESSOR** advised the Council that the objection was not well founded. Mr. Hemming was requested to hand it in.—Mr. **HEMMING** took a further objection to the President presiding at the hearing, on the ground that he had already presided over the meeting of the Penal Cases Committee, and had formed a judgment in regard to the case. Also that Mr. Papa Nicolas had not had an opportunity of being heard by the Penal Cases Committee.—Mr. Hemming was requested to hand in his objection. The **LEGAL ASSESSOR** advised the President and the Council that this also was not well founded.—Mr. **HEMMING** then lodged a further objection to any member of the Penal Cases Committee taking any part in the proceedings. The **LEGAL ASSESSOR** advised the Council that this also was not well founded.

Mr. **NEILSEN** then called Mrs. Agnes Mary Murphy as a witness, whereupon Mr. Hemming took a further objection that the Standing Orders had not been complied with, inasmuch as the complainant had supplied no statutory declaration as to the facts within the meaning of the rules. This objection was also handed in. The **LEGAL ASSESSOR** advised that it was not well founded.—Mr. **HEMMING** took objection that Standing Order, Chapter XIV., 16, had not been complied with. The **LEGAL ASSESSOR** explained that this rule had no reference to cases adjourned from day to day, but to those in which the facts had been found to be proved, but judgment had been postponed. Mr. **HEMMING** attempted to raise another objection which the **LEGAL ASSESSOR** ruled had reference to the merits, and could be dealt with later.

Mr. **HEMMING** then requested that Mr. Atkinson should be recalled for further cross-examination. The **LEGAL ASSESSOR** advised that this should not be permitted, as Mr. Atkinson had already been examined, and cross-examined, and re-examined by Dr. Hugh Woods.

Mr. Hemming then took an objection on the ground that the Standing Orders, Chapter XIV., 12, had not been complied with. This objection was over-ruled.—Mr. Hemming took further objection to the manner of the printing and circulating of the documents and evidence, and also to the fact that, as he alleged, his client had no proper opportunity of preparing his defence in November, 1907.—Mr. Hemming took further objection to the form of the charge, and to the words "and to others" which he desired to have struck out.—The Legal Assessor ruled that, as no evidence would be tendered, Mr. Papa Nicolas was entitled to an acquittal so far as the charge that he had systematically canvassed in Catford for patients by personal visits to persons other than patients of Mr. Thomas William Atkinson was concerned.

Mr. Hemming requested that Dr. Hugh Woods should be the next witness on the ground that he had undertaken to present himself for examination at the last Session.—The Legal Assessor pointed out that this was when Dr. Woods was conducting his own case, and that Mr. Neilsen must be allowed to conduct his case in his own way.

Mr. Neilsen then again called Mrs. Murphy as a witness and examined her; she was cross-examined by Mr. Hemming, and re-examined by Mr. Neilsen. No member of the Council desired to put any questions to the witness.

Mr. Neilsen called Mrs. Elizabeth Sarah Flora Rednall as a witness and examined her. She was cross-examined by Mr. Hemming. Mr. Neilsen did not desire to re-examine Mrs. Rednall, nor did any member of the Council desire to put a question to her, through the Chair.

Mr. Neilsen then called Miss Edith Ross, a nurse, and examined her. Miss Ross was cross-examined by Mr. Hemming.

Mr. Neilsen did not re-examine the witness, nor did any member of the Council ask her any questions, through the chair.

Mr. Neilsen called Mrs. Florence Robinson as a witness, and examined her. She was cross-examined by Mr. Hemming, and answered questions put to her by the Legal Assessor.

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That Standing Order IV., 2, be suspended in order that the Council may meet on Saturday at 11 a.m., and sit till 4 p.m., with an interval from 1 to 2."

After Mr. Hemming had completed his cross-examination of the witness, the Council adjourned.

FIFTH DAY.—Saturday, May 30th, 1908.

The President, Dr. MacAlister, in the Chair.

The minutes of the previous meeting were read, amended, and confirmed. The whole time of the meeting (11 to 1, 2 to 4) was taken up by the consideration of the case of John Papa Nicolas, adjourned from the previous day.

Mrs. Adah Edney was called, and examined by Mr. Neilsen. Her evidence was principally to the effect of Mr. Nicolas having called on her without being sent for, and having mentioned that his fees were smaller than those of Mr. Atkinson.

The witness was cross-examined by Mr. Hemming, mostly with reference to her statutory declaration, and then re-examined by Mr. Neilsen.

Mrs. Susan Hart was called, and examined by Mr. Neilsen with reference to Mr. Nicolas having said that Mr. Atkinson was too old, and of the old school in the treatment of babies, and of having extolled his (Mr. Nicolas's) success in such cases.

Mr. Hemming cross-examined, and Mr. Neilsen re-examined the witness.

Mr. Lawrence Fielder Hemmans, M.B., B.S.Durh., F.R.C.S.Edin., was called, and examined by Mr. Neilsen on a question of partnership. The witness was cross-examined by Mr. Hemming, chiefly with reference to his (Mr. Hemmans') acquaintance with Mr. Nicolas. The witness also answered questions put to him by the Legal Assessor.

Mrs. Emily Bowles was called, and examined by Mr. Neilsen, principally with reference to what Mr. Nicolas had said to her about Mr. Atkinson's medical treatment of her child. The witness was cross-examined by Mr. Hemming.

Mrs. Kate Shepherd was called, and examined by Mr. Neilsen on the same points as the previous witness. She was cross-examined by Mr. Hemming, re-examined by Mr. Neilsen, and answered a question put to her by the Legal Assessor.

Mr. Lawrence, Mr. Atkinson's partner since 1907, was next called and examined by Mr. Neilsen, chiefly with reference to the statutory declarations which had been signed in his presence when he accompanied Mr. Pouter, the Commissioner of Oaths. Mr. Lawrence stated in his evidence that the declarations had always been deliberately read without undue haste to the witnesses before they had signed, and he considered that the witnesses had invariably understood what they signed. The witness was severely cross-examined by Mr. Hemming, the Legal Assessor having to interfere more than once. He was re-examined by Mr. Neilsen.

Mr. Henry Pouter, solicitor and Commissioner of Oaths, was called and examined by Mr. Neilsen, principally as to the method employed in taking the declarations. The witness was cross-examined by Mr. Hemming, and re-examined by Mr. Neilsen, and also answered a question put by the Legal Assessor.

Mrs. Alice Margaret Jacon and Mrs. Ruth Wicks were called, and examined by Mr. Neilsen, and cross-examined by Mr. Hemming, with reference to Mr. Nicolas's canvassing, and disparaging remarks about Mr. Atkinson.

Mr. Neilsen then stated that, as he had now called 13 out of 24 witnesses, he proposed to close his case, but he offered Dr. H. Woods for cross-examination.—After a few remarks from the Legal Assessor *re* the calling of Dr. Woods for cross-examination, as Mr. Hemming insisted on calling the witness, Dr. Woods entered the box and was cross-examined by Mr. Hemming chiefly with regard to Dr. Woods having visited some of the witnesses.

Mr. Hemming made a few remarks, in which he said he considered there was no case against his client, as systematic canvassing in Catford had not been shown, and the law of the Council under which Mr. Nicolas had been summoned included advertising and canvassing, the one excluding the other.

The Legal Assessor pointed out that this was not a law, but a warning.

Mr. Hemming then called and examined Mrs. Lily Pumpfleet with reference to what had been said about Mr. Nicolas's canvassing at Catford.—Mr. Neilsen did not cross-examine.

Mr. Lewis Dysart Bellman, a chemist's assistant, was called and examined by Mr. Hemming.—No cross-examination.

Mr. Hemming then offered himself as a witness, and was examined by his clerk, chiefly with regard to Mr. Nicolas's skill as a medical man.—Mr. Neilsen briefly cross-examined.

Mr. Nicolas then went into the witness-box, but as it was a few minutes to 4, Dr. Saundby proposed, and Mr. Langley Browne seconded, "That the Council should meet on Monday at 11." The motion, however, on being put, was lost by a large majority. The examination of Mr. Nicolas by Mr. Hemming had only just begun, when the Council adjourned.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Pathology.

Meeting held Friday, May 8th, 1908.

The President, A. R. Parsons, M.D., in the Chair.

HODGKIN'S DISEASE.

Dr. F. C. Purser showed the organs of a patient who had been under the care of Dr. Travers Smith, suffering from Hodgkin's disease. The glandular enlargement had been general, the tonsillar enlargement having led to very urgent symptoms. The blood count had shown generally 2,500,000 red cells and 12,000—21,000 white cells, with a high percentage (41—48) of lymphocytes. The latest count, made a fortnight before death, showed 12,500 white cells, 41 per cent. being lymphocytes. The case was further interesting in that he was first seen five years ago with typical primary and secondary syphilitic lesions, and there was a most definite history of the same symptoms 27 years previously. At the time of his death the patient was 53 years old. The pleural cavities and abdomen were full of fluid. The right lung was partly collapsed; both were œdematous. The pleuræ were extensively infiltrated with lymphoid cells. There was no infiltration of the lung parenchyma. The heart was a marked example of brown atrophy. The liver on the surface was almost typical of atrophic cirrhosis, though no interstitial inflammation could be detected on section. The nodules on the surface were composed of masses of lymphoid cells, which also infiltrated Glisson's capsule and the interlobular capillaries. There was little or no overgrowth of fibrous tissue. The spleen was described as three times its normal size, it was soft, but not otherwise remarkable. Though no lymphatic glands had been found enlarged in the thorax, the abdominal aorta was sheathed several layers deep in lymphatic glands, which had lost all typical structure, and were in many cases welded together; into some hæmorrhage had occurred. One nearly occluded the portal vein and explained the ascites, which had been latterly a very urgent symptom. No organ had undergone fatty or amyloid change.

Dr. **TRAVERS SMITH** said the case was interesting as that of a man who had acquired syphilis on two occasions with an interval of 27 years. There was more evidence than Dr. Purser had mentioned that the first attack was genuine syphilis, for he had had a condition of partial blindness after the first attack, which Dr. Joyce considered to be due to an indubitable attack of previous syphilis. The enlargement of his tonsils and retro-pharyngeal adenoid tissue was so great at one time on the last occasion that it led almost to his death from asphyxia. There was great enlargement of his spleen and liver on his last admission to hospital, and he had no doubt that both they and the superficial glands became smaller before he died, though he would be inclined to think that his abdominal glands became larger. He inclined to the diagnosis of Hodgkin's disease, rather than lymphatic leukæmia, both of which gradated into one another.

The **SECRETARY** said it was difficult to understand from the specimens under the microscope how there were only a normal number of leucocytes or lymphocytes in the circulating blood. All the sections were like those seen in lymphatic leukæmia and many of them were markedly infiltrated with white cells. The character of the infiltration in the liver was exactly what was seen in lymphatic and other leukæmias, and was fairly uniform in the respect that all the portal spaces were infiltrated with cells. The kidney was also infiltrated fairly generally, not, perhaps, to such a profound degree as one saw in very marked cases. He had seen cases of undoubted Hodgkin's disease in which they did not get similar infiltration, and he had not seen any in which the lymphatic glands themselves were so like lymphoid tissue as in the case before them.

Dr. **WIGHAM** said he had often noticed in lymphatic leukæmia that the smaller the vessels the more lymphocytes seemed to be got in them. In the larger vessels a large proportion of lymphocytes would be found, and in the large veins they would often find that the blood was very little different from normal. It was quite possible that in a case which was not very severe they might find plugs in the capillaries, and the blood as a whole showing very little increase of lymphocytes. It seemed to him impossible to draw a distinction between the two diseases, and the case might be one of lymphatic leukæmia with practically no leukæmia, and he wondered if a large increase of lymphocytes in the blood was really an essential sign of lymphatic leukæmia.

Dr. **STOKES** inquired as to what was the actual cause of death.

The **PRESIDENT** recalled a case of Hodgkin's disease in which exactly the same thing happened as in Dr. Purser's case as regards the subsiding of the glands. There was no improvement in the patient's general condition, and he got progressively weaker, with uncontrollable diarrhœa and passage of blood-stained mucus, and finally he succumbed. He had seen him in the earlier stages, and there was no material increase found in the number of white blood-cells.

Dr. **PURSER**, in reply, said the most marked symptom presented by the patient was dyspnœa. The lungs were everywhere œdematous, and there was considerable fluid in the pleural cavities. There was marked ascites, and the man died gradually, though quickly. The two diseases seemed to be the same, except that in one case the blood helped them to label it one way or the other, and it was quite conceivable that the formation of lymphoid tissue went on and the cells did not escape into the blood. The blood seemed to him to be simply a channel of communication between the tissues, and was not responsible for the number of leucocytes carried round.

SPINAL ABNORMALITY.

Dr. **HARVEY** said the patient, a girl, æt. 17, came to Dr. Gunn's dispensary at the Adelaide Hospital, complaining of pain in the back for the last two months. She was engaged in collar-making, and the pain only came on after prolonged stooping over her machine. Her father had, however, noticed some three months previously that she held her right shoulder higher than the left. Patient herself, however, believed that she had never had a straight back. The pain complained of did not seem to be very acute, nor did ordinary physical methods of examination cause any distress. The case appeared to be an ordinary lateral curvature, but an X-ray taken of patient's spine showed an irregularity in the vertebral bodies which led me to make the erroneous diagnosis of caries of the dorsal vertebræ. More careful examination of the negative, however, showed that there were only eleven ribs on the left side, and that the left side of the fourth dorsal vertebra was also absent. The case, then, seems to be one of failure to develop the left side of the fourth dorsal vertebra, with total absence of the corresponding rib on the same side.

Professor **DIXON** said the specimen described was one of extreme anatomical interest and also of extreme rarity. The rarity might be gauged from the fact that whenever the condition was alluded to, practically always the same two cases as Dr. Harvey quoted were mentioned. They were extremely fortunate in being able to see such a specimen.

PATHOLOGICAL REPORT OF ROTUNDA HOSPITAL.

Dr. **ROWLETTE** read the Pathological Report of the Rotunda Hospital for the year ending October 31st, 1907. He gave particulars of post-mortem examinations on the bodies of nine adult patients. In one case the *micrococcus rheumaticus* had been obtained in pure culture from the heart valves of a patient dying of acute rheumatism. Two fatal cases of pneumococcus peritonitis had occurred in the gynæcological department, and in each case with infected ovarian cysts. Three fatal cases of puerperal streptococcus infection occurred. Particulars were given of the examinations of curettings and of the different varieties of endometritis encountered. Particulars were given of the various operation specimens examined and of the various bacteria occurring in morbid puerperal cases.

Dr. **HASTINGS TWEEDY** expressed his gratitude for the admirable work done by Dr. Rowlette in the Rotunda Hospital, and for his excellent report, which would add enormously to the value of the hospital as a teaching centre.

The **SECRETARY** referred to a case of abdominal operation where the patient died suddenly two days afterwards, and there was no naked eye evidence as to the cause of death. The post-mortem finding of any practical value was microscopic and in the heart, which exhibited an extreme degree of segmentation with fragmentation of the muscle fibres. It was possible that a similar condition might be found in other cases of the same kind.

HYDRONEPHROSIS.

Dr. **Gunn** read a short paper on the above, and exhibited several specimens.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

Meeting held May 16th and 17th, 1908, at Harrogate.

The President, Dr. W. J. Tyson, F.R.C.P., J.P. (Folkestone), in the Chair.

About 135 Fellows and guests attended this meeting, which proved most instructive and successful. The fact is now firmly established that provincial meetings are very popular with the Fellows of the Society, and are much appreciated.

The Fellows were received at 3.15 p.m. in the Spa Room of the Royal Baths by the Mayor (Dr. Neville Williams), the Chairman of the Baths and Wells Committee (Alderman Milner, J.P.), the Town Clerk, Dr. Mouillot (the Provincial Secretary of the Society), and by Dr. Solly, the President-elect.

Eight new candidates were elected, which makes the total roll over 400.

The proceedings were opened by the Mayor of Harrogate, Dr. Neville Williams, after which the President, Dr. Tyson, took the chair. Mr. C. Fox **Strangways** then read a most interesting paper on "The Geology of Harrogate in Relation to its Mineral Waters," which was followed by a paper by Dr. **Frederick Lever**, President of the Harrogate Medical Society, on "The Harrogate Waters and their Therapeutics."

Tea was then served in the Spa Room, and the members were escorted over the Royal Baths, the Pump Rooms, and the Bogs Field.

At 7 p.m. the Fellows and guests dined together at the Hotel Majestic. The toast of "The Town and Corporation and the Medical Profession of Harrogate" was proposed by the President, and responded to by the Mayor and by Dr. Edgecombe. The toast of "The British Balneological and Climatological Society" was proposed by Alderman Milner, J.P., Chairman of the Baths and Wells Committee, and was responded to by Dr. Bagshawe, Chairman of Council, and by Dr. Leonard Williams, Editor of the *Journal of Balneology and Climatology*. Dr. **Edgecombe**, in the course of his remarks, said the spas and watering-places of this country owed a debt of gratitude to the British Balneological and Climatological Society for the work they had done and are doing in driving home to the minds of the medical men of this country the fact that here in the British Isles we have spas of equal, if not superior value, to any of those abroad, and that many patients hitherto sent abroad can be equally well treated at a home resort. He also considered that those members of the profession who practise at health resorts are under a deep obligation to the Society for its work in helping to raise spa treatment from the slough of empiricism to the domain of rational and scientific therapeutics.

The Fellows were then entertained at a concert at the Kursaal. On the following day (Sunday, May 17th) 84 Fellows and guests proceeded to Ripon, where some of them attended a service at Ripon Cathedral. The Dean of Ripon preached a sermon, the subject being "The Pool of Bethesda."

After the service, Dr. Green, Medical Officer of Health for Ripon, conducted the Fellows over the Ripon Spa Baths, where Mr. Bower, the Mayor of Ripon, and Alderman Wells, Chairman of the Spa Committee, received the party. The Fellows were entertained to luncheon at the Spa Hotel by the proprietors. Afterwards a visit was made to Fountains Abbey, by permission of the Marquis of Ripon. On returning to Ripon, the Mayor entertained the party to tea at the Spa Hotel, and later the Fellows returned by train to Harrogate.

The arrangements throughout the whole meeting were most satisfactory, and the thanks of the Fellows are due to Dr. Mouillot (Harrogate), the Organising Secretary, and to Dr. Garrad (Secretary of the Medical Society of Harrogate), who carried out so completely the intentions and wishes of the medical profession of Harrogate and Ripon in extending such a hearty welcome to the Society.

THE MEDICAL DEFENCE UNION.

The annual general meeting of the above Society was held, by the courteous permission of the Committee of Management, at the Medical Institution, Hope Street, Liverpool, on Thursday, May 21st, Dr. Stamford Felce, M.R.C.P., the President, in the chair.

The President, in moving the adoption of the annual report, traced the history of the Union to the present time. He mentioned that the Union had to thank several well-known members of the profession in Liverpool, notably Dr. Carter, F.R.C.P., and Sir James Barr, F.R.C.P., for valuable help and assistance upon the Council. Mention was made of the disabilities of the present Medical Act, and a hope expressed that some day the protection against unqualified practice under an amended Medical Act would be equal to that afforded by the Veterinary Act.

The death of Dr. Dreschfeld was feelingly referred to. The rapid growth of the Union from 400 members in 1888 to over 7,000 in the present year was referred to as proving the absolute necessity for such organisation. It was a fact that no one could claim immunity from the attacks of unscrupulous patients, and without the assistance promptly and efficiently given by the Union, many a practitioner would be either ruined in pocket or harassed almost beyond endurance. It was a great relief to members to know that their cases were taken over by skilled officials, and the responsibilities removed from the individuals concerned to the broad shoulders of the Union itself. Reference was also made to the steps taken by the Union to stem the torrent of unqualified practice by raising actions for damages against quacks. This has been successful in several cases. It had been suggested that some scheme could be adopted by which the whole risk of adverse verdicts and damages should be taken over, but after serious consideration it was decided that it was not possible, and, further, that it would be against public and professional polity, and likely to lead to serious injury to the profession, if not to actions for champerty and maintenance.

A member called attention to the numerous instances of chemists prescribing and acting as medical practitioners, and the danger which led to infant mortality by such practice as it appeared to him.

The President said the matter should receive attention.

Three vacancies upon the Council were then filled up by the election of Mr. F. C. Larkin, F.R.C.S., and the two retiring members of the Council, Dr. Gunton Alderton and Dr. Messiter, J.P.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 31st, 1908.

MISTLETOE AS AN HYPOTENSOR.

In a recent *thèse* on the hypotensive action of viscum album, in arterio-sclerosis and Bright's disease, M. Vachez, without considering this agent as a panacea or sovereign remedy, believes that it is a useful adjunct to the therapeutical arsenal as an hypotensor in divers affections.

For a long time the medical world in France remained indifferent to the studies made on mistletoe abroad, but within the last few years attention has been brought to it by experiments made by Degny and Gaulthier, who found it effective in albuminuria and hæmoptysis, similar to nitrite of amyl. Viscum album arrests hæmoptysis by lowering the tension in the general circulation, producing depletion in the pulmonary circulation.

Nitrite of amyl, even in small doses, shows its vasodilating action on the peripheric circulation by producing a congestive state of the head, neck and chest in patients who take it. Nothing of the kind has been remarked in patients treated by the extract of mistletoe.

On the other hand, autopsy af animals submitted to toxic doses of the extract showed an intense congestion of the abdominal viscera, while the lungs, on the contrary, were pale and the heart empty.

The action of viscum album had no effect like that of nitrite of amyl on the peripheric circulation, but on the general circulation. Viscum album is, consequently a hypotensor by direct action on the vaso-constrictor and vaso-dilator centres by paralysing the former and stimulating the latter, it produces the vaso-dilatation and depression in the general circulation.

Arterial hypertension, says Prof. Huchard, is the cause of arterio-sclerosis, and the most frequent cause of arteritis by its action on the vascular walls.

The early treatment of arterial hypertension wards off such maladies as arterio-sclerosis, angina pectoris, and certain cardiac symptoms.

M. Vachez reports several typical cases treated by the mistletoe extract. In one case the tension was rapidly lowered after one or two injections, while dyspnœa and coincident nervous disturbance ceased.

In another case, presenting all the signs of uræmia, the vomiting ceased after the first injection, as well as the violent headaches from which the patient had suffered for some time previously.

A woman suffering from arterio-sclerosis and presenting the troubles inherent to the climacteric period, abundant epistaxis, headache, vapours, etc., was completely relieved from epistaxis after the first injection of viscum album, while the other symptoms disappeared with the lowering of the tension.

This treatment presents no inconvenience, the extract of mistletoe, being but slightly toxic, can be administered in large doses without danger.

Perhaps the pillular form is the best method of administration, as injections are painful and irritating. However, we give here the formula employed by M. Vachez:—

Watery extract of v. album, 4 grammes.
Chloride of sodium, 0.70 centigr.
Water, 100.

Thirty drops injected daily.

Stitch.

The vulgar term stitch in the side indicates a special thoracic pain, declaring itself as a symptom of certain acute pleuro-pulmonary affections, constituting an important factor of dyspnœa, because it increases with the amplitude of the respiratory movements so as to become intolerable.

Suddenly or gradually a patient is seized with an acute and spontaneous pain, localised either under the nipple or behind under the scapula, dull and continual or lancinating or fugitive, exasperated by cough, deep inspirations or movements of the trunk.

This special pain is due to irritation of several nerve filaments, sub-pleural, by reason of inflammation of the serous membrane covering them; it is consequently a symptom of pleuritis.

In acute pneumonia the stitch is felt at the very outset and its maximum of intensity is felt in the submammary region of the same side. It rarely persists beyond 48 hours. Its persistence beyond the sixth day, or its reappearance after defervescence, is almost always, says Prof. Barth, an indication of secondary pleurisy.

In the course of bronchitis, pain in the side, when it is not due to pleurodynia provoked by the effort of coughing, is generally symptomatic of bronchopneumonia propagated to the cortical layer of the lung.

Pneumothorax, especially in its septic forms, is announced suddenly by intense pain, cutting like a knife and paralysing the movements of the thorax; the dyspnœa is excessive.

In sero-fibrinous pleurisy, the stitch is rarely absent, it is generally dull, but exasperated by the cough; it disappears when the effusion has separated the two coverings of the pleura, and is replaced by a vague sensation of tension when by the increase of the liquid the lung is compressed, displacing the neighbouring organs.

In purulent pleurisies, the pain is excessively violent, irritation of the terminal filaments of the phrenic nerve, it is localised over the false ribs, and pressure in this part provokes almost phenomena of suffocation.

In purulent pleurises, the pain is excessively violent, the slightest pressure over the point provoking great suffering.

Consumptive patients suffer frequently from dull pains seated at the apex of the lungs or beneath the scapulæ, which they attribute to rheumatism, but in reality they are due to dry pleurisy.

GERMANY.

Berlin, May 31st, 1908.

At the last meeting of the Medical Society, Hr. B. Fraenkel discussed

The Reduced Mortality from Tuberculosis, and its Causes.

He said that from a large array of statistical material it had been shown that since the year 1887 the mortality from tuberculosis, which up to that year had for several years maintained a uniform level, had been steadily diminishing. This diminution had been less considerable in the country than in the towns. It had been greater in the western parts of the monarchy than in the eastern. Two extraordinarily important factors in the history of tuberculosis were contemporaneous with this reduction: the discovery of the tubercle bacillus by Robert Koch in 1882, and the establishment of sick clubs. Hand-in-hand with this was an undeniable improvement in the social position of the working classes and of their mode of life. Statistical observations in Great Britain showed that social position was an important factor. In England and Scotland the mortality curve of tuberculosis ran parallel with our own. In Ireland it was almost at the same height as it was 20 years ago. The only reason for this could be that social distress had diminished but little or not at all in comparison with the two other countries. At the same time it showed the virulence of the bacillus had not diminished, nor had the resisting power of the individual increased from custom or any other cause, but that factors played a part that were not independent of the human will—namely, improvement of the mode of life.

The objection that the discovery of the tubercle bacillus had refined the diagnosis, and that it was given as the cause of death more rarely than formerly, did not hold, as statistics showed that during the same period the number of other diseases of the respiratory tract had not increased. We were, however, indebted to our knowledge of the importance of the tubercle bacillus and of the nature of tubercle for a possible rational campaign against this disease of the people—the principles of it, the disinfection of sputum, early diagnosis, isolation of the patient, and, together with all this, the campaign against bovine tuberculosis and inspection of meat.

The speaker then passed on to the importance of curative resorts, shown by the fact that from 1900 to 1906 the number of workmen invalided gradually diminished, as a major part were cured. Along with this importance for the individual patient, these institutions were of great importance for the community at large, for it was not a matter of indifference that about 40,000 sick people were isolated for three months, and about 6,000 bacillus expectorants a year lost their bacilli and ceased to be a source of danger to the public.

The *Deutsche Med. Zeitung*, 39, gives a *résumé* of a case of

Late Changes in the Peritoneum after Perforative Peritonitis in Consequence of Spontaneous Recovery from Gunshot Wound of the Intestines.

A soldier who had received a gunshot wound of the abdomen in the Russo-Japanese war, from that time suffered from repeated attacks of abdominal pain, occurring especially after partaking of food that was indigestible. Fourteen months after receipt of the injury an operation was performed, at which it was found that cicatricial bands were present, one of which united two portions of intestinal wall and was hollow within. It corresponded in situation to the cicatrised intestinal wound. Besides this, a number of sub-serous "tubercles" were found, some of which were removed for microscopical examination. The bands were resected, and the patient recovered. At the examination of the "tubercles" it was found that vegetable remains were present in them, surrounded by collections of giant, mononuclear, and polynuclear cells, the mononuclear cells predominating, of the type of the fibroblasts and polyblasts. The case was therefore an example of encapsulisation of extruded intestinal contents, with pseudo-tuberculous changes in the peritoneum. Such cases were very rare. On the other hand, the case showed that such so-called recoveries after injuries of intestines that had been treated expectantly were really no recoveries at all, and occasionally rendered a subsequent operation necessary.

AUSTRIA.

Vienna, May 31st, 1908.

Toxine of Fatigue.

At the Gesellschaft f. Innere Medizin, Gellhorn gave a history of his experiments with "keno-toxine," "anti-keno-toxins," and "keno-precipitine," all of which are closely connected with the fatigued muscle. "Keno-toxine" is obtained from the muscles of exhausted animals by pressure after death, while the antitoxine is got from the serum of another animal that has been immunised. This potent substance can also be obtained from albumin, chemically, by shaking at a temperature under 40° Centigrade, and the antitoxine at boiling point. It appears that the first transition is from the antitoxine precipitate or keno-precipitine, as Gellhorn is pleased to call it, which does not act on native albumin, but on other forms is potent. In the urine of men at rest, none, or a trace of the precipitine may be discovered, but in the urine of the exhausted it is met with in abundance. It is also found in the breath of those suffering from bacterial poisoning, as well as in the excretions of the febrile. He therefore found no keno-toxine in healthy infants, but met with it in large quantities in febrile conditions, which disappeared on the child regaining health.

Function of the Thymus Gland.

Sommer gave a description of his experiments with young animals not exceeding 14 days old and principally confined to cats and dogs. In some cases he extirpated the thymus gland, in others transplanted it in order to demonstrate its effect on the organism. Without exception, thymectomy of the cat brought about an intercurrent disease in two months after the operation that led to death. In the case of transplantation, six or seven months sufficed after thymectomy. After the operation the animal usually became plump and unable to walk, while the hair was rough and dry. His Röntgen photographs of sections of the long bones showed that after the thymectomy they became shorter and thicker than the bones of the control animal, while the bones of the transplanted thymus became longer. Microscopically, he found changes in the other organs which were difficult to analyse at the present time.

Senile Chorea.

Weygandt showed a patient who suffered from convulsive cough and inco-ordinate movements in the muscles of the extremities. Nothing could be seen in larynx or found in the chest to account for the uncontrollable cough. He thought the prognosis was bad, and the case hopeless, and attributed the convulsive movements to an arterial sclerosis of the cerebral vascular system.

Pure Treatment.

Stumpf again brought forward his favourite subject of the "Bolus Alba" as the most essential principle in the treatment of all diseases. His theory is that all treatment should be anti-bacterial, both food and medicine, as in surgical cases. Cholera, diphtheria, and puerperal fever readily yield to this form of treatment, which he considers the correct method.

Narcosis of the Arabians.

Moeller tells us that in 704 A.D. the Arabians made use of cannabis indica and opium for relieving pain in operations. There was also a pulverised stone of Memphis which was dissolved in acetic acid, producing a narcotic that we seem to know nothing of. From the Greeks they obtained "mandragora" and "alraun" root for producing anæsthesia, but their pharmacology must have been bad, as out of 712 treated 704 died. Urwa was called in to the Kalif, who seems to have suffered from gangrene in the right foot, and decided that the foot must come off, which the Kalif declined. Urwa avowed that he would die if the swelling rose to the knee. Consent was obtained, but the Kalif would take no drug, saying he was no Boor and required no such preparation. He suffered the operation without wincing, and lived eight years thereafter, although another operation had to be performed, probably for sloughing.

Some assume that taumelboch, lolium temululentum was the most likely narcotic used. Another solution produces a powerful narcotic of lolium, which induces vomiting tremor, altered vision, vertigo, and loss of consciousness. Such were the narcoses of 704.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Munificent Gift to the Aberdeen Royal Infirmary.—Lord Mountstephen, to whose generosity the Infirmary has in the past owed so many donations, has forwarded to the managers of the institution a draft for £26,738. In a letter accompanying his munificent gift, Lord Mountstephen says that he had intended to transfer the sum to the investment fund of the Infirmary, but that he has come to the conclusion that it will be more usefully spent on permanent improvements than on providing a permanent increase of income. The letter concludes: It would be little short of a calamity if what I have done for the hospital should have the effect of weakening the interest of the people of Aberdeen in the old Infirmary, in which I was a patient sixty-two years ago.

Edinburgh University Lord Rectorship.—For the first time in a number of years there is a likelihood that the nominee for this post will be selected on a non-political basis. The two party names suggested were those of Mr. Winston Churchill and Mr. George Wyndham, but after some discussion at a meeting of the students last week the idea of a non-political Lord Rector found general favour. The names proposed are both those of men eminent in the medical profession, namely, Professor Crum Brown, whose resignation of the chemistry chair was announced in these columns a few weeks ago, and Professor Osler, Oxford. It was ultimately decided to approach Professor Crum Brown on the subject. There is much to be said both for and against a political Lord Rector, but one thing at least seems desirable, that the candidate chosen should be of distinction from an academic as well as a party point of view, and in the circumstances it seems that the students are well advised in choosing as their nominee one who ranks second to none in intellectual attainments.

Medical Officer of Health for Edinburgh.—Applications have been sent in by the twelve gentlemen whose names follow. The salary is not less than £800 per annum. G. E. Brooke, M.A., L.R.C.P., Bath; John Brownlee, M.D., D.Sc., Superintendent to the Glasgow Fever Hospital, Belvedere; J. J. Buchan, M.D., M.O.H. for St. Helens; J. H. Garret, M.D., M.O.H., Cheltenham; J. H. Jones, M.D., D.Sc., M.O.H. for Newport, Mon.; Lloyd Roberts, M.D., M.O.H. to a number of Urban and Rural Councils in Wales; R. S. Marsden, M.B., Public Health Department, Birkenhead; H. C. Pattin, M.D. Norwich; Alex. Robb, M.A., M.D., M.O.H., Paisley; Wm. Robertson, M.D., M.O.H., Leith; A. M. Williamson, M.D., Chief Sanitary Inspector, Edinburgh; William Wright, M.D., Deputy M.O.H., Glasgow.

BELFAST.

The Report of the Belfast Health Commission.—A curious situation has arisen in connection with the report of the Viceregal Commission which sat last year to inquire into the alleged excessive death-rate of Belfast. The report, after a very long delay, was published a few weeks ago, and naturally all interested parties wished to procure copies, but the greatest difficulty was experienced in obtaining them. It now appears that only 200 copies were printed, the work being done at the expense of the Belfast Corporation. Of these, 150 copies were taken by the Local Government Board to give to various public bodies, and now no copies can be had. The Corporation objects to the expense of printing more, and there is no power to compel them to do so. Meantime, the Belfast Water Commissioners are complaining loudly, for the report deals particularly with the water supply, and naturally they wish to read and digest it before discussing the matter. The only practical outcome of the report so far seems to be an active crusade against the cockle gatherers of Belfast Lough, who are supposed to be more or less responsible for the typhoid which is always present. But in spite of the crusade, 15 cases of typhoid were notified during the last fortnight.

The Corporation and Tuberculosis.—Reference has been made in this column on several occasions to the arrangement made between the Corporation and the authorities of the Forster Green Hospital, under which 25 beds are to be provided and maintained by the hospital for patients nominated and paid for by the Corporation, the arrangement to be binding for 10 years. The preparations for this extension of the Forster Green Hospital are proceeding actively, and meantime the agreement has been extended to include 10 more beds, making a total of 35 extra beds to be provided. The arrangement seems an excellent one, and much better than the starting of a new sanatorium by the Corporation. One difficulty has arisen, and is at present being considered by the local medical societies at the request of the medical staff of the hospital, and that is the position of the members of that staff as regards these municipal patients. The staff is an honorary one, but it seems very doubtful if it is wise that they should give their services free for the treatment of these new rate-paid patients, when their colleagues at the Union Infirmary are paid for attending the rate-paid patients in the Whiteabbey Sanatorium. The matter rests with the Board of Management of the Forster Green Hospital and not with the Corporation, as the terms of the agreement are that the payment of a certain sum per week is to cover all charges.

LETTERS TO THE EDITOR.

CHARGES IN NURSING HOMES.

To the Editor of The Medical Press and Circular.

Sir,—The exorbitant charges made by nursing homes has been brought to my notice several times, but the question may well be asked are there no medical men (or medical women) behind the back of the nursing home manager who poses as proprietor? From what I know "goes on" in the metropolis I have my doubts. All concerned with nursing homes expect a "pinch" out of the profits made from the unfortunate patient, who, in some cases, is recommended by the medical attendant to go to the nursing home in which *he* naturally takes an "interest." I have been in a wretched bedroom, at the top of a large house, where the patient paid five guineas per week. Hardly any furniture (patient recovering from operation) and food principally milk and Bovril! The sooner some nursing homes are found out by the public the better.

I am, Sir, yours truly,
Alex. Duke.

London, W.

THE POPULATION QUESTION.

To the Editor of The Medical Press and Circular.

Sir,—It would seem strange, indeed, had it not occurred at the commemorative period of Empire celebration, that this opportunity should not be seized upon as a pretext for pessimists given to the shedding of tears (be they medical officers of health, prelates, or political economists) to relieve themselves on the grievance of a declining birth-rate. May I be allowed, therefore, to indulge in one or two platitudes which "Surrey Doctor" and others may do well to grasp?

In the first place, as all will admit, the declining birth-rate is limited or confined to certain portions of the globe (amongst which ours is one). In other words, no depopulation is going on in the world at large, as the Census of the present compared to any past generation clearly indicates. The injunction, therefore, "Be fruitful and multiply," is being consummated at somebody's expense. It is obvious that in the animal economy there will, in the process of time, at the present ratio of increase, be no more room for extension of the human race; hence either plague, pestilence, war, or famine must deplete the earth; otherwise, artificial means of stemming the tide of overflowing population will inevitably be resorted to at some future date. Why, therefore, should a handful of squeamish folk, themselves, no doubt, comfortably provided for, belie their less fortunate brethren for working out their present and own salvation.

It is often urged that the decrease of population is indicative of national decadence. This *may* be so. On the other hand, there is no evidence forthcoming to decide that a decline of birth-rate is not rather the effect than the cause of racial decadence. Assuming, however, for argument's sake, that a continuous and low birth-rate may be the cause of national decay, again, what evidence is there to show that an unwieldy surplus population may not (through rearing in semi-starvation, over-crowding, and otherwise unhealthy conditions) conduce to disease and premature death, and hence destroy the sinews of a race far more expeditiously than a declining or stationary birth-rate?

It is wildly presumptive to conclude that the game of Empire-building (the supposed safety-valve or receptacle for our redundant population) will always prove a paying game. Few, indeed, seem to grasp the fact that the British Empire has developed and been born out of British resources. The British nation is the nucleus and core of our Empire, and if the core become rotten or decayed, the Empire would assuredly sooner or later disintegrate, much as a tree or plant must perish from decay of its root, because when the Colonies and other British possessions have extracted our best blood, as they are encouraged to do, and, indeed, insist upon doing during the selection of emigrants, and so by degrees reducing the British nation to a shrivelled, half-starved and decrepit race (and we are constantly reminded there are twelve millions already on the verge of starvation), our Colonies will no longer respect the Mother Country, but rather feel ashamed of us, and will become patriotic amongst themselves, a dissolution of partnership will probably next take place, and we shall be left, as concerns our Empire, isolated and alone on the high seas.

I am, Sir, yours truly,
Clement H. Sers.

Brighton, May 28th, 1908.

A METHOD IN MADNESS.

To the Editor of The Medical Press and Circular.

Sir,—It is, as you say, "mere hooliganism, and quite inexcusable under any circumstances," for Miss Elizabeth Knight, M.B., and her friends to demonstrate on the Prime Minister's doorstep. It is a question, however, whether such conduct should be dealt with by the General Medical Council, since presumably the lady was there *qua* Elizabeth Knight, and not *qua* M.B. Moreover, since she is suffering at Holloway a penalty deemed by a wise magistrate to fit the crime, it would hardly be fair to punish her over again for the same offence. The other medical lady, having escaped the police, should doubtless be summarily dealt with by the General Medical Council, but unfortunately her identity is unknown.

On the more general question, however, of the methods of the active women suffragists, there are some points we are inclined in our disgust to forget. Are these demonstrations mere outburst of hysteria, mere hooliganism, mere naughtiness, or is there really a method in the madness? So far the policy of virile agitation—if I may use the adjective—seems to have roused little but feelings of disgust. No cause can be good, it is felt, which can make use of such unreasonable methods. This would be a perfect answer to the suffragists if mankind were only swayed by motives of reason. We English, however, are an eminently practical people. We pay attention to the obvious matter of fact, and are quite content to do without appeals to reason. In fact, no reform could be gained among us, were there nothing but *arguments* in its favour. In the history of the last century, social reforms were gained, not because they were felt to be reasonable, but because a party rose to demand them strong enough to make its will felt. Mr. Gladstone entered on his Irish Land policy, not because he thought land reform in Ireland reasonable and right, but, as he admitted, to avert revolution. Irish Land Reform went on, not because it was reasonable and right, but because landlords were shot in Ireland, and Mr. Parnell made government impossible at Westminster. The Education Bill of 1902 has become impossible, not directly because of any injustice in it, but because men went to gaol rather than obey it. The women suffragists have learnt the lesson. The policy of outrage, of breaking the law, of making one's self a nuisance to people, is the way to get what one wants. Being tender-hearted and still somewhat scrupulous their measures are rather half-hearted and so far ineffective. Their methods are doubtless inexcusable, shocking, immoral, but they are the methods which have led other reforms to success. We are an eminently practical people, and we will soon find that it will be much less trouble to give these women what they want than to continue sending them to gaol. They will then get what they want.

I am, Sir, yours truly,
CRITICUS.

Dublin, May 27th, 1908.

[We fear our correspondent's letter trenches on dangerous ground. Our only concern is for the good name of the profession, which we consider to be tarnished by members who behave in the manner described.—ED.]

THE ST. GEORGE'S NAUHEIM INSTITUTE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—There have recently appeared in the lay press notices relating to an injunction which was, by consent, granted against this Institute at the suit of the Hessian Government. As such notices in their abbreviated form, and in the absence of an explanation, are calculated to cause an entirely erroneous impression regarding an Institution of which, in conjunction with my colleague, Dr. Hill, I am in charge, I ask of your courtesy to insert this letter in your widely read paper.

This Institute has been under my control for the past few months, and whilst disclaiming any responsibility for the action of the directors before my connection with the Institute, I feel that it is due both to my colleague, myself, and those of my profession who have so cordially supported me, that an explanation of the very misleading paragraphs that have appeared in the leading daily journals should be given. The injunction was, *inter alia,* to restrain the St. George's Nauheim Institute from representing that they were the agents of the Hessian Government, from using the Hessian Arms, from representing their business as a branch of the Government, and from using the name Nauheim without clearly distinguishing the baths of the Institute from those of the Government. From the fact that the injunction was consented to, it might be inferred that the St. George's Institute had wrongfully committed all these acts, but as a matter of fact Mr. Cozens-Hardy, who represented this Institute at the trial, particularly repudiated such a state of affairs, and agreed to the injunction because it necessitated absolutely no change in any detail whatsoever in the present conduct of the Institute.

From the correspondence that I have seen it would appear that the Institute were warranted in using the Hessian Arms, and announcing themselves as by appointment agents for the State Springs of Bad Nauheim, because a gentleman, a Mr. Ed. Schmidt, of Berlin, writing on the official Government paper, and obviously an accredited agent of the Hessian Government, had specifically informed the Directors of the Institute that they had the right to do so, and as a matter of fact the Institution are the sole agents in Great Britain for the sale of the waters bottled under Government supervision at the State Springs. When, as far back as November 2nd last year, the Hessian authorities wrote asking for information concerning the acts of which they now complain, a letter was sent in reply giving the information asked for, and offering to remove these notices should such removal be insisted on, the courtesy of a reply was not extended, and two months later, viz., on December 29th, a writ was issued, and after several months further delay on the part of the Hessian Government a statement of claim was served.

Mr. McNaughton, K.C., on behalf of the Hessian Government, stated that the Directors of the St. George's Institute had claimed that the Nauheim system can cure every malady that flesh is heir to. Although in no way connected with, or responsible for the statements referred to, I should like to point out that the list of ailments published by the Directors of the Institute is identical with that published by the Society of Physicians at Bad Nauheim in their prospectus, so that it would appear that the Hessian authorities are complaining of the act of their own Society of Physicians. Personally, I think most medical men will agree with me in supporting the Hessian Government in their condemnation of this extraordinarily prolific list of diseases. At all events, since taking charge of the Institute, I have very much curtailed the list of indications.

As for many months past the Institution has been conducted on methods above reproach, and approved by many of the leading physicians and medical journals, the action of the Hessian Government seems to bear only one construction, viz., an attempt to throw odium upon an Institute, which though at present in its infancy, is likely in the future to reduce the income which the town of Bad Nauheim now draws at the expense of English visitors, and of the English medical profession. In other words, the Bad Nauheim authorities are intolerant of any attempt to encroach upon what they regard as their monopoly, but if anything could conduce to an end which they least desire, it will be found in the high-handed and narrow-minded procedure in which they have indulged.

Trusting that I have not encroached too much on your patience and space,

I am, Sir, yours truly,
WM. BAIN, M.B., B.Sc.

6 and 7, George Street,
Hanover Square, London, W.
May 28th, 1908.

OBITUARY.

DR. McCALMAN, OF OBAN.

WE regret to announce the death, on May 25th, of Dr. Dove McCalman, a very well-known practitioner in the West Highlands. He was in his sixty-fifth year, and had been in practice in Oban for twenty years. Holding no public appointments, he was instrumental in founding the West Highland Cottage Hospital at Oban, which has proved an immense boon to the population of the district. He was medical superintendent of the hospital until a year or two ago, when reasons of health compelled his retirement.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Prolapse of the Female Urethra.—Barbour Simpson (*Surgery, Gynæcology, and Obstetrics*, May, 1908) describes the case of a multipara, æt. 56, who came under his care complaining of hæmorrhage and pain on micturition. The attacks of hæmorrhage came on at intervals and varied in severity. An attack which lasted for an hour made her seek treatment. Patient suffered from chronic constipation of a persistent type and had for some time past been in a feeble state of health, having had three attacks of nephritis in five years previous to seeking advice for the dysuria and hæmaturia. Examination revealed protruding from the urinary meatus a red mass the size of a large cherry, which proved to be the prolaped mucous membrane of the urethra, very congested and sensitive. Nothing abnormal was found on vaginal examination. Reduction under anæsthetic was tried, but failed. So the prolapsed mass was removed by scissors, the hæmorrhage being smart, and the mucous membrane united to mucous membrane round the urethral orifice and a dressing applied. In two days the patient could pass water for herself, and in ten days the part was healed. Microscopically, the mass removed was angiomatous in structure. The author points out that the condition has been ascribed to a sudden fall, or a large caruncle dragging on the mucous membrane, or the constant straining at stool coupled with general debility such as was found in the case reported. Cystitis and the presence of a calculus have been known to cause the condition. Kleinwächter has described two varieties of urethral prolapse, one in which the mucosa near orifice is excited, the other in which it becomes loosened higher up, gradually extending down until it appears at the meatus. Treatment for the mere excision with astringents after reduction may succeed, but in cases as described operative measures are nearly always necessary. H.

A Fatal Case of Inversion of the Uterus.—Gunn (*Brit. Med. Journal*, May 23rd, 1908) describes a case of this nature. Sent for by a certified midwife, on arrival was informed that the patient had fainted, but on seeing and examining the woman life was found already extinct. The following facts were gleaned:—The patient has been normally confined about six hours previously, the placenta following spontaneously in about half an hour. The patient afterwards was made comfortable, and the midwife then left. Some five hours later, having a desire to pass water, the patient was assisted on to her knees, and strained greatly in her efforts at micturition, with the result that "something else began to come away." The midwife was again sent for, and on arrival diagnosed the tumour which was presenting at the vulva as the head of a second child. As the patient was in an exhausted condition the doctor was sent for. Having ascertained that life was extinct he examined the patient, and found a flabby sac-shaped mass between the thighs larger than a large child's head, which proved to be the completely inverted uterus. The placental site appeared normal. The perinæum was badly torn in some previous labour and had failed to unite, leaving a gaping orifice. The patient was a vi-para, æt. 27. Dr. Gunn concludes that the straining at micturition while kneeling, coupled with a gaping vaginal orifice, was too much for a feeble non-contracting uterus, thus bringing about the condition, death being probably due to shock. H.

Preservation of the Ovaries Entire or in Part in Supravaginal or Panhysterectomy.—Reuben Peterson (*Amer. Jour. Obst.*, May, 1908).—The investigations upon which this paper is based were undertaken to determine if the preservation of more or less ovarian tissue after the removal of the uterus tended in any way to mitigate the discomforts arising from the artificially induced menopause. The conclusions arrived at were that at least 10 per cent. of all women regularly menstruating at the time of operation will be free from the troublesome symptoms of the artificial menopause after hysterectomy with removal of the ovaries; and the percentage of women with no symptoms after similar operations will be slightly more than doubled if some ovarian tissue be retained. The severity of the symptoms of the artificial menopause is much less when the ovaries are retained after hysterectomy, but it is not necessarily true that the younger the woman the more will she suffer from the symptoms of the menopause after hysterectomy with removal of the ovaries, as the greatest percentage of suffering was found in women operated on between 40 and 44. The frequency and severity of the artificial menopause is not influenced in any way by the kind of hysterectomy performed whether the ovaries are removed or retained, and the severity is the same after hysterectomies with removal of the ovaries for fibroid disease of the uterus and inflammatory disease of the appendages. Retention of ovarian tissue cuts short the period of suffering of the artificial menopause, and the greater the amount of ovarian tissue conserved, the more will the symptoms be mitigated. F.

Intra-Uterine Death of Fœtus in Six Consecutive Pregnancies.—Williamson and Holland (*Jour. of Obst. and Gyn.*, May, 1908).—The pathology of ante-natal death is obscure, and has been but little investigated. Syphilis is justly regarded as one of the commonest causes, and the following case demonstrates that even in the absence of a history of infection or of any clinical manifestations of the disease in the parents, syphilis may be responsible for the death of the child. A woman with a history of having consecutive still-born children, and again pregnant, presented herself for examination and treatment. The question of syphilitic infection was carefully inquired into, but with an absolutely negative result. Her husband was interviewed and carefully examined, and not a single fact, either in the history or clinical examination, which could be regarded as even suspicious was elicited. Neither the wife nor husband followed an injurious occupation. Before any treatment was administered, the woman was again delivered of a still-born child. The post-mortem notes are as follows:—Child premature; about 36 weeks' gestation; macerated, but not foul-smelling. Spirochæta pallida are distributed throughout the whole section of liver examined. Sections of spleen show spirochætes in some abundance, but no spirochætes could be detected in sections of umbilical cord, thus proving conclusively the presence of a syphilitic infection in the absence of clinical manifestations and in spite of a negative history. In her next pregnancy she was treated with mercury and iodide of potassium. Labour was induced, and the patient delivered of living twins. F.

The Abdominal Incision.—Collins (*Surg. Gyn. and Obst.*, April, 1908).—The writer advocates an abdominal incision which passes through both aponeuroses and muscle. The incision in the aponeurosis and the split in the muscle should run in different directions, and this can be done in a large number of abdominal operations. A longitudinal incision should not be made through the linea alba or the sheaths of the rectus, at a right angle to the combined pull of the three side muscles, when it is possible to avoid it. For very large tumours and cases where the character and location of the pathology is in doubt, the longitudinal incision is probably necessary, and if it is necessary the split in the rectus should not be continuous with the aponeurotic incision, but should be placed to one side, and preferably, through its inner half, to avoid the intercostal nerves which enter the outer half. F.

Use of Filigree in Infected Wounds of the Abdominal Wall.—Bartlett (*Surg. Gyn. and Obst.*, March, 1908).—The author strongly advocates the insertion of filigree in infected wounds of the abdominal wall, as a prophylactic measure against incisional hernia. It must be placed beneath the aponeurosis or a layer of muscle. The wound must be clothed in healthy granulations and free from pockets containing pus. In his five cases the healing of the wound was not interfered with by the filigree, and in no case had a hernia occurred after periods varying from two months to two years. F.

MEDICAL NEWS IN BRIEF

The Royal College of Surgeons in Ireland and the Universities Bill.

At the annual general meeting of the Fellows, held on Saturday last, May 30th, Sir Henry Swanzy, President, presiding, the report for the year was submitted and adopted. The following resolution was proposed by Sir Charles A. Cameron, C.B., and seconded by Prof. J. S. McArdle, and passed unanimously:—"That this College, while in no way desiring to interfere in the question of University education, view with alarm the consequences to the College which will be brought about by the establishment under the Irish Universities Bill now in Parliament of a State-endowed Medical School in connection with the proposed new University in Dublin; for it is to be anticipated that serious damage and loss will result to the unendowed school of this College, and therefore to the Royal College itself from that State-aided competition. That it is contrary not only to justice and fair play, but also to the public interest, that this College, established by Royal Charter, and its school, which for a century and a quarter have done great and important work for the State and the country, and which, if permitted, would be competent to continue that valuable work, should be crushed. That the College approve of the steps taken by the Council to bring its claim for a Government grant for its School to the notice of the Chief Secretary, and they hereby express their belief in the justice of that claim, and press it on the favourable consideration of the Government."

Sir Charles Cameron, as a Past President of the College and its Honorary Secretary, gave cogent reasons for the resolution standing in his name, with the subject of which we dealt fully in a "special article" last week. In seconding the resolution, Professor McArdle remarked that he was glad the resolution did not mention any of the three desires so frequently spoken of as dear to their hearts—viz.: (*a*) To be a constituent college of the new University; (*b*) to be an affiliated College; (*c*) to have representatives of the Senate of the new University. If the College became a constituent College, its Council would be no longer required, its individuality would be lost, the Senate would make appointments, direct the Courses, and, in fact, supplant the present managers of both College and School. If affiliation were accepted, nothing but the privilege of educating men for the new degrees would be attained, and as regarded representation on the Senate, that could be of no possible service to the College. He concluded by affirming that the Royal College of Surgeons had done, is doing, and would continue to do good and necessary work, and he therefore supported this resolution in the most whole-hearted way. Sir Lambert Ormsby and Mr. J. Lentaigne (Vice-President) having also spoken in favour of the resolution, the meeting concluded.

Scottish Diplomates' Association Dinner.

A very pleasant evening was spent on May 26th last by the members of the Scottish Medical Diplomates' Association and their guests on the occasion of the fourth annual dinner of the Society. A touch of novelty was given to the proceedings by holding the function at the Waldorf Hotel, and it may be said at once that the dinner from the gastronomic point of view was sufficient to please the most hardened gourmet. A good company assembled under the chairmanship of Dr. David Walsh, President of the Society, and after the knife-and-fork preliminaries, an excellent entertainment was provided in the intervals between the oratorical efforts of the speakers. The toast of the evening, "Success to the Association," was proposed by the President, who spoke feelingly about the disadvantages under which the diplomates of the Scottish Colleges laboured in England, and the efforts made by the Association to assert the rights of its members. The only success that had so far crowned their efforts was the grant of an official gown by the Council of the Colleges, but he hoped for even greater privileges in the future, especially that of granting the style of "member" instead of "licentiate" to the College of Surgeons' diplomates. Dr. Fitzgerald, ex-M.P. for Longford, replied in a witty speech, in which he compared the grievances of the Irish with those of the sister nation. Mr. Sidney Stephenson, in happy terms, proposed "The Visitors," and Dr. McManus, Dr. MacNaughton-Jones and Dr. Hubert Biss replied. Other toasts were "The President" and "The Officers of the Association," both spoken and replied to with enthusiasm. The gathering was graced by the presence of ladies, and was generally acknowledged to have been of an enjoyable and inspiriting character.

Cancer Research at the Middlesex Hospital.

Field-Marshal Lord Grenfell presided on May 28th at the Court of Governors of the Middlesex Hospital, when the weekly board reported that a Special Committee has been established, the members of which will devote themselves entirely to promoting the interests of the Cancer Charity, with a view to ultimately procuring its complete endowment, and ensuring that the important work of investigation carried out by the director of cancer research and his assistants shall in nowise be impeded by pecuniary considerations. In connection with the latter object an urgent appeal has recently been made in the public press for funds to meet the expenses of the current year, and of the £2,500 required for the purpose £1,000 has already been subscribed. Investigations into the difficult and complex problems of cancerous affections involve much labour, and, although it may be long before any decided practical results can be obtained, that labour is by no means fruitless. Every additional fact, however small, contributes to the better understanding of the conditions under which the diseases arise, the manner in which they spread, and the best methods of treatment to be employed. That in due time such knowledge will direct us where to look for the means of checking and preventing cancer there can be no doubt. Such a consummation will, however, only be attained by the exercise of unwearied patience and assiduity on the part of those engaged in the task, and it is essential that, possessing as they do the necessary scientific knowledge, they should have every facility given then to utilise it to the best possible advantage.

Professor Schafer's Method of Resuscitation from Drowning.

The Royal Life Saving Society has issued its annual report, announcing that 7,169 persons have qualified for its various awards as compared with 6,226 in 1906, making a total of 38,436 since the foundation of the society in 1892. The society in 1891 published an illustrated handbook explaining the methods for rescuing and resuscitating the drowning, etc., and so great has been the demand for it that a tenth edition has just been published. In this work most important alterations have been made, notably in the method of resuscitation. The society has adopted a system devised by Professor E. A. Schäfer, F.R.S., of Edinburgh University, which revolutionises the practice formerly deemed the best. The patient is laid face downwards, and natural breathing is encouraged by gentle and regular pressure on the lower ribs at the rate of about 15 times per minute. Among other new features in the book are a new method of rescue suitable for side-stroke swimming, and instruction on back swimming, over-arm, and the new crawl stroke, as also the conditions of examinations for the various awards of the society. Copies can be obtained, price 1s., from the chief secretary, 8 Bayley Street, Bedford Square, W.C.

Proceedings Against a Herbalist.

At Leeds on May 26th John Murgatroyd, a herbalist, aged 72 years, was charged with wilfully murdering Mrs. Kate Ellen Cavanagh, aged 30 years. The prosecuting solicitor said he did not anticipate being able to ask for a committal on that charge, but on one for procuring abortion by the use of instruments. The facts of the case, according to the solicitor, were that Mrs. Cavanagh visited Murgatroyd in the company of a Mrs. Fletcher. The man said he could give her some medicine. He also said he was not certain whether it would have any effect. Mrs. Cavanagh paid 2s. 6d. for the medicine. On August 8th last Mrs. Cavanagh and Mrs. Fletcher paid another visit to Murgatroyd.

There was no reference in the conversation between the woman and the man which would imply that an operation had previously been performed. Mrs. Cavanagh said her condition was unchanged, and finally an operation was agreed to. Immediately after the operation the woman collapsed.

A cab was sent for, and the woman was taken home. She never rallied, however, and made no statement. At four o'clock on the following morning she was seen by a medical man, a period of about five hours having elapsed between the operation and the woman being seen by a doctor.

Death took place on August 10th, a period of about 36 hours after the operation, and as a result of a post-mortem examination the doctor was compelled to come to the conclusion that some mechanical interference had taken place.

The conduct of Murgatroyd, remarked the solicitor, disclosed a callous indifference to the whole facts which was almost appalling. There would be, he continued, further proceedings against the man with regard to a case which had occurred at Burnley.

The man was remanded.

Formation of a Medical Benevolent Society for Yorkshire.

In the East and North Ridings of Yorkshire the need has long been felt of some Society which would have for its object the relief of aged members of the profession, or their widows and orphans. Though the question of the formation of such a Society has been raised on many occasions, it is only recently that any definite action has been taken. Some months ago a Provisional Committee was formed in Hull, which, after investigating the matter, decided that the formation of a Society on the lines of the West Riding Medical Charitable Society was most desirable, and the views of the whole of the medical practitioners (nearly 500 in number) in the East and North Ridings and the City of York were obtained by circular letter. The response was so satisfactory that a meeting was held at York on May 21st, and the Society was definitely formed. More than a hundred members have already joined, including a large number of life members. The annual subscription was fixed at one guinea, and for life members at ten guineas. Only members or their relatives can participate in the benefits. The first officers of the Society are:—President: Dr. J. Mitchell Wilson (Beverley); Vice-Presidents: Dr. Jalland (York), Dr. Godfrey (Scarborough), Mr. R. H. B. Nicholson (Hull), Dr. C. A. Lee (Hull), Dr. H. J. C. Godfrey (Bridlington); Treasurer: Dr. E. M. Hainworth (Hull); and Honorary Secretary, Dr. Edward Turton (Hull). From the support already received the future success of the Society would seem to be assured.

The Status of Prison Medical Officers in Ireland.

In reply to a question in the House of Commons last week by Mr. T. M. Healy, Mr. Cherry replied that, prior to 1877 the prison medical officers in Ireland were entitled to pensions under the Act then in force; but since the passing of the Prisons (Ireland) Act, 1877, only those medical officers who are members of the established Civil Service, and give their whole time to the service, are entitled to pensions. The only officers so entitled are two at Mountjoy Prison and one at Maryborough. Two of the existing medical officers of local prisons, who were appointed before 1877, are also entitled to pension. The remainder of the prison doctors are local medical men who have private practice. The fact that they are appointed for temporary terms of three years does not affect the question of pension. There is no ground for the assumption that these officers are not fully independent in the discharge of their duties. No case has yet occurred in which the temporary appointment has not been renewed at the expiration of three years. The change in the status of medical officers as regards pension was not made by any Government Department, but by statute.

The Elections at the Royal College of Surgeons, Ireland.

The election of the President, Council, and other officers of the College was held on Monday last, June 1st. The following were elected:—

President: *Mr. John Lentaigne, F.R.C.S.; Vice-President: *Mr. Robert H. Woods, F.R.C.S.; Secretary of the College: *Sir Charles A. Cameron. The following were elected members of Council (arranged in order of Fellowship seniority):—*Sir Henry R. Swanzy; *William Stoker, *Sir Charles A. Cameron, *Sir Lambert H. Ormsby, *Richard D. Purefoy, *Henry Gregg Sherlock, *Sir Charles B. Ball, *John B. Story, *D. Edgar Flinn, *Sir Thomas Myles, *Sir Arthur Chance, *Richard Lane Joynt, *R. Bolton McCausland, Thomas E. Gordon, *Edward Henry Taylor, G. Jameson Johnston, *William Taylor, *R. Charles B. Maunsell, *William Ireland Wheeler. (Those marked * have previously served as Councillors.)

Army and Navy Male Nurses' Co-operation.

The Hon. Secretary of the above Co-operation writes to draw attention to the fact that a misleading statement has appeared in print that it is not the intention of the Committee to deduct a sufficient percentage from the earnings of the nurses to cover the working expenses of the Co-operation. If this statement is allowed to go uncorrected, the public will conclude that the Committee will be continually appealing for funds, which is in itself a depressing thought. On the contrary, it is hoped that within a comparatively short time, and with a suitable deduction, sufficient nurses will be in employment to render the Society self-supporting. Already the demand for nurses is increasing every month. Funds are needed for equipping a residential home for the nurses and for advertising this most national enterprise.

Royal British Nurses' Association.

The annual meeting of the Royal British Nurses' Association will be held at 2.45 p.m. on Friday, June 5th, in the Council Chamber of the Caxton Hall, Westminster. H.R.H. the Princess Christian of Schleswig-Holstein will preside. Before the business meeting Her Royal Highness will present diplomas to the candidates who were successful in the Spring Examination of the Corporation. The reunion of members will take place at the Franco-British Exhibition, where tea will be served at 5 p.m.

Combined System of Medical Scholarships.

A combined examination for twenty-three medical entrance scholarships and exhibitions of an aggregate total value of about £1,500, tenable in the faculties of medical sciences of University College, King's College, and in the medical schools of King's College Hospital, St. George's Hospital, Westminster Hospital, and the London School of Medicine for Women, will be held in London by the London Inter-Collegiate Scholarships Board on September 22nd and following days. Candidates will be admitted to the examination for the scholarships and exhibitions under the various regulations governing them. Full particulars and entry forms may be obtained on application to the Secretary of the Board (Alfred E. G. Attoe, University College, Gower Street, London, W.C.), or to the deans (or secretaries) of the medical schools concerned.

NOTICES TO CORRESPONDENTS, &c.

☛ **Correspondents** requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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Subscriptions may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance For India, Messrs. Thacker, Spink and Co., of Calcutta, are our officially-appointed agents. Indian subscriptions are Rs. 15.12.

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Contributors are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

SUCCESSFUL ANÆSTHESIA.

A **coroner's** jury at Birkenhead recently came to a strange decision. A man underwent an operation and "died almost immediately from syncope, consequent on the action of chloroform." The jury then "returned a verdict in accordance with the medical evidence, and found that the anæsthetic was properly and successfully administered." If these words have any meaning, we can only conclude that the jury judged from the medical evidence that the doctors desired to kill their patient. At any rate, they are to be congratulated on their frankness.—*John Bull.*

Occupans.—The total number of cases of poisoning and of anthrax reported to the Home Office under the Factory and Workshops Act during April was 61, consisting of 53 cases of lead poisoning, 2 of arsenic poisoning, and 6 of anthrax. In addition to the above, 13 cases of lead poisoning (including 2 deaths) were reported during April among house painters and plumbers.

Arma Virumque.—It is rather a curious point to put to a medical editor! But, in order to justify the omniscience you impute to us, we may inform you that *any* motto may be used by any armigerous person. There is no grant of a motto, and consequently no heredity in it. If your opponent likes your motto and adopts it, you have no remedy beyond moral suasion.

OUT OF DATE AND UP TO DATE SURGERY—A CONTRAST.

The old time surgeons, dirty and unkempt,
Seldom from vermin or bacteria exempt,
Carried "death's warrant underneath their nails."
Men wondered why their operations failed;
But Lister came, and with him came the light,
Pasteur and Lister—names we must unite;
In common justice, *both* must share the praise,
They sought the goal, but both by different ways.
Now their results we all rejoice to see,
Aseptic! Cleanly! Modern Surgery!

London, W. A. D.

Mr. Hy. Watson.—Dr. Dakhyl, about whom you inquire, is a Turkish subject, having French degrees. The present position has arisen through his unsuccessful libel action against *Truth*, and his consequent liability for the costs, amounting to over £3,000.

F.R.C.S.I. will find full reference to the subject in our last issue. The report of the meeting of College on Saturday last, at which the question was discussed, will be found on reference to our "News" column in present number.

F. B. E.—Pressure on our space this week has precluded the insertion of your letter. It will be considered and inserted in our next, if deemed desirable.

Medical Officer.—We regret to state that the Society, which has done such excellent work, has gone to pieces. We understand that it may possibly be revived.

Meetings of the Societies, Lectures, &c.

Wednesday, June 3rd.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.)—4 p.m.: Mr. T. P. Legg: Clinique (Surgical). 5.15 p.m.: Lecture: Dr. F. J. McCann: How to Diagnose Cancer of the Womb (with lantern slides).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Clinics:—2.30 p.m.: Medical Out-patient: Dr. Whipham. Skin: Dr. Meachen. Eye: Mr. Brooks.

Thursday, June 4th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture:—Mr. J. W. T. Walker: The Treatment of Stricture of the Urethra.

Friday, June 5th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. H. Tilley: Clinique (Throat).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic:—Surgical Out-patient: Mr. J. H. Evans. 2.30 p.m.: Surgical Operations: Mr. Edmunds. Clinics: Medical Out-patient: Dr. Auld. Eye: Mr. Brooks. 3 p.m.: Medical In-patient: Dr. R. M. Leslie.

Appointments.

Davis, H. J., M.B.Cantab., M.R.C.P.Lond., Physician-in-Charge of the Throat and Ear Department at the West London Hospital.

English, Samuel, M.B., Ch.B.Glasg., Honorary Surgeon to the Pendleton Branch Dispensary of the Salford Royal Hospital.

Fothergill, W. E., M.D.Edin., Lecturer on Clinical Obstetrics and Gynæcology in the University of Manchester.

Hill, William, Surgeon-in-Charge of the new Department for Diseases of the Ear, Nose and Throat at St. Mary's Hospital.

Howarth, William James, M.D., D.P.H.Vict., County Medical Officer for Kent.

Kearney, J. J., M.B., B.S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Rosscarbery District of the county of Cork.

Kelly, M. Fitzmaurice, M.B., B.S.Lond., F.R.C.S.Eng., Surgical Registrar at St Mary's Hospital.

Roberts, W. R. S., M.B., B.S.Birm., Certifying Surgeon under the Factory and Workshop Act for the Ongar District of the county of Essex.

Vacancies.

Royal Lancaster Infirmary.—House Surgeon. Salary £100 per annum, with residence, board, attendance, and washing. Applications to the Secretary.

Infirmary of the City of London Union.—Assistant Medical Superintendent. Salary £150 per annum, with furnished apartments at the Infirmary, rations and washing. Applications to Edward R. Woodward, Clerk to the Guardians, 61, Bartholomew Close.

Leicestershire and Rutland Asylum.—Junior Medical Officer. Salary £130 per annum, with board, lodging, and washing. Applications to W. J. Freer, Esq., 10, New Street, Leicester.

Burton-on-Trent Infirmary.—House Surgeon. Salary £120 per annum, together with furnished rooms, board, coal, and light free. Applications to the Hon. Secretary, Mr. John Wood, the Infirmary, Burton-on-Trent.

Lord Mayor Treloar Cripples' Home and College, Alton, Hants.—Resident Medical Officer. Salary £150 per annum. Aplications to Sir William Treloar, 122-3, Mansion House Chambers, E.C.

Carmarthenshire Infirmary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing. Applications to Howell Howell, Secretary.

County Asylum, Burntwood, near Lichfield.—Junior Assistant Medical Officer. Salary £150 per annum, with board, lodging, attendance and washing. Applications to the Medical Superintendent.

Darenth Asylum.—Third Assistant Medical Officer. Salary £150 per annum, with rations, lodging, attendance, and washing. Applications to the Superintendent, Darenth Asylum, Dartford, Kent.

Norwich City Asylum, Hellesdon-next-Norwich.—Assistant Medical Officer. Salary £130 per annum, with rooms, board, laundry, and attendance. Applications to the Medical Superintendent.

Metropolitan Hospital.—Secretary. Salary £350 per annum. Applications to be sent to the Chairman, Metropolitan Hospital, Kingsland Road, N.E.

Births.

Barradell-Smith.—On May 24th, at 396, London Road, South Lowestoft, the wife of S. Barradell-Smith, M.B., B.C., of a son.

Bawtree.—On May 27th, at The Lodge, Maldon, Essex, the wife of Frank Bawtree, M.R.C.S.Eng., L.R.C.P.Lond., of a son.

Hughes.—On May 20th, at 4, Kirtleton Avenue, Weymouth, the wife of Fleet-Surgeon Hughes, R.N., H.M. Dockyard, Malta, of a son.

Sowry.—On May 28th, at 4, King Street, Newcastle, Staffs, to Dr. and Mrs. Sowry—a son.

Soltau.—On May 30th, at 1, Lansdown Place, Plymouth, the wife of A. Bertram Soltau, M.D., F.R.C.S., of a son.

Wilson.—On May 22nd, at 185, Chevening Road, London, N.W., the wife of Thomas Wilson, F.R.C.S., of a son.

Deaths.

Richards.—On May 27th, at his residence, 150, Westhill, Putney, Samuel Atkinson Richards, L.R.C.P., M.R.C.S., L.S.A., etc., in his 76th year.

Ridge.—On May 25th, at Carlton House, Enfield, Middlesex, John James Ridge, M.D., B.A., B.S., B.Sc.Lond., Medical Officer of Health for Enfield, aged 61.

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‘Tabloid’ Liquorice Compound Powder is supplied to the Medical Profession, in bottles of 25 and 100, at *7d.* and 1/4 per bottle. Each product is equivalent to 30 gr. of the official powder, and represents Senna, gr. 5; Liquorice, gr. 5; Sublimed Sulphur, gr. 2½; etc.

⁂

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An efficient stomachic and carminative combination, which reinforces the normal gastric function. The ‘Tabloid’ product, containing exact amounts of pure active ingredients, enables a saline draught to be made with a minimum of trouble.

Each product contains Magnesium Sulphate, gr. 15; Magnesium Carbonate, gr. 2½; and Oil of Peppermint, min. 1/32. Supplied to the Medical Profession, in bottles of 100, at 1/8 per bottle.

⁂

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A valuable preparation of astringent, aromatic, antispasmodic and anodyne power. With the ‘Tabloid’ product an efficient draught is readily prepared, containing the complete activity of each constituent.

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⁂

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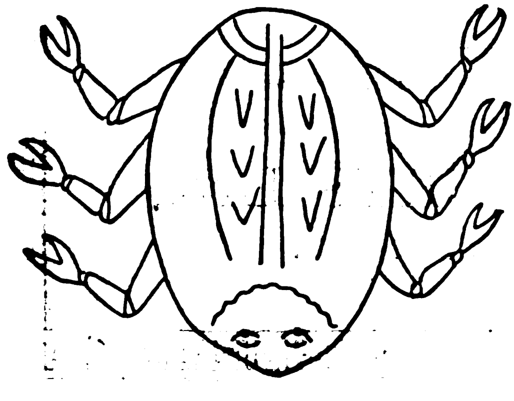

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"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JUNE 10, 1908. No. 24.

NOTES AND COMMENTS.

Accommodation for Seamen.

THE Medical Officer of Health for the Port of London has spoken out in strong and fearless terms about the accommodation for seamen provided on merchant vessels, and it is quite time that the matter engaged the attention of the Board of Trade. The good persons who bewail the disappearance of the British sailor, and his replacement by Norwegians, Lascars, and other foreigners, have only to consider how low a standard of comfort and healthiness is reached by the conditions of life on a merchant ship, before realising that the seaman who prefers turning land-lubber to sailing on the deep is no bad judge. As the surroundings of the working-classes rise in complexity and healthiness the poor gain new ideas of decency and comfort, and it is not to be expected that men will give up their homes and go to sea if insanitary quarters are provided for them. Consequently foreigners, who have not British ideas of the necessaries of life, take to manning the merchant service in larger and larger numbers. Shipowners are fond of talking of patriotism when it suits their purpose, but it is an evil form of treason that makes them offer British seamen the alternative of living in pig-styes or being replaced by foreigners.

Abaft the Binnacle.

DR. WILLIAMS describes the accommodation provided for seamen as a "disgrace to the twentieth century," and he attributes this state of affairs to shipowners apportioning as little space as possible to the staff in order to have more space for cargo. It is recognised by many medical men that whereas a sailor's life should be the healthiest possible, especially as regards pulmonary tuberculosis, as a matter of fact, the cramped sleeping quarters and the want of ventilation when the men are below, more than outweigh the advantage of fresh sea air when they are on deck. Dr. Williams points out that one of the great difficulties in lighting and ventilating the men's quarters is that they are situated in the forecastle, where the amount of light is limited, and where in bad weather the ventilators have to be removed. The sea is the most conservative of institutions, and the chief reason why men are lodged in the forecastle is that they always have been from time immemorial, though there is no reason known to anyone why they should not be accommodated aft, where light and air in abundance can be easily provided. By the Merchant Shipping Act of 1906 great improvements were intended in the seaman's life, but if the administration of the Act is not better enforced than seems to be the case, it will not be of much benefit to anyone. Among the conditions found in forecastles by Dr. Williams were six square feet of floor space allowed per man; another where vermin abounded and the floor was covered with accumulated filth; and a third where no natural light penetrated to the men's quarters. It seems, therefore, that we have not yet exorcised methods of barbarism from the merchant service.

Open-air Schools.

THE Education Committee of the London County Council, it may be remembered, tried an interesting experiment last year, namely, that of establishing an open-air school at Bostal Heath. The report on this departure has just been issued, and we are not far wrong in characterising it as period-marking, if not epoch-making. The children selected for instruction were all weakly or anæmic, and the joint report of the medical officer and the executive officer shows that, as regards health, the results were little short of astonishing. Every single child was benefited, some more and some less, but in certain cases the result was remarkable, especially in the case of children suffering from active disease. Encouraged by their success, the Committee propose this summer to hold three open-air schools, at Forest Hill, Kentish Town, and Shooter's Hill respectively, each school to accommodate seventy-five children, under a head-teacher, three assistant teachers, a nurse, and a cook. The committee reckon that £2,000 will be needed for the establishments, but this sum is not to include food, and they are appealing for £400 or £500 to be subscribed privately for this purpose. It is not our business to suggest where the money should come from, but it is a simple fact that unless plenty of good food is forthcoming, fresh air in the greatest abundance will not restore children to health. At any rate, we heartily congratulate the Education Committee on their departure from tradition, and on the demonstration they have afforded of the possibilities of schooling under natural conditions in this country. We hope the experiment will soon become a practice.

Inquests and Operations.

MR. TROUTBECK is apparently anxious to be known as a reforming coroner, which is another way of saying that he likes to make specious departures from the methods of his fellows. Last week he held an inquest on the body of a woman who died in the Bolingbroke Hospital after an operation, performed by Sir Victor Horsley, for the relief of cerebral tumour. Sir Victor himself was called as a witness, and he took the opportunity to remark that the case presented no features of unusual interest, and he did not therefore understand why an inquest had been held. Mr. Troutbeck rejoined that operations were getting much more frequent, and that inquests on patients who died after them were imperative. In addressing the jury, he proceeded to say that if death were accelerated by an operation, the case was one for inquiry before the coroner, because the death was not a natural death. He believed the country was in a state of complete ignorance as to the proportion of deaths accelerated by surgical operations. "It was a serious matter, and one for which a legal remedy was undoubtedly required." In the Bolingbroke Hospital, he remarked 14 deaths after operations had occurred during the year, and with the delicate consideration which he shows when there is a chance of casting a slur on medical men, he remarked that one could not tell whether these deaths had been accelerated by the operations or not, "but a very serious condition of things stood revealed. He did not intend to let the matter rest." Mr. Troutbeck is out on the warpath, and with the support of his faithful henchman we can scent further trouble in the wind.

New Methods.

If it is proposed to hold inquests on all patients who die within measurable time after surgical operations, we shall be faced with a situation of grave possibilities. Presumably Dr. Freyberger will be called to decide if the operation accelerated death or whether the operation was justifiable, and it is hardly likely that surgeons will be content to accept the verdict of a coroner's jury founded on such evidence. In the first place, the calibre of the average coroner's jury is little calculated to cope with the immense difficulties of clinical medicine and the deductions drawn from clinical signs and symptoms; secondly, Mr. Troutbeck has not established a reputation for entering sympathetically into the difficulties of medical practice; and, thirdly, Dr. Freyberger is not accepted by English medical men as an authority on surgery. It would seem the merest of platitudes to say that only experienced surgeons are qualified to say in a given case whether an operation gives a patient a better chance of relief or of life than abstaining from an operation.

New Results.

But there are other and very serious dangers to the practice. If surgeons know that every death after operation is to be made the subject of debate and criticism in ill-natured halfpenny journals, there will be an inevitable tendency to consult their own reputations more than the patient's benefit, and they will abstain from those operations which the patient is quite willing to undergo, but which involve serious risk. The holding of inquests may make the number of deaths after operation fewer, but it will in a much greater degree increase the number of deaths which might have been averted by operation. Moreover, with the odium and publicity of an inquest staring them in the face, the relatives of patients will be unwilling to consent to surgical procedures in severe cases, and, again, the number of those who might have been saved will increase. It is necessary to look at this matter from the broadest standpoint.

LEADING ARTICLES.

THE ROYAL COLLEGE OF SURGEONS OF IRELAND AND THE UNIVERSITIES BILL.

Our readers have already been made aware of the danger which threatens the Irish College of Surgeons under the Irish Universities Bill, but we make no apology for returning to the subject. The annual meeting of the College last week showed to the world the unanimity which exists among Irish surgeons as to the need for the continued existence of the College and its School of Medicine. The spirit exhibited should be a sufficient answer to those cavillers who suggest that in the settlement of Irish education questions the College need not be considered. Among those who rallied to the support of the College of Surgeons were professors and teachers of other schools, who recognise how necessary to the profession is the threatened institution. The Royal College of Surgeons has been in existence for some hundred and thirty years, and though receiving small grants for a time, for the last hundred years it has received no public money whatever. Its income entirely depends on the receipts of the School, for at present it has no funds invested beyond some £7,000 accumulated in more prosperous times. That the School still holds its place in spite of the multiplication of medical schools is shown by the fact that last winter there were some hundred and forty students entered for classes in anatomy. There are five other medical schools in Ireland, of which four are substantially endowed. The Universities Bill now before Parliament proposes to establish a richly endowed school instead of the fifth, at present unendowed. Every one of these schools will be a university school, and will naturally train its students for university degrees. By reason of their endowments these schools will be able to offer education at very low fees, and will presumably be able to provide attractive bursaries and scholarships for poor but able students. The natural result will be that the School of the Royal College of Surgeons will be starved out, and as the College has no source of income but its School, it must go under also. In his speech at the annual meeting, the President-Elect, Mr. Lentaigne, now President of the College, cleared away some misunderstandings which may be present in the minds of those who do not understand the position of medical education in Ireland. It will be asked why the College needs a school, since the sister College in London has none. In the first place, the College will have no means of existence if its School disappears, and we do not think there is any need to labour the case for the persistence of the College. Again, there is no analogy between the conditions in Ireland and those in London. In Ireland schools of medicine are all attached to some examining and qualifying body, and none of them belong to hospitals. In London, as we know, the schools are attached primarily to hospitals, and are merely affiliated to, or recognised, by the qualifying bodies. In Ireland the question at present is of starving out the only non-university school by giving endowments to five university schools. As the College has clearly stated, it does not fear competition, but it claims that the handicap should be fair. The School has maintained its high position in open competition with its rivals, and it claims its right to continue in fair competition with them. We cannot do better than quote a few sentences from a letter addressed on behalf of the College to Mr. Birrell:—

"It may be asked why we have not obtained endowment from private sources, as our English sister College has done. But Ireland is a poor country, and in it benevolence flows along religious channels, while Government aid is most successfully sought for by organisations savouring of party. It is our pride that we have excluded from the purview of our College all matters other than 'the regulation of the profession of surgery,' and the maintenance of 'reliable and extensive system of surgical education.' We seek no monopoly of medical education. We do not desire to hinder or delay educational proposals wished for by any body of our countrymen. We only ask that, when such proposals are being carried into effect, provision will be made to prevent the destruction of an ancient and distinguished College, the closing of a large and increasing school, and, incidentally, the beggaring of such of its professors as rely solely upon the income of their Chairs for their livelihood. The most simple and effective safeguard would be an annual grant of an amount sufficient to permit us to maintain our College and its School in a state of efficiency. This sum we estimate at £5,000 per annum. Such an endowment would have the advantage of not disturbing whatever arrangements may have been entered into with regard to the new University, while it would leave us—an independent body—to fulfil our duties and to follow our traditions without interference."

The College, if it is to obtain its deserts, must have the unanimous support of the medical profession of the entire kingdom. We confidently claim for it that support.

MEDICAL LAW REFORM.

IN the speech of the President at the opening of the Session of the General Medical Council, a brief extract of which was contained in our report of the proceedings of that body, Principal MacAlister remarked that "the difficulty of obtaining remedial legislation, even for admitted evils, affecting the practice of medicine, was illustrated by the slow progress of the Medical Companies Bill in the House of Commons." This remark suggests, first, that the President, for a man in his position, is singularly lacking in acquaintance with methods necessary to set in motion legislative machinery; and, secondly, that he is still more ignorant of the quality and quantity of remedial legislation that is needed in any way effectually to remedy the defects of existing statutes. If the President will inquire, he will find that very few Bills of any class can nowadays be carried through by private members, and that in medical legislation the introduction of a measure by a medical member is almost alone enough to ensure its destruction; for then the powers of ignorance, prejudice, and fanaticism in both Houses are surely arrayed against it. The chances of the passing of the Bill now in the hands of Sir J. Batty Tuke are extremely remote, in spite of the respect in which he is held; but if the Bill did become law it would not inflict more than the most trivial of pin-pricks upon the huge monster, quackery, against which it is directed. Not more than one per cent. of quacks are practising under the cloak of the Companies Act, and if they were forbidden to do so they would be subject only to a very temporary and trivial inconvenience. There are more than a dozen other ways, besides practising as a company *not* "limited," in which they could with impunity palm themselves off on the public as fully qualified practitioners; and not one of them would need to give up his nefarious business in consequence of the proposed new law.

The case for drastic medical law reform is overwhelming. It is a pity that the General Medical Council do not recognise that fact, and take part in promotion of the movement by which alone the desired enlightenment of our legislators can be brought about—namely, through the medium of a Royal Commission. This fact has already been acknowledged, and is about to be acted upon by the British Medical Association.

A Royal Commission has been made more than ever necessary by the attitude of the newspaper Press. Hitherto it has been possible to name a certain number of leading papers which have refused admission to fraudulent advertisements, and on occasion have exposed and denounced medical quacks and quackery. The number of such papers is rapidly diminishing. Nearly the whole Press—like that of the United States and Australia—is now practically suborned by quackery; and it is, as a rule, impossible for an editor to attack this gigantic system of cruel and murderous fraud without stultifying himself in a fashion at once ludicrous and deplorable. We have before us a recent issue of one of the foremost papers of the day, containing an editorial article dealing with a system of quackery lately exposed in the Law Courts, and deploring the fact that advertisements, on the face of them misleading, should find admission to respectable papers. In the same issue of the same paper appears the advertisement of the quack alluded to. This advertisement had appeared previously for many months in an especially expensive column, and has since been printed in the same place on many occasions.

The Medico-Political Committee of the British Medical Association recommend that a report on illicit practice and the traffic in quack medicines and apparatus—the cloak for a great deal of fraudulent practice—should be prepared before application for a Royal Commission is made. In this the General Medical Council could easily take an important part, and we commend it to their consideration. Either of them alone, the Association or the Medical Council, have it within their power to draw up a report which would not only suffice to show the need for Government inquiry, but would be alone almost enough to compel the interference of Parliament. We base this opinion upon a study of the Report of the Australian Commissioners, with a copy of which we have been favoured by Mr. Beale. Mr. Beale was commissioned to inquire but had no power to call witnesses and examine them on oath, and nearly everything he has set down could be repeated with equal authority and more effect by the bodies we have designated. Mr. Beale, as a layman, unaware of the magnitude of the evils he was called upon to lay bare, was evidently filled gradually with amazement, horror, and indignation as the story unfolded itself, and his report is to some extent weakened by the constant expressions of his emotions. But, discount it as one may, it is an astonishing narrative of popular credulity on the one hand, and of cynical knavery on the other. Presentation of a similar report to our home Government would make the demand for a Royal Commission irresistible, and a Commission would make it plain that, whatever advantages to the profession might be given by adequate legislation, these advantages would be outweighed literally a thousand times by the benefits conferred upon the people and upon the classes—the poor, the ignorant, the weak—who have most claim upon the guardianship of the State. Instead of the paltry tinkering with the law to which the President of the Council referred, would it not be better for the

Medical Council to direct all its energies to the promotion of reforms which would promise to be at once sweeping, effectual, and permanent?

CURRENT TOPICS.

The Forthcoming Meeting of the British Association.

WE are glad to learn that the arrangements are well advanced for the meeting of the British Association which is to be held in Dublin at the beginning of next September. It is now some thirty years since the Association visited the Irish capital, though six years ago it held its meeting in Belfast. Naturally, great interest is being taken in the visit, and public bodies and private persons are vying in offers of hospitality to the Association and to its principal members. Trinity College, the Royal University, the Royal Colleges of Physicians and Surgeons, and the Royal College of Science, are opening their doors for the meetings of the various sections, and as these buildings are all within short distance of each other, the passage from one section to another will be easy. Of late years, of course, the scientific importance of the meeting has somewhat dwindled, and it is now rather a social gathering of people interested in science than a conference of men of science. The social side of the meeting, therefore, will be well looked after, and many social functions are in process of arrangement. Few cities are more pleasantly situated as regards surroundings than Dublin, and doubtless many excursions to places of interest will take place. Medical men who can fit the meeting into their summer holiday will enjoy the visit to Dublin under such conditions.

Dentists and Anæsthetics.

AT the meeting of the General Medical Council, the case adjourned from November of a medical man who had been charged with administering anæsthetics for unregistered dentists, was before the Council, and the Council, having gone fully into the matter, did not adjudge him guilty of "infamous conduct in a professional respect." As we read the case, however, this judgment was given in view of the gentleman's statement that he was unaware he was committing any offence, and no doubt seems to remain that if such a case should occur again, the Council might come to a different decision. In doing so, they would have the good sense of the profession behind them, for it would be quite wrong that unregistered dentists should obtain the assistance of qualified medical men in such a way as to mislead the public into regarding them as reputable practitioners. The medical profession is willing to assist the dental profession in the suppression of quackery, but something is owing in return. It is not merely in the interests of the medical profession, but of the public, that we maintain that it is improper for anyone but a qualified medical man to administer an anæsthetic. If dentists expect the support of medical men in the guarding of their professional privileges, they must be careful themselves not to trespass. The giving of anæsthetics by a dentist, who is not a medical man, or, still worse, by the dentist's mechanic, as commonly happens, is not only a gross infringement of the privileges of the medical profession, but a serious danger to the public. We trust that the British Dental Association, which has already done much to preserve the dignity of the dental profession, will draw the attention of its members to this consideration.

Enteric Fever in Belfast.

IT seems probable that at last the cause of the hitherto unexplained constant prevalence of enteric fever at Belfast has been discovered. The discovery is due mainly to the labours of Dr. Darra Mair, an inspector of the Local Government Board, and a member of the Commission appointed in 1907 to investigate the question. Exhaustive inquiry in every possible direction furnished no clue to the prime origin of the infection. The local water supply was completely absolved, and although one limited outbreak was traced to infected milk, and although it was evident that the general prevalence of the disease must from time to time have led to occasional or accidental sources of diffusion, the true source remained concealed. Dr. Darra Mair was, however, in the end able to demonstrate with sufficient clearness that the continued and exceptional prevalence of the disease was really due to the unrestricted gathering of cockles and other shell-fish from the sewage-laden shoals of the Lough, and the consumption of the molluscs generally uncooked—by the poorer classes of the people. It is now proposed to prohibit the gathering of the contaminated shell-fish for human food; but we do not notice any proposal to suitably reward Dr. Mair for the service he has rendered to the locality and to the State, in the carrying out of his laborious scientific investigation. Similar services to the public by any profession, except the medical, would not be allowed to pass without some recognition beyond the mere verbal thanks which the local authority may or may not be pleased to accord to Dr. Mair.

The New Peril.

THE introduction of electricity into daily life has been the means of creating a whole series of risks to the detriment of His Majesty's lieges. A fluid which flows with incredible facility and in unlimited quantity through solid metal, for the passage of which mere superficial contact establishes continuity, is obviously a force to be very carefully kept in hand, metaphorically speaking. Like the wind, we know not whence it comes nor whither it goes. A live wire comes into chance contact with a telephone wire, and incontinently the operator, hundreds of miles away it may be, is stricken even unto death. A broken trolley wire touches the tramway rail, and forthwith human beings and animals in the line of fire, irrespective of distance, writhe in their death agony on the ground, and he who seeks to succour them does so at his peril. The enemy awaits us at odd corners and springs upon us unawares. The pavement is strewn so freely with metal covers of various kinds of "boxes"—sewer, telephone, telegraph, coal-holes, and so on, that in a crowded thoroughfare the averages pedestrian impinges on about ten a minute. Any one of the metal covers may, at a given moment, be directly or indirectly in contact with a live something, and the unsuspecting passenger falls gasping to the ground, never to smile again. The superstitious "touch wood" to avert certain contingencies, but in future they will do well to concentrate their attention on the necessity of not touching iron. It has come to this that the careful man will shy at the sight of metal in the roadway lest by inadvertently treading upon it he may become post-mortem material. In this country the risk has been minimised by prohibiting the putting up of naked wires for the transmission of powerful currents of electricity, but the risk has in great measure only been transferred from the air, where it is out of the way, to the ground, where it may be impossible to elude, should it break loose. One simple precaution would be to insist that all box covers in the public way should be covered with an insulating material, and another would be the more general use of rubber soles to boots. A very reasonable suggestion is that all live rails should be painted in a bright colour, scarlet for choice, as a warning to trespassers. The next few years will witness an untold development of these dangerous conduits, suicide will be reft of its terrors, and in the event of a railway accident the travellers will be electrocuted long before they can be either saved or burnt alive. This may not be an unmixed disadvantage, but it is an alternative which we can hardly be expected to view with philosophical indifference.

A Tuberculosis Exhibit.

An interesting feature of the Irish village at Ballymaclinton is the Tuberculosis Exhibition on view in the Village Hall. This is a reproduction, on a small scale, of the Tuberculosis Exhibition now on tour in Ireland, and includes the following four sections, namely, Pathological, Veterinary, Appliance, and Statistical. The Pathological Section consists of specimens of human lungs and intestines in various stages of tubercular disease. The Veterinary Section comprises examples of tuberculosis in the lower animals, including diseased and healthy bones for contrast. The Appliance Section includes sputum flasks, tissue paper handkerchiefs, cheap spittoons from cardboard and peat, milk sterilisers, and appliances for the preparation of food for invalids and infants. This section is not yet complete, but when finished will include models of châlets and simple open-air shelters, with photographs of various Irish sanatoria. The Statistical Section consists of diagrams and maps showing the appalling death-rate from tuberculosis in Ireland. Copies of literature distributed through the medium of the Tuberculosis Exhibition in Ireland are displayed on a large reading-desk. This literature covers every aspect of tuberculosis: the causation, prevention and treatment, including, as it does, copies of lectures delivered by the Registrar-General of Ireland, Sir Robert Matheson, Prof. Osler, Prof. McWeeney, and Sir John Byers, together with simple directions as to ventilation, cleanliness, food and milk supply. The "contrast" bedrooms which were shown by the Exhibition on tour are reproduced here, and form a valuable object lesson. On the one side thorough ventilation, brightness, cleanliness and simplicity are portrayed; on the other, darkness, dust, heavy curtains, ragged carpet, tightly-closed window—in short, every accessory for the development and spreading of disease. Throughout the day brief lectures are delivered, and altogether the Exhibition is a striking example of ingenious enterprise.

PERSONAL.

Dr. Gerald Leighton, M.D., F.R.S.E., has been appointed Professor of Pathology and Bacteriology in the newly-constituted Chair of those subjects at the Royal Veterinary College, Edinburgh.

Miss Janet M. Campbell, M.D., has been appointed to the medical staff of the Board of Education.

Dr. D. Ferrier, F.R.S., will give the Bolingbroke Lecture of the South-West London Medical Society on Friday next at 9 p.m. His subject will be "Hysterical Paralysis."

Dr. Charles W. Chapman will preside at the annual dinner of the Southern Branch of the Durham University Medical Graduates' Association.

Sir Thomas Clifford Allbutt, K.C.B., F.R.S., will preside at the dinner of the Cambridge Medical Graduates' Club, to be held on June 20th at Downing College, Cambridge.

On the occason of a visit of the French Medical Association to London to visit the Franco-British Exhibition, Professor Landouzy will deliver an address to medical men in the Great Hall of St. Bartholomew's Hospital

Dr. James Kerr will deliver the Inaugural Lecture of a Whitsun course on School Hygiene organised by the Incorporated Society of Medical Officers of Health on June 9th.

Messrs. Pearce Gould and Harrison Cripps are offering themselves for re-election upon the Council of the Royal College of Surgeons of England at the expiry of their term of office, and amongst the new candidates are Messrs. Lynn Thomas, C.B., George Eastes, Arbuthnot Lane, C. B. Lockwood, and W. F. Haslam.

Mr. Grant Andrew has been elected President of the Glasgow Southern Medical Society.

His Excellency the Governor of Bombay has consented to preside at the Medical Congress to be held in that Presidency in February of next year.

Dr. A. F. Hertz, Assistant Physician at Guy's Hospital, has been appointed Lecturer in Materia Medica and Medical Pharmacology in the University of Oxford; and Dr. J. B. Leathes, Lecturer in Physiology in St. Thomas's Hospital, Examiner in that subject in the same University.

Dr. C. Powell White will give three lectures on Cancer under the Pilkington Cancer Research Foundation of the University of Manchester.

Mr. John Lentaigne has been elected President of the Royal College of Surgeons of Ireland for the ensuing year; Mr. Robert Woods, Vice-President; and Sir Charles Cameron, C.B., Secretary.

Sir William Church presided at the annual meeting of the Convalescent Homes Association on May 20th.

The Board of Governors of the Richmond, Whitworth, and Hardwicke Hospitals have appointed Dr. C. H. O'Rourke, house physician, and Dr. G. T. Shepherd house surgeon.

A Clinical Lecture

ON

SOME LANDMARKS IN THE STUDY OF TUBERCULOSIS. (a)

By WILLIAM ST. CLAIR SYMMERS, M.B., C.M.Aberd.,

Professor of Pathology, Queen's College, Belfast.

That tuberculosis is a contagious disease is the conviction of most modern physicians. Still, the whole subject is beset with so many difficulties, and is attended with so many conflicting views, that it may interest us to look into a few of the more important issues of the case.

At the beginning of the last century, many of the leading French clinicians denied the contagiousness of pulmonary phthisis—*e.g.*, Laennec, Andral, Chomel, Trousseau—all men of outstanding ability and of great clinical acumen and experience, taught that phthisis was not a contagious malady. Laennec (1) stated that the passage of tuberculous material from a diseased to a healthy man, with *phthisis* as a result, was improbable. He argued that, among the poor, a large family could live in a single room with a phthisical person among them—a husband could live with a phthisical wife, and still no transmission of the disease takes place. Again, he had known repeated examples of people using the unwashed mattresses and bed-clothes of those who had died of phthisis, and no untoward result followed.

Among his examples of the non-contagiousness of phthisis, he cites a certain sisterhood over which he had medical charge, and in which, during ten years, the whole household, with a few exceptions, was renewed two or three times owing to deaths from phthisis (2). In this case he attributes the phthisis, not to contagion, but to melancholy emotions—*passions tristes*—attendant on the extreme rigour of the life and constant thought of the more terrible aspects of religion. But in this same connection he states (3), as if in reserve of judgment, that "many facts go to prove that a disease which is not usually contagious may become so under certain circumstances." Laennec held the view that tuberculous matter once developing in a pre-disposed person—once forming "tubercules" in the body—was metastatically infectious, and so invaded the tissues of the individual, involving a greater or lesser area until the patient succumbed. But still, while denying the phthisis-producing power of tuberculous material, denying that phthisis is contagious, he gives (4) a masterly description of a tubercle forming contagion in his own personal experience. Having inoculated his left forefinger by a scratch when sawing a tuberculous vertebra, there developed a small yellowish nodule exactly resembling a "crude yellow tubercle." This accident happened to him in 1799, and after twenty-one years he showed signs of phthisis incipiens. He died of phthisis six years later. There are not wanting authorities (*e.g.*, v. Behring) (5) who believe that the finger wound was in all probability the original infection of the phthisis of which Laennec died twenty-seven years after. By the side of this view, be it mentioned that Laennec's mother died of phthisis when he, afterwards so justly renowned, was a child of six years of age.

Nineteen years after Laennec's death, J. A. Villemin (6), latterly of the Val de Grace Hospital in Paris, published (1865-1869) a series of memorable experiments in which he demonstrated once for all that the products of tuberculous lesions were capable of conferring tuberculosis when inoculated into animals. In these experiments he used principally rabbits, and he showed that these and other animals could be infected with tuberculous matter—that is, that if tuberculous matter from phthisical cavities, or caseous matter from various human organs were introduced into the body of the rabbit (by placing such matter subcutaneously at the root of the ear), these animals became tuberculous. Further, he found that tuberculous matter from the cow was also capable of producing tuberculosis in the rabbit, and he states that this infective material from bovines was effective in communicating a much more rapid and more generalised tuberculosis than was obtainable with the matter from human sources (7). Thus he was acquainted with a fact which has been insisted upon in recent years—viz., that bovine tubercle produces in rabbits a more rapid and more extensive infection than is obtainable when human tubercle is inoculated into these animals. Goats and guinea-pigs were also proved to be inoculable, but dogs were more resistant, and sometimes remained unaffected—they never died, but tubercles were found if the animal were killed. Three cats were subcutaneously inoculated, and two of them showed slight signs of tuberculosis. As to birds, it was found that repeated inoculations of a cock and a ringdove led to no trace of tubercle. This is in accordance with the modern view that fowls do not contract tuberculosis from swallowing human tuberculous sputum. Further, he found that sputum from phthisical patients was infective to rabbits when subcutaneously injected. One of the rabbits thus tuberculised was found to show no lesions in the lungs. This fact, says M. Villemin, was the first example (8) that he obtained of an exception to what was known as the "Law of Louis," this law formulating that the lungs are particularly prone to tuberculosis, that they are always the first and occasionally the only organs to become affected. In continuation of these epoch-making experiments, Villemin investigated the infectivity of caseous pneumonia and of scrofulous glands, of the blood of tuberculous men and rabbits; also the effect of intra-tracheal injections; and among other positive results he showed that tuberculous matter is continuously infective when passed from rabbit to rabbit through a series of these rodents. As to the blood, he succeeded in producing tubercle by subcutaneously injecting 2 c.c. of defibrinated blood from the rabbits' femoral artery. Again, 2 c.c. of blood from the liver of a man who had died of phthisis produced, in a rabbit, tuberculosis of marked intensity and extent, with a fatal termination in six weeks' time. But, with blood obtained by "cupping" from living patients, the results were less striking. Three of the four rabbits used remained unaffected. The fourth showed a local caseous mass the size of a "small nut" at the point of inoculation, and a few grey tubercles in the lungs.

In marked contra-distinction to the positive results obtained by inoculation of tuberculous matter was his uniform and invariable failure to produce tuberculous lesions when he injected non-tuberculous products—*e.g.*, pus from various sources, "cancerous" material, pneumonic products, the exudate from a pleurisy complicating typhoid fever, and also, in answer to certain criticisms, he showed the non-tuberculous nature of the so-called "verminous tuberculosis" (9) of sheep. Moreover, he pointed out to his critics that spontaneous tuberculosis of the rabbit is an extremely rare condition, and he insisted that the well-known tuberculiform disease of rabbits was anything but a genuine tuberculous condition, but was due to certain peculiar "oviform bodies" now known to be of protozoal nature—coccidia (10).

(a) Lecture delivered to the Students of the Royal Victoria Hospital, Belfast, February 22nd, 1908.

Villemin's famous demonstrations were speedily tested, and verified by various observers (Klebs, Cohnheim, Salomonsen), and then, under the influence of Pasteur's work, men began to look for a *living* germ. Baumgarten (11) was the first to see a bacillus, by treating sections of tuberculous organs with diluted caustic potash, which was doubtless the responsible organism. But, as all the world knows, it was reserved for Robert Koch (12) to place the matter beyond all dispute by his immortal discovery of the specific bacillus in 1882, by its isolation, its cultivation, and by the proof that all the protean manifestations of tuberculosis are due to the parasitism of a definite vegetable micro-organism in the animal body. At least, so it seemed for several years after Koch's great achievement. At first tubercle bacilli were regarded as being of one kind, or species, as being identical, no matter from what animal they were obtained. Thus the bacilli from human, bovine and avian sources were considered to be one and the same thing—to be identical. Then certain doubts arose.

Professor Koch (13) was the first to demonstrate acid-fast bacilli in the lesions of the so-called tuberculosis of fowls, and he saw what has since been repeatedly observed—viz., that these bacilli are present in much greater numbers than in mammalian tuberculous products. Koch did not at that time cultivate the bacillus from the fowl, and, moreover, he was only partially successful in inoculating fowls and pigeons with pure cultures of mammalian tubercle bacilli. Soon other observers began to find great difficulty, or, indeed, met with total failure, in transmitting mammalian tubercle to fowls—*e.g.*, Strauss and Wurtz (1883) (14) fed a number of hens for six months to a year with tuberculous sputum and with pieces of tuberculous human lungs, and to such an extent that each hen swallowed in all 4 kilogrammes of sputum, and yet there was no emaciation and no trace of disease! But still, cases were reported of hens becoming affected when they swallowed tuberculous sputum—*e.g.*, by Johne and by Bollinger. A very curious thing was reported by Martin (15). He inoculated hens and pigeons intra-peritoneally with mammalian tubercle. These animals remained in perfect health, but when killed some months after the inoculations, it was found that their blood, on injection into guinea-pigs, was infective, and tuberculosis developed as the result. Rivolta (16) had a somewhat similar experience. He inoculated hens with tuberculous material. After 34 and 54 days the hens were sound, but the inoculated material still contained tubercle bacilli, and when removed from the hen to guinea-pigs, rendered the latter tuberculous. Again, it was found that avian tubercle bacilli did not produce in guinea-pigs and rabbits the characteristic lesions that are so easily produced in these animals when mammalian bacilli are injected. Both avian and mammalian tubercle bacilli kill these rodents, but the avian bacillus does not produce the macroscopic tubercles, or at least such tubercles, both in the guinea-pig and the rabbit, are very exceptionally produced by the avian, but are the rule in infection with the mammalian bacillus.

In short, as far back as 1883, the Italian worker Rivolta concluded from his experiments that a distinction must be drawn between tubercle bacilli of avian and mammalian sources. Rivolta argued from the difference shown by these micro-organisms in their action on the experimental animals, the bacilli are admittedly alike in certain important respects, but they do not coincide in pathogenic action on rabbits and guinea-pigs. Rivolta goes so far as to declare that "fowl tuberculosis is called forth by an infection which specifically differs from human and bovine tuberculosis."

Rivolta's views, as just stated, were based on animal experimentation. These views were soon to be strengthened by the work of Angelo Maffucci (17), Professor of Pathological Anatomy in the University of Pisa. Rivolta had received a culture of the avian bacillus from the famous French veterinarian Nocard, Nocard being the first to obtain such cultures, which he succeeded in isolating from a pheasant. Rivolta gave cultures from this to Maffucci, and the Pisan savant (1888) showed that there are marked differences between the avian and mammalian bacillus to their cultural features, and Prof. Koch (Tenth International Congress, Berlin) agreed with Maffucci. Moreover, Maffucci, working with cultures isolated from hens, as well as with Nocard's original strain from the pheasant, was able to adduce a number of important verifications of previous work, and also to bring forward new facts pointing to a distinct dissimilarity between avian and mammalian tubercle bacilli. For example, these cultures were tested on hens in various ways by intra-peritoneal, intramuscular, intra-venous and intra-tracheal injection, the result proving that the bacillus infected the hens with tuberculosis, and was therefore the cause of the disease. The liver and spleen are the organs most extensively affected, whereas the lungs are much less liable to the tuberculous changes. Maffucci's endeavour to infect hens by *feeding* them with pure cultures and with the liver of a diseased fowl (swarming with myriads of bacilli) resulted in a complete negative. This failure is in accordance with the previous attempt of Ribbert to infect fowls by feeding them with the dejecta of tuberculous hens. Ducks succumbed to intra-peritoneal injections. The rabbit was more resistant. One out of two showed some scattered caseous nodules in the lungs four months after peritoneal injection, whereas subcutaneous inoculation, although leading to emaciation and death, was unproductive of any positive tuberculous lesions. Dogs were still more resistant than the rabbit. Guinea-pigs could be killed by injections of the bacillus, but even when the bacilli were introduced in large quantities directly into the circulation, there was no formation of tubercles in the organs.

An important fact determined by Maffucci (18) is that it is impossible to infect a series of guinea-pigs by transmission from animal to animal. The bacillus disappears completely after the second passage. Maffucci concluded from this fact that he was not dealing merely with a weakened tubercle virus, seeing that the bacillus, instead of acquiring increased virulence by passage through an animal eminently susceptible to mammalian tubercle, actually was destroyed in the body of such an animal even after two passages. Since avian tubercle bacilli do not communicate a genuine tuberculosis to the usual research animals, how do mammalian bacilli affect fowls? This question has been answered in no uncertain voice by many investigators, as already mentioned. In Maffucci's hands the result was a practical negative: 22 hens were variously treated with tubercle bacilli of human or bovine origin—*e.g.*, 2 were injected with tuberculous sputum—result, no lesions; 3 were intra-venously injected with bacilli—result, 2 died greatly emaciated after two months, but there were no tubercles to be seen; the third was also free from every trace of tuberculiform eruption. In fact, 1 hen alone showed anything like a tuberculous infection; this hen had been injected (intra-muscular?) with bovine tubercle bacilli (or tuberculous material?), and died 35 days afterwards. There were a number of hard, grey nodules on the intestinal serosa, and nothing else. These nodules microscopically discovered no bacilli; neither could cultures be obtained from them; but they produced tuberculosis in guinea-pigs. It is very interesting to note that these tuberculous nodules, when further inoculated into a second hen, were fatal, but from the liver no cultures were obtained, neither were there histologically any traces of tubercle in any of the organs. Thus it appears that the fowl reacts to mammalian tubercle as the guinea-pig does to avian tubercle. Each may succumb to an intoxication or partial infection, but in each case the animals show a high degree of insusceptibility and a complete racial immunity. To repeat: the fowl rejects mammalian tubercle, the mammal refuses avian infection. But here it must be mentioned that the parrot (19) occupies a peculiar position in its susceptibility to tuberculosis. It can acquire avian tuberculosis, but it is more susceptible to the human bacillus, and still more so to the bacillus of bovine tuberculosis. And again: Lydia Rabinowitch (20) has found bacilli of the mammalian type in two

African eagles, and in some other birds of prey in the Berlin Zoological Gardens.

Thus it would be going too far to say that birds *never* suffer from mammalian tuberculosis; but it would seemingly be a still greater error to assume that the ordinary "tuberculosis" of birds is in causal agency, absolutely identical with that of the mammalian disease. Also bacilli of avian imprint are said to have been found in men and other mammals, and, if this be true, we must be prepared to recognise pathological conditions due to this form of infection (21).

The duality of avian and mammalian tubercle bacilli, however interesting in itself, sinks to a secondary place when compared to the next phase of the question—viz., Is mammalian tubercle a unity? Are human and bovine tubercle bacilli identical organisms? As pointed out by Dr. P. W. Lathom (22), in the *Lancet*, Virchow, two years before Koch announced the discovery of the tubercle bacillus, laid great stress on the anatomical characters that distinguish human from bovine tuberculosis (perlsucht). In reference to Kleb's success in producing "pearl nodules" in a calf by injecting human tuberculous matter, Virchow recalls the fact that other substances also may cause tubercle-like formations, and he postponed his decision until the presumed bacillus should be discovered. In the meantime he pointed out that perlsucht runs a different course from human tuberculosis, that firmer nodules are formed, and that there is less tendency to caseation and ulceration. Phthisical ulceration of the lung does not occur in cattle. Koch himself states that from the first he was reserved in identifying human and bovine tubercle bacilli, having no sure proof either of their identity or their distinctions. Among those that latterly began to doubt the identity of the two bacilli, we may particularly mention the American bacteriologist, Theobald Smith (23), who in 1898, published certain results which point to differences between tubercle bacilli from human and bovine sources respectively. Bovine bacilli (and also those from cats, horses, pigs) grow on culture media less luxuriantly than do tubercle bacilli of human origin. Bovine bacilli are short, thick, plump, unequally staining rods, whereas human bacilli are delicate, slender rods, often somewhat curved, and stain equally throughout. Again, the two bacilli act differently on the glycerine in the culture media (24), the bovine causing a lasting diminution of acidity, but the human, after a preliminary diminution, causes a persistive increase of acidity. In other words, the bovine bacillus is an alkali-former, whereas the human bacillus begins as an alkali-former but ends as an acid-producer. Theobald Smith also found that the bovine bacillus is much more virulent to the rabbit than is the human bacillus. Thus he, working with cultures, verified what Villemin many years before had found while working with the tuberculous products of the then unknown bacillus. Smith, therefore, distinguished a "human" or "sputum" and a "bovine variety" of the tubercle bacillus. The question was soon to become of world-wide notoriety, not only among scientific workers, but owing to its economic implications it was also to occupy the attention of most of the greater Governments. This extended interest dates from a lecture delivered by Koch (25) in London, July 23rd, 1901, before the British Congress of Tuberculosis. On that day the distinguished German scientist announced his conclusions, with sufficiently sensational effect:—"I feel," said he, "justified in maintaining that human tuberculosis differs from bovine, and cannot be transmitted to cattle." And in discussing the converse problem—viz., man's susceptibility to bovine tubercle, he said:—"I should estimate the extent of infection by the milk and flesh of tuberculous cattle, and the butter made of their milk, as hardly greater than that of hereditary transmission, and I therefore do not deem it advisable to take any measures against it." As regards hereditary transmission, he had stated at the beginning of his address that it does occur, but is extremely rare, and "may be left absolutely out of account." In support of his main contention—viz., the non-transmissibility of human tubercle to cattle—Professor Koch detailed certain cattle experiments which, during the two previous years, he had carried out in conjunction with Professor Schutz, of the Berlin Veterinary School. The gist of these experiments is as follows:—Nineteen animals were tested with tuberculin, and, being found free from tuberculosis, were subjected in various ways to tubercle bacilli of human origin. Sputum or bacilli were injected subcutaneously, intra-venously, or intraperitoneally; moreover, some of the calves were fed almost daily for seven to eight months with tuberculous sputum. After eight months the animals were killed. None of them were tuberculous, although some showed small suppurative foci containing tubercle bacilli, exactly what happens when dead tubercle bacilli are injected under the skin of susceptible animals. "So the animals we experimented on were affected by the living bacilli of human tuberculosis exactly as they would have been by dead ones—they were absolutely insusceptible to them." But when, as a control, cattle were inoculated with tubercle bacilli of bovine origin, they showed, after about a week's incubation, signs of disease, fever, weakness, emaciation, and died in from six weeks to two months. Post-mortem their bodies showed extensive tuberculous disease. "In short, the cattle proved just as susceptible to infection by the bacillus of bovine tuberculosis as they had proved insusceptible to infection by the bacillus of human tuberculosis." Feeding experiments showed an equal distinction between the two bacilli. Such, then, was the trend of Koch's remarkable address. The result has been that an extensive amount of research work has been directed toward this question. Commissions have been appointed by Germany, England, Russia, Sweden, and the United States of America to inquire into the subject, and numerous independent workers have busied themselves in this great controversy, which, indeed, is still a matter of the keenest difference of opinion. Among British investigators it is generally held that Koch's views are utterly mistaken. For example, there is one argument advanced by Koch which is certainly assailable, resting, as it does, upon a pure assumption—viz., Koch argues against the intestinal origin of abdominal tuberculosis in children on the ground that primary disease of the bowel is rare. This, of course, assumes that the intact intestinal wall is impervious to the tubercle bacillus, and that a lesion of the bowel, a primary lesion, is necessary if the bacillus is to infect the body by this channel (26). He states that if infection occurs by alimenta, there should be primary intestinal tuberculosis. He himself has only twice seen such a thing, and he quotes Biedert as having observed the condition in only 16 out of 3,104 autopsies. The answer is simple: tubercle bacilli do pass through the wall of the intact gut, and, in so doing, leave not a trace behind. This fact has been established by various observers by direct experiment, and has been taught for years—*e.g.*, I have a vivid recollection of hearing this fact emphasised by Professor Hamilton, of Aberdeen, more than twenty years ago—the fact, namely, that abdominal tuberculosis in children is seldom accompanied by a tubercular lesion of the intestinal mucosa, and the suggestion that the frequency of mesenteric tubercle in children, with disease of the intestinal mucosa, points to the strong possibility that the bacillus passes through the intestine to the glands without causing a lesion of the former. The truth in this suggestion met with its first experimental verification at the hands of Sidney Martin (27), who, in 1895, proved, by feeding 4 pigs with bovine tuberculous matter, that the mesenteric glands became tuberculous, while there was no sign whatever of a mucosal lesion of the bowel. Moreover, the recent beautiful experiments of Calmette and Guérin (28), and of Vansteenberghe and Grysez (29), convince us more elaborately of the same infective peculiarity. Nor, indeed, is this traceless transpassage of the bacillus to be much wondered at, seeing that the larvæ of anchylostomum duodenale—objects greatly larger than bacteria—are able to penetrate the unbroken skin, leaving no trail behind them (30). The analogy, although forced, is not uninstructive.

As an example of the tenour of recent work in answer to Professor Koch's experiments, we may cite certain results obtained by Hamilton and McLauchlan Young (31), in an investigation into the relationship of human tuberculosis to that of bovines. Broadly speaking, the Aberdeen investigators obtained results that were in direct contradiction to those alleged to have been obtained by Koch and Schutz. I need not detail these experiments. They were numerous, they were surrounded by elaborate precautions, they were guided by the greatest English-speaking pathologist of the day—D. J. Hamilton—and they were in open contradiction to the statement that cattle are insusceptible to human tubercle. "Human tubercle is probably not so virulent for the calf as that derived from bovines, yet can be readily inoculated upon that animal." "When human tubercle has been engrafted upon a calf, it gains enormously in virulence by being re-inoculated upon a second calf." "When administered by the mouth, tubercular sputum induces an abdominal lymph-gland tuberculosis without necessarily the intestine being in any way involved." Such are some of the conclusions reached by Hamilton and Young. Further, these workers favour the view that the human bacillus and that of bovines are identical, but modified somewhat by their environment. The morphological characters of the bacillus may vary, but are no sure guide as to its source. But still the question is open to new elucidations, is not yet beyond the doubts of controversialists. Dr. Weber (32), of the Imperial Health Department of Berlin, implies an objection to at least one of Hamilton and Young's experiments. He thinks that the spraying of tuberculous sputum in large quantities into the nostrils of a calf may have owed its successful infection to the enormous quantities used. He finds that here is a bovine type and a human type of the bacillus; that the human type is not progressively pathogenetic for cattle; that men may at times harbour the bovine bacillus, and such men furnish a bacillus which, naturally, is infective for cattle.

When we pass away from the question as to the susceptibility of cattle to human tubercle bacilli, and approach its converse—viz., are men infectible with bovine tubercle bacilli?—we, of course, encounter a subject that cannot be put to the arbitrament of direct experiment. And, unfortunately, some reputed cases of infection with bovine bacilli—*e.g.*, by tuberculous milk—have been so uncritically reported, and have so completely broken down on careful examination, that, instead of teaching a valuable scientific lesson, they have had only the more modest merit of suggesting considerable scepticism in adopting information. A bad argument is worse than no argument. The most monumental of these anecdotes is, perhaps, the one furnished by Auguste Ollivier (33), in reference to tuberculosis in a ladies' school at Chartres. It appears that 13 girls died of tuberculosis within a space of two years, and that the milk had been taken from a tuberculous cow with a tuberculous mammitis. This was claimed as an example—*une démonstration catégorique*—of the transmission of tuberculosis by milk. But later on M. Ollivier gave some further details. The first girl to die of tubercle had succumbed before the cow was bought, and the remaining twelve never received a drop of this cow's milk, it having been served exclusively to the teaching staff and servants, none of whom contracted the disease. This grim farce is not without its merits—it is a pleasing thing to note that M. Ollivier did not hesitate to do all that he could to redeem his first communication by a prompt relation of more accurately ascertained facts.

In conclusion of this brief introduction to a great subject, I should like to refer to the work of Vansteenberghe and Grysez (34) in reference to the passage of ingested matter from the intestines to the lung. Certain of their experiments have been repeated recently by Sir William Whitla and myself, and it appears that their statements are statements of facts. These fascinating investigations bear upon the fate of carbon particles introduced into the stomach of the research animals, and it is practically—nay, even absolutely certain that such particles pass through the intestinal portals *viâ* the lymph channels to the lungs. This occurs in the case of the adult guinea-pig with little or no hindrance from the mesenteric glands, whereas with immature (baby) guinea-pigs the mesenteric glands act as a sieve and retain the offending bacilli or carbon particles, with the result that a "tabes mesenterica" occurs. Whitla and myself found tubercle bacilli in the lungs four hours after introducing tubercle bacilli into the stomach of an adult guinea-pig. Take a concrete example: Whitla and myself, repeating the experiments of Vansteenberghe and Grysez, introduced, through an œsophageal tube, a thick emulsion of Indian-ink into the stomach of a fully-grown guinea-pig. This we repeated daily for four days; then the animal was sacrificed, and we found the intestines and the mesenteric glands completely sound, whereas the lungs were veritably crammed, nigrified, with collections of jet-black carbon accumulations forming a pulmonary picture of anthracosis that was striking in the extreme. Tubercle bacilli, when swallowed, or when artificially placed in the stomach, are "absorbed" by the intestinal lymphatics, and are carried with surprising rapidity to the lungs. Prophecy is seldom apt, but I venture to believe that within a few years there will not be an instructed pathologist whose creed will exclude the entire acceptance of the doctrine of an intestinal origin for tuberculosis of the lungs. A modified view of the ingestional origin of pulmonary tuberculosis is that so strongly upheld by v. Behring (35), who believes that the disease results from an intestinal infection, but that almost invariably this infection dates from an early age, remains latent, it may be for many years, and then in adult life the victim succumbs to an infection contracted in infancy. This view was announced by v. Behring in February, 1903, at Cassel.

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NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor Aristide Malherbe, M.D., Surgeon to the National Institution of Deaf Mutes, Paris. Subject: "How to Distinguish the Different Varieties of Chronic Deafness."*

ORIGINAL PAPERS.

A NEW GENERALISATION IN SERUM THERAPY. (*a*)

By D. MONTGOMERIE PATON, L.R C.S. AND P. EDIN.

EHRLICH'S theory of the formation of antitoxins by cast-off cell receptors, and its seeming confirmation by the success of diphtheria antiserum, have been potent factors in establishing present opinion on the subject, and yet no two things have contributed so much to hinder the real progress of this method of treatment.

Ehrlich's theory conceives of cell receptors cast off by an increased cell reaction and floating in the blood. Hence the possibilities of treatment under such a theory are limited to the neutralisation of toxin, while it is still unattached, and has not attacked the tissue cell. True, by it the cell can still react for itself, but, so far as the theory goes, it is practically beyond the reach of any further assistance from the anti-serum which is being used.

The theory takes no notice of the elements in the serum which have caused the reaction in the cell which produced the excess of cell receptors, nor of whether they can also be transferred to the patient to produce the same cell reaction in him as in the animal producing them. These elements are in all serums, and yet they are unaccounted for.

The theory includes all the defence under the one method of resistance. It does not differentiate between the product of a tissue cell, which can only reproduce itself or its parts, no matter what the nature of the attack is, and a gland or system of glands like the lymphatic which is capable of elaborating a definite chemical secretion, the nature of which is determined by the character of the stimulus applied to it. And this capacity such glands have within fairly wide limits, while it is entirely absent from other tissues. The consequence is that, while this does not matter much in the animal itself, it has a profound effect on the hypodermic injection of the serum in determining what elements, and how much of them, can be successfully transferred to the patient.

Ehrlich's theory limited itself to antitoxins and bacteriolysins, but the advent of opsonins has shown that there are other resistances which are quite beyond the limits of the theory, and for whose existence the theory does not account. The same theory also explained the presence of the antitoxins and bacteriolysins as the response to a bacterial invasion, while opsonins are found under physiological and normal healthy conditions.

Many other objections could be raised, but it is quite evident that Ehrlich's theory, while it may be true in part, cannot by any means account for the whole resistance to microbic invasion, and it may be further stated that it does not by any means explain the actual results which have been already obtained.

The results of the oral use of serum which the writer has been obtaining for the last ten years have been the main factors, first, in creating discontent with accepted ideas, and, second, in bringing forward what to him seems a solution of the problem in which the work of all may be harmonised, and the way made clear for further advance.

The net results of investigation into serum therapy may be summarised as follows:—

(1) Antitoxic Serums.—Specific for the infection, and successful if given in time (diphtheria and tetanus).

(2) Bacteriolytic Serum.—Specific for each organism *in vitro;* of some value, but unreliable at any stage of the infection (streptococcus and plague).

(3) Serums derived from animals rendered immune, but which serums are of no value at any stage of the infection (typhoid and pneumococcus).

In each case the animal has been rendered immune, but the hypodermic exhibition of their serums divides them into three classes, according to its success or otherwise in transferring the immunity of the animal to the patient. Is there any rational explanation of such a differentiation in therapeutic value? A very extraordinary parallel is found to exist between the varying therapeutic value of those serums and the lymphatic resistance to the organisms used in their production:—

(1) The lymphatics are the first line of defence, and resist the entrance of toxin and organism.

(2) This resistance is vital in character; a specific glandular secretion, chemical in nature, and is not merely that of a filter, as it allows larger non-pathogenic organisms to pass freely.

(3) Therefore, lymphatic antitoxin must antagonise toxin and lymphatic bacteriolysin the organism.

(4) The quantity of this antitoxin and bacteriolysin in the serum will vary with the efficiency of the lymphatic resistance.

(5) The therapeutic value (the efficiency) of the serum depends on the quantity of antitoxin and bacteriolysin in it, and therefore depends on the lymphatic resistance.

Take the three varieties of serum, and their therapeutic value will be found to be exactly in proportion to the lymphatic resistance to the organism used in their production.

(1) Antitoxic Serums.—The organisms of diphtheria and tetanus are effectually excluded except in later stages of the disease.

(2) Bacteriolytic Serums.—The streptococcus and plague bacillus are very vigorously resisted, but the resistance is unreliable in its efficiency.

(3) Other Immune Serums.—The lymphatic resistance to typhoid and pneumococcus is in exact proportion to the therapeutic value of their antiserum, and that is of no practical value.

Professor Sir A. E. Wright, of late years, has made us familiar with opsonins, and it is clear that these substances are in all serums whether they be normal or the product of acquired immunity. Ehrlich's theory contemplates the production of surplus cell receptors only in response to pathological stimuli. When the cell and its surroundings are considered, it is clear that there must also be stimuli of a physiological character, which will produce a surplus of the same receptors. The cell has its normal function to perform, during which its vitality is often severely trenched upon, and the necessary stimulus is required just the same as though the cause had been a pathological one. Then it has to feed itself, and receptors have to be maintained for its food, and also for the taking up of the materials which go to maintain its integrity and function. The cell is in a continual condition of flux and reflux, and there is every reason for the presence of a surplus of cell receptors constantly present. A very small contribution by each cell would produce a considerable quantity of surplus receptors, and there would then be a physiological surplus which would act as an antitoxin to any toxin introduced whose haptophores fitted the floating receptors, and would be a combined protection to each cell producing them, by either completely antidoting the attacking toxin, or so modifying it that the cell would have time to prepare itself for the coming attack. This is natural immunity.

With this conception of the formation and presence of tissue antitoxins, the writer is unable to see any difference between them and opsonins.

In the successful cases of vaccine treatment of disease there is found co-incident with the rise of the opsonic index, a corresponding increase in the patient's general resistance. This can easily be understood, for if the opsonins consist of surplus receptors, the cell itself must first benefit by the treatment. And this would also make clear the improved general condition

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(*a*) Abstract from the "Intercolonial Medical Journal of Australasia," February 20th, 1908.

sometimes found without any marked rise of the index. The stimulus given to the tissue cell has only been sufficient to raise its tone, but not enough to enable it to produce a surplus of receptors.

From this it will be seen that it is quite beside the question to say that all chemical antitoxins and bacteriolysins are specific for their respective infections, and can be of no avail for any other infection. No one disputes such statements, and were such elements the whole of the resistance in an animal, and the serum contained them alone, there would at once be an end to all discussion on the use of serums for other diseases than those for which the animal producing them had been immunised. But when the question is one of haptophore and receptor, the issue widens at once, for any element (physiological or pathological), which has a haptophore to fit the cell receptors must necessarily be able to attach itself to the cell for good or evil. This is the very element which enables the tissue to supply itself with food, and to select exactly what suits it.

A recent experience confirms such a conception of cell economy. The writer treated three stubborn chronic cases of staphylomycosis with hypodermic injections, using trypsin as a vaccine. All three were decided successes, and the cures persist. The first, a case of recurring boils, following a very severe carbuncle, had five injections, each of 30 mm. of a 2 per cent. solution of trypsin, one every second day. The constitutional effects were marked by lassitude and malaise, and the local effects in his case were pain, and a spreading erythema after the last two injections. That was six months ago, and he has not had a recurrence.

The second was a similar case, but the furuncles both preceded and followed the carbuncle. Five injections were sufficient, although when he had his fifth the negative phase was so marked that he had a painful pustule on his neck. This soon cleared up, and there has been no return. That was four months ago.

The third was a case of sycosis of five years' duration. Each injection immediately caused an exacerbation of the skin condition, so that they had to be administered at longer intervals. It was observed that the recovery from these exacerbations became more rapid after each injection as the case proceeded. His face has quite cleared up, and his general health has been much improved. He had nine injections altogether.

The first two cases, in their acute stages, were treated with anti-diphtheritic serum orally (1 dr. Parke Davis and Co.'s serum for oral use, from four to six times a day), and they did exactly the same as though they had been successfully vaccinated for the infection. The action of the serum, however, is only passive, and on its being discontinued, the cases relapsed after a short interval. To produce this element in the serum, there must have been in the toxin used for its production an element similar in action to the staphylococcus. The tryptic action of diphtheria toxin is well recognised. Hence we find that no less than three quite different agencies act alike on the same tissues, and produce the same results—the digestive element in diphtheria toxin, the staphylococcus and trypsin—all have haptophores capable of attaching themselves to the same tissues, and of producing the same results.

The writer also recently reported the result of experiments carried out on himself, in which the oral ingestion of anti-diphtheritic serum materially raised the opsonic index to the staphylococcus.

It is clear that, to obtain Ehrlich's excess cell receptors and Wright's opsonins, there must necessarily be a cell reaction, whether physiological or pathological. The cell reaction is the main element in the resistance, for on it depends the tissue antitoxins or opsonins. This cell reaction, *plus* the tissue antitoxins or opsonins, is the "tissue resistance" to which in "New Serum Therapy" (*a*) the writer ascribed the results obtained. Whether the serum was normal, or the product of acquired immunity, its action was to raise the tissue resistance, either in non-microbic conditions such as traumatism, or in infected conditions, in the diseases to which the animal supplying the serum was naturally refractory, or had been rendered so by the necessary treatment. That is, the cell reaction alone was required where the element producing the damage was non-microbic, and the cell reaction *plus* the excess cell receptors or opsonins where the pathological condition was produced by the microbic action. Hence Ehrlich's excess cell receptors or tissue antitoxins and Wright's opsonins are only part of the tissue resistance of the writer, and all harmonise.

The next question which arises is: If the tissue cells are stimulated to produce surplus receptors, by what means is the reaction in the cell initiated and maintained? Physiology of late has made us acquainted with hormones which act as stimulants on certain tissues, by which stimulus those organs are enabled to perform the function required of them. Three, at least, have been discovered and defined—the peptic, pancreatic and mammary. It is a rational postulate to say that all tissues have their own hormones, which have a selective action on the tissues for which they are produced. This obtains fully in the hormones already discovered and defined. These hormones, all of which are doubtless of glandular origin, are present under normal conditions in physiological quantity, but under pathological conditions are capable of very considerable development. That they act directly on the tissues has been definitely demonstrated in dentistry. Over 300 cases of the local injection of a solution of anti-diphtheritic serum for septic conditions were reported to the Melbourne Odontological Society, and the experience covered a period of six years, and was in the hands of various operators. All had been successful, except one case of advanced tuberculosis with pyorrhœa alveolaris. No culture had been made in that case, and the organism was unknown. The serum was of no value except on a raw surface, or injected into the tissues, and its action was entirely local. Thus the hormones in the serum had to come into contact directly with the tissues to produce the results obtained.

In the production of antitoxins, it has been found that the quantity of antitoxin present depends, amongst other factors, on the culture medium used in the growth of the organisms. If that is so with regard to the chemical antitoxin, it is quite true with regard to the hormones produced to invigorate the tissues attacked by the toxin.

The conclusions we thus arrive at are:—That resistance to infection in man and animals consists of the following elements, and that these elements are in their serums:—

(1) Antitoxin and bacteriolysin of lymphatic origin, chemical in nature, and capable of acting *in vitro*. Present only in response to the stimulus of infection.

(2) Tissue antitoxins or opsonins, consisting of excess cell receptors. Present normally in physiological quantity, and increased by pathological stimuli. With the cell reaction necessary for their production, they form that "tissue resistance" described in "New Serum Therapy."

(3) Hormones—for all tissues—present at all times, but increased by pathological stimuli. They act only in contact with the tissue cells, and not *in vitro*.

CONCLUSIONS.

The conclusions, therefore, are that:—

(1) Lymphatic antitoxins are absorbed when injected hypodermically, and act as though produced by the patient. They are not absorbed on oral exhibition.

(2) Tissue antitoxins, opsonins or surplus tissue receptors are not capable of being transferred to the patient by any known method without destroying their specific character.

(3) Hormones are changed to anti-hormones on hypodermic injection as soon as they reach the lymphatics. In the lymph spaces they act locally in contact with the tissue cells.

Rectally or orally exhibited, they act on all tissues physiologically in normal serum, and with increased power on tissues which have been pathologically affected in the animal from which the serum has been drawn.

(*a*) "New Serum Therapy." By D. Montgomerie Paton. London: Bailliere, Tindall and Cox.

The recognition of the double lines of defence, instead of one general resistance, and the consequent dual character of the resulting serum, with the necessity for each antibody to be passed directly into the system in which it originated, throws a flood of light on the whole problem of serum therapy. By it the success of the hypodermic injection of serums is rationally explained, and by it the limit of the same method and its failures are seen to be inevitable. By it also there is discovered how rational and in accord with natural methods is the oral and rectal use of serums.

By this conception it will be possible, in suitable cases, by a combination of the methods to obtain the whole resistance of the animal for the patient in hand, and as far as the writer can speak from experience in diphtheria, the results are simply ideal. For the first time we have a conception of serum therapy as a whole which blends the accepted theories and facts into harmony, and reconciles the results obtained and recorded, the character of which has hitherto made serum therapy a chaos of contradictions.

THE MILK PROBLEM,

OR THE

PRODUCTION AND DISTRIBUTION OF PURE, CLEAN MILK. (a)

By JOHN C. THRESH, D.Sc.Lond., M.D., D.P.H. Camb.,

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(Continued from page 608.)

So far, we have dealt with the more important points, the production of clean milk from healthy cows, but there are other matters to be considered if we want this pure milk delivered pure and fresh to the consumers.

As we have seen, even clean milk contains bacteria, and if this clean milk is not properly treated it may reach the consumer in anything but a satisfactory condition. These bacteria multiply with enormous rapidity unless something is done to prevent their growth, either by cooling the milk or by heating the milk so as to sterilise it or to destroy all but the spore-bearing organisms (Pasteurisation) or by adding preservatives. I do not propose to discuss the relative merits of sterilisation or Pasteurisation, or chemical treatment by the addition of preservatives. We do not want our milk Pasteurised or sterilised or chemicalised; or, if we do, we will ask for such. We want milk with all its vital properties unimpaired.

I am glad to say that many of the largest milk dealers in London, and probably the same applies elsewhere, refuse to accept any milk if the temperature upon delivery exceeds 50° F. This has been of immense benefit. Refrigerating apparatus are now found in the majority of large dairies around London and the milk is cooled immediately after being taken from the cows.

The milk, again, should be sent in locked churns, they should be under cover when in the station, and be transmitted in vans, the temperature of which can be kept at any desired degree. For short distances, and assuming the milk is thoroughly cooled in the first instance, the refrigerating van may not be a necessity, but when the milk has to travel for several hours some means of keeping it cool should be insisted upon.

Our troubles are not yet ended. When it reaches the distributor it frequently remains on his premises over night before distribution, and opportunity occurs for further multiplication of the bacteria if the low temperature is not maintained. In these cases cold storage should be provided and the churns placed therein until the carts are ready to go their round. This is done at the present time by some dairy associations, and I am not aware that they charge more for their milk than other dealers.

Milk which has been delivered to the smaller dealers is often kept under very unhygienic conditions, occasionally under conditions which render dangerous contamination possible, if not probable, and when sold from the shops it is often kept in open vessels exposed to dust and flies and where it may absorb emanations from other articles in the vicinity, and milk has an extraordinary capacity for absorbing volatile odorous matters.

In all shops from which milk is sold the milk should be kept in properly-covered vessels, so that flies and dust cannot gain access, and if things besides dairy produce are sold the vessels should be stored in a special cupboard or case capable of being kept cold in summer, and nothing but dairy produce should be kept in the cupboard.

Having procured our clean milk and delivered it to the consumer, it is still liable to serious pollution or deterioration in the home. I think it may be found possible to deliver an unpolluted milk—a milk which would form a wholesome diet to our children, but amongst the poorer classes how long will it remain in this condition? It has been seriously argued that the greatest danger arises from home pollution. I am unable to agree with this, but it is certain that in the houses of the poor it is almost impossible to keep milk many hours in a wholesome condition. There is no cool larder and the mother's ignorance is too great for her to recognise the necessity for taking what to us are obvious precautions. The people perish for lack of knowledge. We can only hope for an improvement by the better education of the rising generation. Some impression may be made upon the present generation by means of the Press and local health associations, and by the influence of health visitors, female sanitary inspectors, and others who are engaged in spreading the gospel of health, but our chief hope is centred on the education of the future mothers—on our children.

In this connection I may suggest that a crusade against the common house-fly might be of greater advantage to the community than the crusade against rats, as the former are really the more dangerous disease carriers in this country.

Before giving you briefly my views upon the means necessary for effecting the reforms I have indicated, may I say a few words which may be of interest to the farmers, for unless we can convince the farmer of the reasonableness of our demands and of their practicability, we shall meet with the most strenuous opposition. I assert, therefore, that not only are our demands reasonable and practicable and in the interests of the general well-being of the community, but that they are actually serving the best interest of the great dairy industry.

I want in the first place to show them that the amount of milk used at the present time is only a fraction of the amount which should be used, and which will be used, when a purer milk is available.

An old student and assistant of mine, Dr. Sowden, the Medical Officer of Health for East Ham, with a population of over 100,000 persons, chiefly of the working class, has made a careful estimate of the amount of fresh milk and other forms of milk used in that borough. He obtained the information through the milk dealers and from the retailers of tinned milks.

He found that the amount of fresh milk used daily averaged a little less than 3oz. per person, or one pint per person per week. I have reason to believe that in many districts it is even less than this. The 100,000 people used 960 dozen tins of condensed whole milk and 1,800 dozen tins of condensed separated milk per week. Assuming that each tin represents 1 quart of milk, this gives a weekly consumption of ¼ pint of whole milk per person, and ½ pint of skimmed milk per person. The total consumption of milk of all kinds is under 2 pints per person per week, and of this very nearly half is imported milk, and over one-fourth is skimmed milk.

The importation of milk in tins is an enormous and increasing industry, and in our towns it seems probable that nearly half the milk consumed is this imported variety, yet its cost is two or three times that of fresh milk of similar quality.

If by gaining the confidence of the public this sale could be decreased it would be of very great advantage to our milk producers, and what is of even greater importance, it would be to the advantage of the poor. Dr. Sowden's results confirm the conclusions of others—namely, that few deaths from diarrhœa occur amongst breast-fed infants, and that the largest proportion occur amongst those fed (? starved) on the tinned milk; this fact wants bringing home to every mother in the country.

(a) Abstract of paper read before the Birmingham Branch of the Incorporated Institute of Hygiene, March 30th, 1908.

Besides the competition of the tinned milk producer, another rival has to be encountered, the manufacturer of dried milk. This dried milk is of recent introduction and the demand for it is rapidly increasing. I know of one medical officer of health who is supplying it from the Municipal offices at a very low price, and he informs me that children fed upon it have done remarkably well, and that in the diarrhœal season few of those who used it suffered from diarrhœa, and that many children who had been attacked and were quickly placed on the new diet of dried milk made rapid recoveries. One gentleman occupying a prominent position in my county recently said that dairy farmers were between the devil and the deep sea. The devil being myself, who, it was alleged, wanted money, which the farmers could not afford, spending on the production of pure milk, and the deep sea being my friend the Medical Officer of Health, who, to save the lives of infants, was urging parents to feed them on dried imported milk.

I think that I have said enough to show that if the dairy farmer does not realise the seriousness of the position and make some effort to meet the demands we are making, his industry will become a decaying one, both prices and demand will decrease, and ruin stare him in the face.

With the greatest possible benefit to ourselves we could consume from four to ten times as much milk as we do at present. Is it not, therefore, to the advantage of the dairyman to encourage us to do so?

Do the farmers want to prevent the competition with Municipalities, so many of whom are establishing milk depôts? If so, let them supply us with pure milk.

We are now dependent upon the farmers on the Continent for much of our cheese and butter, and unless the farmers bestir themselves we shall soon depend upon them for much of our milk also. A little energy and a little enterprise and we may retain this national industry, whereas apathy and delay may result in our losing it. It is chiefly for the farmer to say whether we lose or retain it.

Finally, allow me to summarise our demands and to indicate how they may be met. This will concentrate our thoughts upon the more important points in the problem and possibly aid us in any discussion which may follow the address.

Firstly, there is the veterinary inspection of all milk cows and the elimination of all diseased cows, and more especially of cows suffering from tuberculosis. For this purpose veterinary inspectors must be appointed, and if they are to be beyond the effect of local influence, they must be appointed by some central authority, the Department of Agriculture, the Local Government Board, or the County Councils, and they must be paid such a salary that they can devote their whole time to their duties.

Animals likely to yield disease-producing milk must be promptly dealt with. They must not be allowed, as at present, to be sold and sent into some other district to be used as milk cows there. They must be slaughtered, and, under certain circumstances, I think some compensation should be paid to the farmer. This is a very vexed question, and, though very important, it is not one which we can adequately discuss at this meeting.

Secondly, there is the absolute necessity for uniform regulations with regard to the ventilation, cleanliness, etc., of cow-sheds, and with regard to the cleanliness of the operations necessary for the collection of milk. These regulations must apply to the whole country, and not depend upon adoption by local authorities. I am of opinion that local authorities should be held responsible for seeing that they are carried out, but that County Councils should act as supervising authorities, and have powers which would enable them to see that they were carried out.

The veterinary inspector might report to these local authorities all cases in which he found water supplies defective, cows ungroomed, or when he had reason to believe any of the regulations were infringed, and if at a subsequent visit he found that the local authority had not taken action, he should then report to the authority by whom he is appointed.

Thirdly, all milk not sold locally and within three or four hours of being drawn from the cow, should be cooled down to 40° F., and, if sent away by rail, placed in locked churns, and the railway companies should be compelled to deliver this milk at its destination at this temperature.

Fourthly, all premises used for producing milk, cooling milk, storing milk, and for the sale of milk, should be registered, and every person carrying on the trade of a cowkeeper or milk dealer be licensed. Registrations and licenses should be renewable annually, and be withdrawable at any time for persistent breach of regulations.

Fifthly, and lastly, the sale of milk from a diseased cow, and the sale of unclean milk, should be made an offence of a far more serious character than the mere adulteration of milk by the addition of water, or preservatives, or the abstraction of fat.

I do not think there is anything unreasonable in these demands, and I believe that all are feasible, and that all will in the near future be conceded.

The result of the reforms here suggested cannot but be a great decrease in the rate of infantile mortality and a great benefit to British agriculture. I know of no two objects which could be of greater interest to you as citizens of a great city, and as subjects of a great Empire, whose continued prosperity depends so much upon agriculture and upon the rearing of a virile race.

EMPYEMA IN CHILDREN.

By STEPHEN J. ROSS, M.D., Ch.B.,

Assistant Surgeon to the Bedford County Hospital.

Empyema occurring in children is by no means a rare condition, but is frequently overlooked. The most frequent symptoms calling attention to the condition are that a child who has passed through an attack of pleuro-pneumonia, or broncho-pneumonia, does not satisfactorily convalesce; the cough and the fever persist, then fluid in the pleural cavity is discovered. Or a child has an indefinite illness, followed by marked emaciation. This leads to an examination of its chest, and the discovery of fluid in one of the pleural cavities. The organisms present in empyemata may be: (1) the pneumococcus; (2) streptococci and staphylococci; (3) tubercle bacilli.

Etiology.—Pleuro-pneumonia and broncho-pneumonia are not infrequently the precursors of empyema. Scarlet fever, measles, diphtheria, and typhoid, are sometimes complicated by empyema.

Symptoms.—The onset of empyema is often very insidious—the history being a deferred convalescence from pneumonia, and frequently we note very marked wasting.

In other cases the onset is very acute, and if effusion be rapid the probabilities are in favour of empyema.

Physical Signs.—The breathing is rapid and shallow. There may be bulging of the intercostal spaces on the affected side.

On palpation, the apex beat of the heart may be displaced to the right or left according to the side upon which the effusion occurs. This is a very important sign, as many of the other signs are equivocal. On percussion, we find dulness; the dulness is wooden, and absolute; percussion must be light.

Auscultation.—Breathing may be tubular or bronchial. Friction sounds may be present; vocal fremitus is often increased.

The breath sounds on the normal side of the chest are exaggerated.

Treatment.—This resolves itself into aspiration or resection of part of a rib. The cases I am now about to record will indicate the usefulness of the minor or major operation. While deciding as to treatment, we must remember that young patients bear shock badly, and that an anæsthetic must not, without careful consideration, be given.

Case I.—I saw a child, æt. 4, who was suffering from wasting which was supposed to be due to consumption. Upon examining his chest, I found an effusion into the left pleura; the apex beat of the heart was situated in the epigastrium. I introduced an exploring needle into the sixth left intercostal space and withdrew pus. The causative organism I found to be the pneumococcus. The child was very feeble; his pulse was very frequent and weak; his respirations were very laboured. He would not stand an anæsthetic, so I aspirated his chest, withdrawing a pint of thick pus. He made an uninterrupted recovery. When aspirating a chest it is always wise to use a needle with a wide bore. There was no re-accumulation.

The second case was that of a child, æt. 3, who had been ill six weeks with pneumonia. His temperature when I saw him was 103°, and the right side of his chest was full of fluid, the dulness extending to his right clavicle. Under ACE, I resected part of his eighth rib, put in a large drainage tube, and he made an uninterrupted recovery.

A girl, æt. 8, had an empyema upon the left side. This I drained in the eighth intercostal space behind and below the inferior angle of the left scapula. For ten days she improved markedly. Then her temperature rose to 103° and I thought she had some fresh infection. I examined the pus and discovered streptococci. Above my incision I discovered a patch of dulness, and, introducing forceps through my original wound, 3 ounces of pus escaped. I injected her with 5 c.c. of anti-streptococci serum, and her temperature fell from 101° to normal. The following morning I gave her a second injection of 5 c.c. She made an uninterrupted recovery. The point of interest in this case lay in the fact that six weeks previously she had a septic tonsillitis, doubtless the origin of the empyema.

My final remarks must be:—

1. If a child be brought to us on account of wasting, never omit to examine the chest.
2. If the child be too feeble to stand the operation of resection of ribs, remember that aspiration sometimes results in cure.
3. If we have a child under our care suffering from pneumonia whose convalescence is protracted, we must never forget to keep a watchful eye for the development of fluid.
4. If after drainage the patient's progress be unsatisfactory, we must remember that loculated collections of pus are not infrequent.
5. It is always necessary to examine the pus for the causal organism. If the pneumococcus be found the outlook is favourable. If, streptococci, the injection of anti-streptococci serum will hasten convalescence. If the tubercle bacillus be discovered the outlook is very unfavourable indeed.

THE SURGICAL TREATMENT OF CHRONIC DYSENTERY

(COLITIS ULCEROSA CHRONICA).

By Prof. H. STEINER, M.D.,

Berlin.

[Specially Reported for this Journal.]

The swing of the pendulum that has taken place in intestinal surgery in general during the past ten years seeming to justify an attempt at surgical measures, at the suggestion of my colleague, Prof. Boas, I lately undertook the operative treatment of a case of chronic dysentery that was apparently incurable, and to all appearance lost.

The idea of relieving the ulcerated parts of the bowel from the passage of fæces was the less remote, as an analogous treatment of the rectum—the site of syphilitic ulcers—by making an artificial anus in the sigmoid flexure had been brought forward.

The two clinical histories, which I sketch in outline, show that a success was obtained only by great patience on the parts of both patient and surgeon. Especially the perfecting of a system of washing out the bowel—in both peristaltic and anti-peristaltic directions—the temperature and force of the stream required many trials before we succeeded in carrying out the procedure in a painless manner.

The first case was that of a lady, æt. 27. The disease began nine years before I saw her, and its progress had been gradual and creeping. Frequent attacks of diarrhœa alternated with periods of constipation; at last the evacuations were of a pronounced loose character and were very frequent. Slight febrile attacks occurred, with abdominal pain; even to the eye the stools consisted of blood and pus mixed. The microscope showed mucus, pus, blood, and numerous Charcot-Leyden crystals. Tubercle bacilli and amœbæ were sought for in vain. The patient was a virgo; there was no trace of leucorrhœa.

After Professor Boas had had the patient under treatment for three years with strict diet, and all the known internal remedies, with washings-out of the bowel as well, without any good result, he decided to send her to me for operation. He was led to this through a favourable report on the operative treatment of the condition from America. The condition of the patient on admission into the Klinik was very unfavourable. She looked pale and suffering, had a hectic fever, and was so weak that she could scarcely stand. Day and night the copious evacuations were watery, and even to the naked eye contained mucous, blood, and pus; in addition to this there were colicky pains along the course of the colon. The abdomen was slightly distended and tender to pressure. Examination by the rectum showed only normal conditions.

Under an anæsthetic I made a large cæcal anus præternaturalis, the opening just below the valvula Bauhini. When the abdomen was open the small intestine was seen to be intact; the serosa of the colon was swollen in places.

After the artificial anus had begun to act the temperature fell, and the colicky pains ceased. The passage of the fæcal matter by the colon became less frequent and less in amount.

The real treatment now began, in daily washing out of the colon through the cæcal anus; 4 or 6 litres of water of the body temperature—a lower temperature set up by the colicky pains—were allowed to run through every day. When in this way all the stagnating secretions from the bowel and ulcerated surfaces had been washed away, and the water came away clear, a medicated wash was passed in (also in the anti-peristaltic direction) in which mild protargol solutions were made use of. These washings-out, which I looked on as the chief curative agents, were kept up seven and a half months, latterly every second day, as up to this time microscopic examination still showed the presence of pus and Charcot-Leyden crystals, but in diminishing quantities.

When, from the character of the water that came away after the washing it appeared probable that the intestinal ulcers were healed, and about nine months after the operation, I blocked up the artificial anus with plugs of lint steeped in vaseline, and in this way obtained a passage of fæces by the rectum. This trial of the natural passages continued for about five weeks, and as it showed that the fæces could pass without reaction, the artificial anus was closed after it had been in action for about a year.

Since that time about six years have now elapsed. The patient has gained about 60 pounds in weight, she is perfectly well, and carries on her affairs with satisfaction.

As the history of the second case, independent of its duration, is very much like the first, I need only mention the essentials. The patient, a female, æt. 30, came under my care in April, 1904. Since July, 1903, she had suffered from diarrhœa which first came on during a pregnancy, and was at first taken but little notice of. After the labour the diarrhœa could not be controlled; the patient had also abdominal pains and fever. Professor Boas made a diagnosis of ulcerative colitis.

In the beginning of January, 1904, a cæcal anus was made by Professor Israel. In April of the same year the patient was discharged from hospital, when I began to wash out the bowel carefully, as in the first case. The patient weighed 85 pounds. Most of the evacuations were passed per *vias naturales*, and contained a good deal of blood and pus, and numerous Charcot-Leyden crystals. After daily washings-out for two months, the colon was brought into the desired condition, and after testing the function by temporarily blocking up the artificial anus, it was finally closed in July. The patient very quickly put on 40 pounds in weight.

Neither of the patients were restricted as to diet, but the colon or cæcum, or both, are very susceptible to chills, which sometimes appear when the flannel binder is left off. The tendency to constipation then takes another turn, but without the stools showing the ominous mixture of former times. The condition, moreover, passes away as soon as the fault had been rectified. Both the patients have taken up their former activities since leaving the Klinik, and may both be considered as quite recovered. It may be mentioned in addition that neither amœbæ nor tubercle bacilli were ever seen in the stools, nor had either of the patients ever had syphilis.

As regards other methods of operation, proposed and carried out, that of opening the colon at the sigmoid flexure should be absolutely and unconditionally rejected, as the autopsy *in vivo* has shown that the ulcerative disease, though principally seated in the transverse colon, also affects the ascending portion.

Appendicostomy, *i.e.*, opening of the vermiform appendix and suturing it to the abdominal walls, also fails to fulfil the requirements of rational treatment—shutting the affected parts off from the passage of fæces, and allowing free washing-out. Another method, the formation of a cæcal anus, with complete separation of the ileum, and suturing it to the abdominal walls, has the advantage that no trace of fæcal matter can find its way into either cæcum or colon; but it has one great disadvantage, that it does not allow a testing closure of the artificial anus after presumed healing of the ulcers, but that, after they have healed, at a point of time which it is very difficult to determine—a second very serious operation is called for, whilst closure of the cæcal anus does not even require general narcosis.

I would most decidely pronounce against the ileo-sigmoideal anastomosis—the separation of the ileum from the cæcum, with transplantation of the small intestine into the sigmoid flexure, where a cæcal anus for the passage of the stagnating discharges from the colon must also be made.

I had the opportunity of treating for a long time a patient operated on in this way elsewhere. The anti-peristaltic washings were exceedingly agonising, as part of the washing-out fluid got into the implanted ileum and set up violent colic. Washings out in the peristaltic direction did not completely remove the collections of pus that flowed back into the cæcum and there stagnated. As the patient also suffered from nephritis and was reduced to a skeleton, the very serious operation performed in the two previous cases would have been dangerous; it was therefore declined.

In view of the recovery of my two very serious cases, I can recommend the simple procedure which was adopted, and which consists of the following:—

1. The formation of a large cæcal artificial anus, close to and slightly below the valvula Bauhini.
2. Free anti-peristaltic washings-out of the whole colon (6 to 10 litres).
3. After the washings have become clear, a mild medicated solution of iodine or protargol.
4. After the ulcers in the colon have healed, testing of the bowel by allowing the passage of fæces (blocking up of the cæcal anus with vaseline tampons).
5. After it has been shown in this way that the ulcers have really healed, operative closure of the artificial anus.

Lastly, I would recommend the method in other serious diseases of the colon in which medicines have failed, in place of shutting off of the colon, as has been recently proposed, to which it is preferable in every way.

CLINICAL RECORDS.

A CASE OF RENAL CALCULUS IN A CHILD.

By R. C. DUN, C.M., F.R.C.S.,

Honorary Surgeon to Liverpool Infirmary for Children.

The patient was a girl, æt. 6. For two years she was reported by her mother to have been "ailing with stomach pains," and, from time to time, to have passed blood in her urine. The hæmaturia would appear to have sometimes been considerable, as the water was "dark red." For three months before I saw the child there was no history of blood having been passed. The abdominal pain had never been very severe; it was intermittent, not aggravated by movement, and was always referred to the region of the bladder. At no time had it been accompanied by vomiting.

When first seen in the out-patient department of the Liverpool Infirmary for Children the child looked pale. The temperature was normal. There was some pain and tenderness on palpation in the hypogastrium. No pain was elicited or swelling discovered during the examination of the kidney regions. The urine was normal, according to the ordinary chemical tests. No microscopic examination was made. The bladder was sounded for stone with negative result.

Five days later (April 3rd, 1907) the child was admitted to my ward. The urine had not been discoloured since I first saw her, and the abdominal pain was much diminished. After a few days' rest in bed the girl became quite free from pain. The urinary sediment was daily examined; a few red blood corpuscles were constantly seen under the microscope. There were no pus cells, and on one occasion only were uric acid crystals seen. The usual chemical tests revealed no abnormality in the urine. The kidney regions were frequently and carefully palpated; as a rule no discomfort was experienced, but on one or two occasions slight tenderness appeared to be present about the right kidney. There was no appreciable renal enlargement. For a week the child was kept in bed; she was then allowed up, and encouraged to play about in the ward, but no aggravation of her symptoms resulted.

On April 19th an X-ray photograph was kindly taken for me by Dr. Thurstan Holland. A very definite shadow was seen in the right kidney region, which Dr. Holland had no hesitation in pronouncing to be that of a renal calculus.

Three days later I operated. The right kidney was exposed by a lumbar incision, and brought out through the wound. A hard, small swelling was readily palpable towards the upper pole. On incising the kidney substance the knife at once came in contact with a stone, which was removed without difficulty from the upper calyx. No pus was present. Search was made for other calculi in the lower calyces and ureter, but none were found. The hæmorrhage was inconsiderable. The kidney substance was stitched with buried catgut sutures, and the capsule re-united. The superficial wound was closed, space being left for a drainage tube passing down to the kidney.

The stone removed was smooth, irregularly triangular in shape, and composed of uric acid. It weighed 6 grs.

The child made a satisfactory recovery. The drainage tube was removed on the fourth day, and there was never any leakage of urine through the wound. There was some hæmaturia for a week, after which time all blood disappeared from the urine.

I have seen the child at intervals since the operation. She has had no pain, and I have been unable to find any blood corpuscles in her urine. Uric acid and oxalate of lime crystals have sometimes been present, and appropriate medical treatment is being given for this condition.

I report this case because renal calculi are very rarely met with in children, because the symptoms were of a most indefinite nature, and for the purpose of emphasising the importance of radiography as an aid to diagnosis.

How seldom children suffer from stone in the kidney can be gathered from the following statements.

Holt, in his work on "Diseases of Infancy and Childhood," says that, although minute granules of uric acid are frequently found post-mortem in the kidneys of children, stones of any size are very rarely met with.

Ashby and Wright, in the last edition of their book, state that they have only operated on two or three cases.

Henry Morris, in 96 operations for renal calculus, had no patient under 10 years. The same authority, in a series of 283 operations for kidney stone which he had collected, found that only one had been performed on a child under 10.

In the reports of the Society for the Study of Disease in Children, published from 1901, only 5 cases of renal calculus are included.

In my own seven years' experience at the Liverpool Infirmary for Children I have met with one other case of kidney stone.

The slight and indefinite symptoms in the present case are worthy of notice. The only pain complained of was inconsiderable, and referred to the bladder. The tenderness on deep palpation of the right kidney was so indefinite and so rarely to be elicited that it proved of little value as a diagnostic sign. The blood in the urine was so small in quantity that it could only be recognised microscopically, though there had been a definite previous history of hæmaturia, and crystals were only seen in the urinary deposit on one occasion. There was no kidney enlargement, and the pain and hæmorrhage were unaffected by movement.

Such symptoms could at the most only suggest the possibility of a renal calculus being present. In my opinion they did not justify an exploratory operation, as the general health of the child was but little affected. The radiographer's art made the diagnosis certain, and enabled me to remove the stone before any serious damage to the kidney substance had resulted.

A study of the few reported cases of renal calculus in children shows that practically all of them have come under the surgeon's care suffering from symptoms of hydro- or pyo-nephrosis. Does not this mean that the earlier signs of kidney stone have been overlooked? How slight those signs may be is demonstrated in the present case. Let us be on the look-out for such symptoms, and keep in our minds the great help in diagnosis which may be obtained from radiography. For it is only in this way that an early diagnosis can be made, and the affected kidney saved from serious and, it may be, irremediable damage.

SPECIAL REPORTS.

GENERAL MEDICAL COUNCIL.

EIGHTY-SEVENTH SESSION.

(Report of Session concluded from our last issue.)

SIXTH DAY.—Monday, June 1st, 1908.

The President, Dr. MacAlister, in the Chair

The whole of the meeting was taken up with the further consideration of the case of John Papa Nicolas, adjourned from Saturday, May 30th, 1908.

Mr. Hemming intimated that he had a further objection which he had put in writing, and which he handed in.

The President announced that the document was not an objection, but a protest against the action of the learned Legal Assessor, and that the Council would have an opportunity to place it on its records if it thought fit.

Witnesses for the defence, Lizzie Becker (nurse) and Mr. Howard Wallace (shipbroker), examined by Mr. Hemming and briefly cross-examined by Mr. Neilsen.

Mrs. Edith Ellis, examined by Mr. Hemming, and briefly cross-examined by Mr. Neilsen, also answered questions by the Legal Assessor.

Mr. Cordery (surveyor) and Mr. P. J. Holt (surveyor) were examined by Mr. Hemming and cross-examined at some length by Mr. Neilsen. Mr. Holt also answered questions by the Legal Assessor.

Mr. Hemming called Mrs. Emily Holt as a witness, and examined her. Mr. Neilsen did not cross-examine the witness.

Mr. Hemming called Miss Nellie Taylor as a witness, and examined her. She was cross-examined by Mr. Neilsen, and answered questions put to her by the Legal Assessor.

Mr. Hemming called Mrs. Phœbe Adelaide Taylor as a witness, and examined her. Mr. Neilsen did not put any questions to the witness.

Mr. Hemming called Mrs. Isabella Lydia Burton as a witness, and examined her. She was cross-examined by Mr. Neilsen.

Mr. Hemming called Mrs. Rebecca Baker as a witness, and examined her. Mr. Neilsen did not cross-examine the witness.

Mr. Hemming called Mrs. Rose Rimmell as a witness, and examined her. She was cross-examined by Mr. Neilsen, and answered a question put to her by the Legal Assessor.

Mr. Hemming called Mrs. Kathleen Burton as a witness, and examined her. She was cross-examined by Mr. Neilsen.

Mr. Hemming called Mrs. Catherine Dalbin as a witness, and examined her as to a statutory declaration which he proposed to put in, annexing a statement signed by about eighty patients of Mr. Papa Nicolas who had not been canvassed by him. Mr. Neilsen objected to this being done. The Legal Assessor advised that the document should be admitted.

Mrs. Dalbin was cross-examined by Mr. Neilsen. She was re-examined by Mr. Hemming, and answered questions put to her by the Legal Assessor. She also answered questions put to her through the Chair by members of the Council.

Mr. Hemming obtained leave to put a further question, through the Legal Assessor, to the witness.

Mr. Hemming then tendered himself as a witness in order to put in the draft of the declaration which had been put in during the examination of the last witness.

Mr. Neilsen cross-examined the witness, who also answered questions put to him by the Legal Assessor. He also answered a question put to him by a member of the Council, through the Chair.

On a motion by Dr. Norman Moore, which was seconded by Dr. Latimer, and agreed to, it was decided that the Council should meet at 11 a.m. on the morrow.

Other witnesses, Miss Lillie Cullen, Mr. H. E.

Lavallin, and Miss Kate Cullen, were examined and cross-examined.

Mr. J. P. Nicolas then went into the witness-box, and was examined by Mr. Hemming, principally with regard to the period during which he (Mr. Nicolas) had acted as assistant to Mr. Atkinson. Mr. Hemming put in ten testimonials given to Mr. Papa Nicolas, some of which he read.

The Council adjourned before the end of Mr. P. Nicolas's examination.

SEVENTH DAY.—Tuesday, June 2nd, 1908.

The President, Dr. MacAlister, in the Chair.

The Chairman of the Business Committee announced that, in view of the late period of the Session, Dr. Langley Browne had withdrawn a motion of which he had given notice, and the consideration of which would take some time.

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That the Office Site Committee, consisting of the President, the two Treasurers, and the Chairman of Business, should be empowered, in consultation with the Solicitor, to deal with any application for a licence to assign or underlet the existing lease of 16, Hanover Square, and, if necessary, to affix the corporate seal to any licence."

Moved by Dr. McVail, seconded by Sir Christopher Nixon, and agreed to:—"That the two reports of the Examination Committee be received and entered as appendices in the minutes."

The reports dealt with the medical examinations of Boards and Universities of the United Kingdom, and of Indian and Colonial Universities, and the Assistant Examiners had expressed themselves as satisfied with regard to the manner in which the examinations were conducted.

Moved by Dr. Norman Moore, seconded by Sir John Moore and agreed to:—"That the Report of the Pharmacopœia Committee be received and entered on the minutes."

The report deals with the sales of the B.P. and Addenda, and also referred to a recent publication which appeared to the members of the Pharmacopœia Committee to infringe the statutory rights in the Pharmacopœia.

The Council resumed the consideration, adjourned, on the motion of Mr. Morris, from Tuesday, May 26th, 1908, of the Report of the Executive Committee in regard to the duties of the Assistant Examiners to the Apothecaries' Hall, Dublin. With reference to recommendation, it was moved by Sir Thomas Myles, and seconded by Dr. Saundby:—"That it be amended by the insertion after the words 'held by' the words 'the Society of Apothecaries of London and the.'"

The Council then further considered the case of John Papa Nicolas, adjourned from the previous day.

Mr. Hemming resumed his examination of Mr. Nicolas, and put questions to him relative to the correspondence regarding his case which had passed between the Registrar and himself, and between the Solicitor to the Council and Mr. Hemming. He also took him, *seriatim*, through the statutory declarations which had been put in by the complainants, and examined him as to the accuracy of the statements made by the declarants in the documents and in the witness-box.

One o'clock having arrived, the examination of the witness was suspended.

Moved by Mr. Tomes, seconded by Mr. Morris, and agreed to:—"That the Report of the Dental Education and Examination Committee be received, entered in the minutes, and adopted."

Moved by Dr. Langley Browne, seconded by Dr. Mackay, and agreed to:—"That the Interim Report from the Unqualified Practice Prevention Committee be received, and entered in the minutes."

Moved by Sir Hugh Beevor, seconded by Dr. Norman Moore, and agreed to:—"That the Report of the Students' Registration Committee be received, entered in the minutes, and approved."

Moved by Dr. Latimer, seconded by Dr. Saundby, and agreed to:—"That the Executive Committee be requested to consider and report on the course to be followed in the case of practitioners who apply to be removed from the *Medical* or *Dentists' Register*."

Moved by Mr. Tomes, seconded by Dr. Little, and agreed to:—"That the Report of the Finance Committee be received, entered in the minutes, and adopted."

Moved by Dr. Norman Moore, seconded by Sir Christopher Nixon, and agreed to:—"That the nominations of the Branch Councils for the Examination Committee be adopted."

The following members had been nominated by:—(*a*) The English Branch Council: Dr. Pye-Smith, Mr. Young, Dr. Caton. (*b*) The Scottish Branch Council: Sir Thomas Fraser, Dr. Finlay, Dr. McVail. (*c*) The Irish Branch Council: Sir John Moore, Sir Charles Ball, Dr. Kidd.

Moved by Dr. Norman Moore, seconded by Sir Christopher Nixon, and agreed to:—"That the nominations of the Branch Councils for the Education Committee be adopted."

The following members had been nominated by:—(*a*) The English Branch Council: Dr. Norman Moore, Sir G. Philipson, Sir John Williams. (*b*) The Scottish Branch Council: Dr. Mackay, Sir John Tuke, Dr. Lindsay Steven. (*c*) The Irish Branch Council: Sir Thomas Myles, Sir C. Nixon, Dr. Little.

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That the nominations of the Branch Councils for the Public Health Committee be adopted."

The following members had been nominated by:—(*a*) The English Branch Council: Dr. Cocking, Mr. Power, Dr. Langley Browne. (*b*) The Scottish Branch Council: Dr. Norman Walker, Dr. Lindsay Steven, Dr. McVail. (*c*) The Irish Branch Council: Sir John Moore, Dr. Adye-Curran, Dr. Kidd.

Moved by Dr. Norman Moore, seconded by Mr. Morris, and agreed to:—"That the following be the members of the Pharmacopœia Committee:—The President, Chairman; Dr. Norman Moore, Dr. Barrs, Sir John Moore, Sir Geo. Philipson, Sir Thomas Fraser, Dr. Little, Dr. Caton, Dr. McVail."

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That the following be the members of the Finance Committee:—Mr. Tomes, Chairman; Mr. Morris, Sir John Tuke, Dr. Little."

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That the following be the members of the Dental Committee:—The President, Chairman; Mr. Morris, Sir Thomas Myles, Mr. Tomes, Mr. Hodsdon."

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That the following be the members of the Dental Education and Examination Committee:—Mr. Tomes, Chairman; Mr. Morris, Sir Thomas Myles, Dr. Lindsay Steven, Sir Charles Ball, Dr. Finlay."

Moved by Dr. Norman Moore, seconded by Sir John Moore, and agreed to:—"That the following be the members of the Students' Registration Committee:—Sir Hugh Beevor, Chairman; Dr. Norman Moore, Dr. Adye-Curran, Sir John Batty Tuke, Sir Christopher Nixon, Dr. Mackay."

The Council proceeded to ballot for the election of the Executive Committee and the Penal Cases Committee.

Mr. Hemming resumed his examination-in-chief of Mr. John Papa Nicolas. Mr. Papa Nicolas was cross-examined by Mr. Neilsen.

In the course of his cross-examination, Mr. Neilsen asked a question in regard to the witness's statement to his solicitor as to the terms of the proposed partnership with Mr. Atkinson, to which Mr. Hemming objected. The Legal Assessor admitted the question. Mr. Hemming requested that his objection should be recorded, and this was agreed to.

At 4 o'clock p.m., the cross-examination of Mr. Papa Nicolas was suspended.

The President announced that the following had been elected members of the Executive Committee:—Sir Hugh Beevor, Dr. Pye-Smith, Mr. Young, Mr. Tomes, Sir John Tuke, Dr. McVail, Sir John Moore, Sir Charles Ball. And that the following had been elected members of the Penal Cases Committee:—

Dr. Saundby, Mr. Tomes, Dr. Finlay, Sir Christopher Nixon.

Mr. Neilsen then resumed and completed his cross-examination of Mr. Papa Nicolas. Mr. Papa Nicolas was re-examined by Mr. Hemming, who asked Mr. Atkinson and Dr. Hugh Woods to produce the bill which Mr. Papa Nicolas had sent in to Mr. W. Tacon, and on which he had been cross-examined. Mr. Neilsen stated that it was not in the possession of the complainants. Mr. Hemming requested that his application should be recorded. Mr. Papa Nicolas answered questions put to him by the Legal Assessor in regard to the alleged payment of five shillings to a witness, which had been asserted by him in the course of cross-examination. He also answered other questions put to him by the Legal Assessor.

Mr. Hemming then called Mr. Edward Woods as a witness, and examined him. Mr. Woods was cross-examined by Mr. Neilsen, and re-examined by Mr. Hemming.

Moved by Dr. Norman Moore, seconded by Mr. Thomson, and agreed to:—"That Standing Order IV., 2, be suspended in order that the Council may meet at 10.30 o'clock a.m. to-morrow."

Mr. Hemming then called Mrs. Mary Ann Richardson as a witness, and examined her. She was cross-examined by Mr. Neilsen, and answered a question put to her by the Legal Assessor.

Mr. Hemming applied for information as to how he should deal with the affidavit of a witness who was too ill to appear.

The Legal Assessor advised him to show it to Mr. Neilsen with a view to its being put in without opposition, if possible, and to obtain a medical certificate as to the inability of the witness to attend.

The Council then adjourned.

EIGHTH DAY.—Wednesday, June 3rd, 1908.

The President, Dr. MacAlister, in the Chair.

Nearly the whole of the day (10.30 to 1, 1.30 to 6.45) was devoted to the further hearing of the case of John Papa Nicolas, adjourned from the previous day.

Mr. Hemming first called and examined a few more witnesses, who denied having been canvassed by Mr. Nicolas, and then he (Mr. Hemming) made his speech for the defence. This speech lasted nearly five hours, and dealt with the entire case, mostly questioning the credibility of the complainants and their witnesses.

Mr. Neilsen then answered, and the Legal Assessor said a few words.

Strangers having been requested to retire, the Council deliberated *in camerâ* for an hour.

On the readmission of strangers, the President called Mr. John Papa Nicolas, and announced to him that the Council had found him guilty of infamous conduct in a professional respect, and that the Registrar had been ordered to erase the name of John Papa Nicolas from the *Medical Register*.

Mr. Hemming then asked that the Registrar should be ordered to suspend action for a month.

The President answered that Mr. Hemming must make an application in writing.

The Council postponed the consideration of the Report from the Executive Committee in regard to proposed alterations in Chapters XIV. and XV. of the Standing Orders; also the consideration of the Report of the Executive Committee in regard to the duties of Assistant Examiners to the Apothecaries' Hall, Dublin, with motion and amendment thereon; also the motion by Dr. Adye Curran, seconded by Dr. McManus:—"That reports by the Assistant Examiners in Surgery of the Apothecaries' Hall of Ireland be discontinued for the present"; also the consideration of a resolution of the Standing Committee with reference to Standing Order IX., 3.

A motion of Mr. Morris, seconded by Mr. Tomes:—"That the minutes which have been printed and circulated be taken as read, instead of being read *in extenso* by the Registrar," was referred to the Executive Committee.

The Report from the Public Health Committee was received and entered on the minutes.

The motion of Dr. Mackay, seconded by Dr. Norman Moore, "That the Chairman of the Education Committee be authorised to communicate to the Licensing Bodies for verification of the statistics therein contained, an Interim Report of the Education Committee on various proposals submitted to them referring to the curriculum in medicine," was adopted.

The Report of the Education Committee was adopted. This report dealt with the reply of the Council to a resolution adopted by members of the Medico-Legal Society with regard to the administration of anæsthetics.

The motion of Mr. Tomes, seconded by Dr. McVail, "That, together with the reports of the Dental Committee, the prints of the documents and evidence placed before the Committee be circulated to the members of the Council," was adopted.

Mr. Henry E. Allen was appointed General Registrar.

The Council then rose.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 7th, 1908.

Diabetic Retinitis.

Whereas retinitis in Bright's disease is accepted by all, that observed in the course of diabetes is contested by some, who say that if retinitis is met in diabetic patients it is due to the presence of albumin accompanying sugar in the urine.

Nothing is less exact, says Prof. Dieulafoy, as albumin is by no means a proof of Bright's disease, and also retinitis can be observed in diabetes, of which the urine is free from albumin. All the portions of the eye are touched in diabetes: the external muscles (paralysis), internal, with troubles of accommodation, crystalline with cataract, vitreous body with hæmorrhage, retinitis with hæmorrhage and white spots.

Diabetic retinitis exists independently of Bright's disease, and is essentially different from that of this affection, where the white spots are larger and more abundant, and form a fan around the macula, while in diabetes these spots are punctated, and form a circle around the macula.

A woman of 60 years of age complained of thick cloud suddenly covering the vision. Examination showed disseminated hæmorrhagic spots on the retina, as well as whitish exudation around the macula. She suffered also from thirst and vulvalar pruritus; a considerable quantity of sugar was found in the urine, and no albumin. Under the effect of treatment, the sugar diminished notably, and the condition of the eye improved.

Another patient, besides ocular trouble, had a recrudescence of his diabetes under the influence of milk diet. The symptoms and signs of retinitis were similar to the preceding case, and albumin was present in the urine, as well as sugar. Under the effect of antipyrin and the suppression of the milk diet, which is not suitable for every case of diabetes, the sugar disappeared, but the albumin persisted.

In reality, albumin is found in more or less quantity in the urine of most diabetic patients, but it does not follow that the cause should be ascribed to Bright's disease. The cause is rather explained by the existence of bulbar irritation of gouty or arthritic origin, which produces both sugar and albumin. An intelligent antidiabetic treatment is capable of effecting a cure.

Broncho-Pneumonia.

In treating broncho-pneumonia, no time must be lost in employing energetic measures, and notably the wet pack. A towel is steeped in cold water, applied around the thorax, and covered with impermeable tissue. The application is removed at the end of two or three hours, when it is renewed after a smart rubbing of the chest. Warm baths succeed better than cold baths, especially when the heart shows signs of weakening. The patient is put into a bath of 100°, and the temperature gradually increased to 104°. The bath may be renewed twice in the 24 hours.

These means considerably abridge the duration of the malady.

The mustard bath might be utilised as an energetic revulsive, but a method which literally, says M. Hirtz, has brought back to life patients considered as absolutely lost, consists in placing the patient in a half bath of warm water and pouring over his body cold water (64°).

Internally, stimulant agents find their indication :—

Syrup of tolu, 4 oz.
Brandy, 1 oz.
Acetate of ammonium, 1 dr.
Water, 4 oz.

Every two hours a tablespoonful. No drugs that would lower the temperature should be given.

GERMANY.

Berlin, June 7th, 1908.

At the Medizinische Gesellschaft, Hr. Plehn showed a case of

Pernicious Anæmia.

The patient was a young man who was admitted into hospital in a very much reduced condition, so much so that his death was expected every hour. Suddenly, improvement set in, with rapid increase in the blood corpuscles and increase of body weight, so that in the course of six weeks he gained 32 lbs. The hæmoglobin increased to 60 per cent. The treatment had consisted in washing out the stomach and subcutaneous injections of arsenic. Notwithstanding the rapid increase in the red blood corpuscles, those containing nuclei had not increased. Notwithstanding the present good condition of the patient, the prognosis was still very doubtful.

Hr. Senator observed that the hæmoglobin was the last to re-establish itself.

Hr. Ewald brought to mind other observations of rapid improvement, which did not, however, exclude relapses.

Hr. Joseph showed a child, æt. 8, who had a nodule at the umbilicus which was at first taken for a hernia until suppuration appeared in it. In the Koenig. Poliklinik the pus was aspirated, when it appeared that the fluid aspirated was urine. A catheter introduced through the fistula showed in the bladder. The speaker now opened up the fistula, which led, first of all, into an abscess cavity; this could not be excised, as it was too firmly adherent. He then contented himself with tamponade, when the flow of urine became less.

The Keating-Hart Fulguration Treatment of Cancer

was then discussed. Hr. Max Cohn thought the treatment suitable for inoperable cases. He made flap incisions in the skin so that the sparks could act on the uncovered tumour. The action was entirely mechanical. Hr. Abel showed an improved apparatus for applying the treatment, which admitted of accurate dosage. Deep narcosis was necessary for the applications. They lasted a long time, and they were by no means indifferent to the suffering patient. The action of the sparks was only superficial. There was no bactericide action, for when cultures were exposed to its influence the growth of the organisms was not influenced in the least. No opinion as to the value of the method could be given at present. The subject was also discussed at the German Society for Surgery. Hr. Czerny, Heidelberg, said the current no doubt destroyed cancer cells and connective tissue, but the final results were not yet known. There was no question of permanent healing. The lightning did not destroy carcinomatous tissues completely. The distant action was but slight. The treatment was exceedingly painful. Hr. Sonnenburg said the *technique* was extraordinarily troublesome, but the method was strictly scientific, and well deserving of attention. Schultze, Berlin, did not believe in an elective action of the current; it burnt and destroyed everything alike.

Hr. Kocher, Berne, spoke on

The Technique of Transplantation of the Thyroid.

He rejected the direct transplantation of the thyroid into the marrow of bones. The hyperplastic gland substance was eminently adapted for transplantation. The vascular supply should be taken care of up to the moment of transplantation. For a covering only the firm periosteum was made use of. He took freshened tissues, and only removed the capsular parts when the piece had been placed in the cavity made in the tibia. The advantages of the operation lay in the lesser danger and risk. Hr. Payr, Greifswald, said that in his own case the result was by no means an ideal one. Hr. Garré, Bonn, in a case of chronic tetanus had transplanted epithelial corpuscles from a case of Basedow's disease into the epiphysis. There was a marked improvement after two months. The capsule of the epithelial corpuscles must be allowed to remain.

Hr. Czerny transplanted the thyroid into the spleen. Death followed from pneumonia. The thyroid was found properly healed in within the spleen. Hr. Müller, Rostock, had had bad results, as had also Moskowicz, of Vienna.

AUSTRIA.

Vienna, June 7th, 1908.

Bony Defect in Head.

Latzko showed an infant to the Gesellschaft with a defect in the left parietal bone from prolonged pressure *in utero* owing to a narrow deformed pelvis. In this case it was important to get a live child, and the conjugata vera being no more than 8 centimetres, or 3 inches, grave doubts were entertained of success. The mother had been 22 hours in labour, with a temperature of 37.5 Centigrade, it was clear something must be done, as delivery by the natural channel was scarcely possible. Then arose the question of operation, which should be adopted, symphysiotomy, hebostotomy, or the Cæsarean section. He decided on the latter, with Frank's modification of supra-symphysarial liberation. By this method Frank maintained that he could prevent infection of the peritoneum in the Cæsarean section by making a free opening in the uterine cavity below the peritoneal sac. The great secret of his operation was in a transverse section of the peritoneal membrane; he formulated the mode of performing the operation by first raising the pelvis, making a transverse section of the skin and muscles two or three ctms. above the symphysis; next, entering the peritoneum transversely over the bladder, and raising the loosened peritoneum above the lower uterine segment, and sewing both anterior and posterior walls of the sac to prevent any infection rising higher in the abdomen; after this the uterus was entered transversely at the lower segment, the child removed, drainage provided for, and the uterus closed, while the abdominal wall was left partially or completely open. Latzko thought these directions too complicated and sought to enter externally by a long incision along the linea alba till he reached the peritoneum, after which he cut the latter transversely. To assist in guiding the operation he injected 150 ctmcs. into the bladder, then moved the organ by means of a spatula from the cervix of the uterus carrying the loose serous membrane upwards. After this he opened the uterus in the direction of its fibres, removing fœtus and placenta, and then closed the wound in the usual way. Herzfeld thought that the Cæsarean section was an operation in favour of the child and regardless of the mother, and therefore questioned the righteousness of such an operation unless the circumstances were extreme. The great end to be obtained in parturition was asepsis and perfect drainage. Where the channel was narrow, as in the case recorded, craniotomy was still left as an ultimum refugium before the Cæsarean section was reached. He considered the latter too serious a danger to the mother, and thought Frank's operation should always be avoided. The peritoneal cavity is easily infected from the genital canal, and the loose cellular tissue around, no matter how ingenious the operation. Schauta agreed with the preceding speaker that the first consideration in cases of the kind was the safety of the mother. The Cæsarean section was always a momentous operation.

He thought pubiotomy or hebostotomy would have been quite sufficient in this case, and the risks far less. For the simple reason of obtaining a live child the Cæsarean section should never be undertaken. He had never practised Frank's method, nor could he see that lessened the danger of infection, because the vascularity was even greater where he recommended the operation, and the removal of the child was certainly more difficult owing to the depth in the pelvis, where the incision was made in the uterus. Latzko's extra-peritoneal sectio Cæsarea can hardly be called sectio Cæsarea vaginalis, as the vagina is never reached—the cervix being the lowest point. Even though the vagina were reached, hebostotomy is a superior operation, as the pelvic tissue is well known to be more susceptible to poisons than other parts of the body, and with his section the discharge of the uterus must still pass over the wound. Again, cicatrices would make future parturition still more dangerous.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Edinburgh Medical Faculty.—With the resignation of Professor Crum Brown two chairs are now vacant in the Faculty of Medicine. The chair of chemistry is under the patronage of the Curators, and applications are requested to be sent into the Secretary, Mr. R. Herbert Johnstone, W.S., on or before the 4th of July next. There is a considerable feeling of disappointment, if not of dissatisfaction, at the long delay in filling up the chair of clinical surgery, which has now been empty since the beginning of the year. Whoever be nominated, there must in consequence be a considerable re-shuffling of junior surgical appointments, and the holders of such as may be influenced in this way are naturally perturbed by the delay. Presumably, however, the new Professor will be nominated in time to take over his duties at the beginning of next October.

BELFAST.

Death of Dr. Sydney Brice Smyth.—The tragically sudden death of Dr. Sydney Brice Smyth on Thursday last has cast a great gloom over the medical profession in Belfast, where he was a universal favourite. To the general public he had seemed in the best of health and spirits, though his intimate friends knew that he had latterly had frequent signs of asthma and easily became cyanosed. He was making arrangements for a holiday in Sweden in a few weeks 'time, and no special anxiety was felt for him; but on the morning of the 4th inst. he was found dead in bed, having evidently passed quietly away in his sleep. The deepest sympathy is felt with his relatives, and specially with his father and two brothers, all medical men. His father, Dr. Brice Smyth is a senior member of the profession in Belfast, and after enjoying one of the best general practices in Ulster for many years he was gradually lessening work as his eldest son took more in hand. The three sons were educated at Uppingham School and Trinity College, Dublin. Dr. Sydney Brice Smyth began practice in Belfast about fifteen years ago, and devoted himself specially to obstetrics and diseases of children. He was appointed to the staff of the Belfast Children's Hospital, and later to the Maternity Hospital. He devoted a great amount of time and trouble to his work at the Children's Hospital, and was rewarded by attaining a high place in his profession, for though only 39, he had become a recognised authority in the treatment of children, and was frequently called out in consultation by his colleagues. He had also a large and valuable midwifery practice. He used to be an ardent cricketer, but lately had become very stout, and took almost no exercise, except yachting on Saturdays during the summer months. His kindness and good nature were proverbial, and among a wide circle of friends and patients he was not merely liked, but loved. He was a bachelor, and spent much of his spare time with his father and youngest brother, Dr. Malcolm Brice Smyth, who is also in practice in Belfast. His other brother, Dr. R. Brice Smyth is deputy medical superintendent at the County Asylum, Gloucester. The funeral, which took place on Saturday morning, was strictly private.

LETTERS TO THE EDITOR.

THE STATUS OF PRISON MEDICAL OFFICERS IN IRELAND.

To the Editor of The Medical Press and Circular.

Sir,—I was much interested in your editorial *re* Prison Medical Officers in your issue of the 3rd inst., Irish Poor-law and Lunacy Intelligence.

The question is a very simple one, and the mere statement of facts will show what an injustice the medical officers appointed to prisons since the passing of the Prisons (Ireland) Act, 1877, suffer from. By the Act of 1873, the position of gaol surgeons as regards pensions was definitely settled. They were placed in the same position as civil servants. On completing their service, and reaching the age of 60, or, in case of illness, prior to that age, they were entitled to one-sixtieth of their salary for each year's service completed, the maximum pension obtainable being two-thirds of their salary. There was this important distinction from civil servants—they were not called on to resign when the age of 60 was reached. Under a clause in the Prisons Act, gaol surgeons in future were to be appointed by the Lord-Lieutenant. The wording of the section is somewhat intricate, but the Government have acted on the assumption that the Lord-Lieutenant has power to determine the tenure of office. By making the appointment of gaol surgeons for a period of three years (renewable at the discretion of the Lord-Lieutenant), the office of gaol surgeon ceases to be pensionable. Several questions arise:—

(1) Have the Government interpreted aright the section of the Prisons Act empowering them to override the Act of George, whereby these officers were secured in their tenure for life? The House of Commons never intended that any alteration in status should be made. In the case of prison medical officers, who also held the appointment of county infirmary surgeons, a special clause was inserted to clear up an ambiguity as regards *their* pensions.

(2) A much more important question than that of pensions is raised by allowing the tenure of medical officers to prisons, viz., the independence of the medical officers—they are placed in a position of extreme responsibility—their business is to maintain the health of the prisoners while not interfering with the general discipline of the prison. They are the only safeguard vouchsafed to the prisoner, to prevent rigorous confinement on a scanty diet, causing a deterioration in health or *morale*. Without independence, vexatious interference by a controlling power is possible, and not only possible, but certain to take place. If a Royal Commission on Prisons in Ireland was appointed, similar to that of 1884, I think numerous instances would be forthcoming. If for no other reason, the alteration in tenure of prison medical officers, is a retrograde step fraught with danger to the prison population—when a class is deprived, though it be through their own acts, of medical attendants of their own selection, it is doubly imperative on the Government that their medical attendant, for the time being, should be placed in a condition of perfect freedom from restraint or interference. I write with 31 years' experience as a prison medical officer, but, happily, as a permanent pensionable officer, doubtless one of the two referred to by the Attorney-General.

The Attorney-General's statement that only those medical officers whose whole time is given to these offices, are entitled to pension, is perfectly true; but why? Because the Government have altered their tenure of office; if they were permanent officers the Act of 1873 made them pensionable. The House of Commons legislated for medical officers whose whole time was not given to the Service; mine is a case in point. There are ex-medical officers now, who are drawing pension, whose whole time was not given to the Service. If, instead of the Treasury attaining this paltry saving in pensions, the Government had gone to the House of Commons and attempted to alter the tenure of medical officers by legislation, they would have been defeated. The House of Commons has not altered its opinions since 1873, when they specifically granted medical officers, whose whole time was not given to the Service, pensions. Had they proposed this the entire strength of the Irish M.P.s would have been cast against them, together with those English and Scotch M.P.'s whose sense of fairness and sympathy is not alienated by party discipline.

While the emoluments of the office are utterly disproportionate to its importance, it is grossly unfair to the profession at large that any of its members should be deprived (by a side wind) of privileges Parliament granted them in 1873, and intended them to enjoy till such time as in their wisdom it saw fit to repeal.

There is much more that I could write on this subject, but my position precludes me from entering into details in support of my contention. I only, therefore, deal with the broad constitutional question, and must express my regret that the subject does not present itself to M.P.'s (especially Irish M.P.'s) with the importance it deserves.

I am, Sir, yours truly,
Hercules MacDonnell, M.D.,
Medical Officer H.M. Prison, Dundalk.

THE GOVERNMENT COMMISSION ON WHISKY.

To the Editor of The Medical Press and Circular.

Sir,—Incidentally to the Whisky Commission, much has been talked and written on the subject of "What is Whisky?" May I, as a member of the trade who, with forty years' experience in the tasting and sale of whiskies, am, rightly or wrongly, regarded as an expert, state a few simple facts (abstaining from all trade technicalities), and give the result of my experience, which may be of some interest to your readers.

The public taste and the demand for Irish whisky, which, in certain well-known brands, claims to be "all malt," has for many years declined, whereas during the same period the trade and demand for blended Scotch whiskies has, both in this country and abroad, enormously increased, and this only since the introduction of the skilful Scotch blends of malt and grain of good quality, which blends have made the reputation of Scotch whisky.

Distributors like my firm (who are neither distillers nor blenders) obtain practically the same rate of profit on the sale of *all malt* as on *blends*, and therefore hold no brief for either; but as a taster and merchant who during a lengthened period of years has sold considerable quantities of both, I unhesitatingly state that "all malt" does not suit the public taste, a fact which, apart from every-day business experience, I have verified specifically at three different periods: the first about the year 1892, the second in 1898, and the third in 1905, when on each occasion I purchased appreciable quantities of the finest and oldest pure malt that money could purchase, and had such bottled, sold and distributed at a moderate price amongst a large number of purchasers. Few repeat orders were received for this undoubted pure old malt of best quality, which was not appreciated, whereas during the same period repeat orders and evidence of appreciation were received daily for best blends of malt and grain. "All malt" is almost invariably found "heavy, heady and bilious," whereas blends of good malt and grain, well aged, are more appreciated.

In my opinion, the great desideratum is a skilful blend of good quality malt and old grain, both aged in cask for at least three years before blending.

The Whisky Commission can do some good by recommending that whisky should not go into sale for consumption before having been kept in bond for at least three years, a step which the medical profession has all along insisted on. This would inflict no hardship on "the trade," as blends of good whisky of an age up to twenty years can be and are sold to the public at as low a price as 39s. per dozen.

I am, Sir, yours truly,
F. B. Ehrmann.
Finsbury Square, London, E.C.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Three Cases of Acute Appendicitis.—The first case operated on by Mr. Corner was that of a little girl, æt. 9, who had been ill with abdominal pain, sickness, and inaction of the bowels for 48 hours. She presented all the clinical features of acute abdominal trouble. At her age, Mr. Corner said, such a condition was far and away most likely to be due to appendicitis; other causes being such uncommon events as obstruction by, or inflammation of, Meckel's diverticulum. An examination of the child showed absolutely no feature that she was suffering from disease of the appendix—the diagnosis being in consequence made on probability gained by previous experience. There were two or three clinical peculiarities about her case: the pulse was rapid, 130 to 140, out of all proportion to the signs of disease found by abdominal examination. In such cases it must be remembered that the disease causing the rapidity of pulse and the other serious constitutional signs was in all probability situated in the pelvis, where its presence need not be obvious on abdominal examination. Peritonitis when in the pelvis was particularly liable to affect the peritoneum over the small intestines, in which case it spreads rapidly over an enormous area producing severe constitutional symptoms in a very short time. Under such circumstances it was of the greatest importance when considering the question of surgical interference to ascertain whether the infection is spreading, perhaps insidiously, *viâ* the pelvis. A rectal examination which should never be omitted in acute abdominal conditions had been made in this case, and confirmed his conjecture that in her case the peritonitis had involved, and was spreading rapidly over, the small intestines and the pelvis. Under these circumstances operation would be undertaken without delay. The incision used to open the abdomen in such cases was best made over the right rectus muscle, the fibres of which are separated; the peritoneum can be opened, if necessary, from the ribs to the pubes, and the whole abdomen explored. Little free fluid was present in the peritoneal cavity, though previous to the operation its presence had been suspected, the confusion arising from the inability of the clinical examination to distinguish between fluid free in the peritoneal cavity and fluid within the coils of the bowel. The appendix was situated near the brim of the pelvis, and was gangrenous. The infection from it on account of its situation affecting the small bowel in the pelvis and lower part of the abdomen rather than the contents of the abdomen proper. The pelvis and lower part of the peritoneal cavity were carefully sponged out with long gauze plugs. The appendix was removed. There were two points of value, Mr. Corner remarked, in the prognosis which were indicated before the abdomen was closed: in the first place the patient was a child where the prognosis is far more uncertain than it is in young adults; in the second place it was noted that the intestines were red and dilated, but they showed no lymph or other traces of reaction on the part of the body against the infection. The wound was partially closed, gauze drains being left leading to the pelvis and to the lower part of right iliac fossa to be removed in forty-eight hours.

The child had a stormy convalescence, but ultimately recovered.

The other two cases:

1. Acute appendicitis mimicking acute cholecystitis in a woman, æt. 40;
2. Very acute early appendicitis in which the diagnosis could not be confirmed until the appendix had been removed and opened,

will be published in "Operating Theatres" in a future number.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Pneumonia Due to Friedlander's Bacillus.—Apelt, as a result of his research work, has come to the conclusion (*Munch. Med. Woch*, 1908, No. 16), that there are undoubtedly cases of pneumonia brought about by the diplo-bacillus of Friedlander. The bacillus can be found in the blood, the sputum, and ultimately, in fatal cases, in the lungs. This form of pneumonia is characterised by an absence of herpes and rigor, by a very severe onset, by a strongly mucoid expectoration, caused, apparently entirely by the pneumo-bacillus, and by the peculiar bright red appearance of the lung on section. Throughout the section, in addition, small mucoid areas can be detached. The treatment is the same as for pneumonia caused by the pneumococcus. M.

Adenoid Vegetations Among the Japanese.—Dr. Sakai has contributed to the February and March numbers of the *Sei-I-Kwai Medical Journal* a report of his study of adenoid vegetations amongst the Japanese, and has devoted special attention to the changes in the upper jaw brought about by their presence. He presents the following conclusions:—(1) The disease is most frequent between 6 and 15 years of age, and is met with equally in the sexes. (2) The symptoms most often complained of are occlusion of the nasal cavity, or deafness. (3) The changes found in the upper jaw are of two varieties, and are entirely due to the nasal obstruction. The first variety is found when the adenoids start before the period of true dentition, and is characterised by an increase in the long diameter of the superior maxilla, by the bright and semi-circular curve of the palatine arch, and by the absence of irregularity of teeth. The second variety presents a pointed palatine arch, and teeth irregularity. It is met with when the adenoids occur during the period of dentition. No deformity results if the vegetations appear after the period of dentition. (4) The lower jaw and the milk teeth never present any change. M.

The Cardio-Hepatic Angle.—Calvert presents a brief, but interesting, study of the cardio-hepatic angle in the *Johns Hopkins Hospital Bulletin* (May, 1908, p. 143). Ebstein, following Rotch, gave this name to the angle formed by the right border of the cardiac dulness and the upper border of liver dulness, and Rotch insists that dulness extending in this region beyond the right border of the sternum in the fifth intercostal space is an early and important sign of pericardial effusion. According to the present writer, the following two factors are necessary to materially alter this angle, viz.: (1) Displacement of the root of the lung; either to the right; to the right and upwards; to the right, upward and backward; or backward and upward. (2) Displacement of the lower portion of the right wall of the pericardium, either by an effusion or by very great dilatation of the right auricle. In pericarditis three factors are present to cause the dislocation of the lung, and these are:—(1) Possible displacement of the root of the lung. (2) Pressure of pericardium on lung from root to lower border. (3) Downward displacement of the attachment of the right wall of the pericardium to the diaphragm, thereby lowering the point of greatest displacement of the right wall of the pericardium. These factors are usually absent in cases of enlargement of the heart, in which the lung displacement is likely to be purely local, and in consequence Rotch's sign is of great value in diagnosing pericarditis. It is only in late stages of mitral stenosis that any real confusion is likely to occur. M.

Tumour of the Pituitary Body in a Young Boy.—Eiselsberg and Frankl. Hochwart describe a case of a young boy, æt. 12, who came under observation with characteristic symptoms of a tumour of the pituitary body (*Neurolog. Centralbl.*, 1907, No. 21). The fact that typical acromegalic symptoms were absent and that there were no congestive phenomena, while there was rapid deposition of fat, accompanied by the appearance of symptoms resembling myxœdema, led to the conclusion that the gland itself was the site of tumour formation. X-ray examination also assisted the diagnosis. An operation was undertaken for the purpose of improving the vision, and relieving headache, the tumour being approached through the frontal sinus to the sphenoidal sinus, and a cyst of the pituitary body was found. This was cleared out of a mass of broken-down tumour and blood *débris*, epithelial cells being found in numbers in what was removed. The patient completely recovered, and, except for some loss of olfactory sense, has remained in good health. M.

Coagulation of the Blood.—Robertson, Illman, and Duncan (*Journal of the American Medical Association*, May 16th, 1908) publish a summary of our knowledge of the process of coagulation with special reference to the action of alleged coagulation. The following are the more important conclusions:—(1) During the febrile stage of the infectious diseases coagulation is noticeably retarded. (2) The administration of calcium salts had no invariable effect on the coagulability of the blood. (3) No definite relation could be established between leucocytosis and coagulation time. (4) Citric acid prolonged the coagulation time and diminished the viscosity of the blood. R.

The Testicle and Typhoid Fever.—Fox (*Bulletin of the Ayett Clinical Laboratory of the Pennsylvania Hospital*, December, 1907) discusses the occurrence of focal necroses in the testicle in the course of typhoid fever. For some time it has been known that focal necroses are a marked feature of the pathology of typhoid fever. First discovered in the liver, they were afterwards found in the spleen, in mesenteric lymph-glands, and in bone-marrow. Fox studied the testicles from 26 cases of typhoid fever, from 17 cases of pneumonia, and from 9 miscellaneous cases, including nephritis, peritonitis, purpura hæmorrhagica, myocarditis, and carcinoma of the stomach. There were two striking features noticed in the testicles from cases of typhoid fever: the large number of epithelioid cells in the tissues between the tubules, and the almost complete absence of spermatogenesis. In the testicles from pneumonia, on the other hand, spermatogenesis was active. In 12 of the 26 cases of typhoid, focal necroses were found in the testicles. As a rule, the foci were fairly large, but they varied greatly in number. The general features of the lesion were an area densely packed with small round cells and large epithelial cells, with a very few polymorphonuclear cells. The centre of the area was necrotic, and about the border of the necrotic portion there was nuclear fragmentation and granular detritus. Hæmorrhages were also common in the glands. In one case of pneumonia there was a focus of necrosis in the epididymis, but in none of the others, nor in any of the miscellaneous cases were any necroses discovered. Fox discusses the various theories as to the cause of focal necroses in typhoid fever, and inclines to the view that a bacterial toxin is the direct cause of the lesions. There was no thrombosis or vascular change sufficient to account for them, and there was no evidence to suggest that they were due to the action of the bacilli on the cells themselves. The suggestion of Flexure is quoted with approval, that in capillaries in which the circulation is much diminished the toxic irritant may cause so much damage to the vessel-wall that free transudation of toxic fluid takes place into the tissues of the neighbourhood, resulting in destruction of the cells. R.

Pneumococcal Peritonitis.—Cuff (*Brit. Med. Journ.*, April 18th, 1908) collects five cases of primary pneumococcal peritonitis. His views support recent teachings regarding the wide distribution of the pneumococcus as a pathological agent in the body. He notices a peculiarity about the pus in cases of pneumococcal infection of serous membranes. There is always a large quantity of coagulated lymph like curdled milk. He concludes from his study of the five cases:—(1) An acute or localised peritonitis may be the sole symptom of a pneumococcic infection. (2) Such cases form a considerable proportion of those anomalous cases of peritonitis without visible lesion of any of the abdominal viscera. (3) They may be followed by pneumococcic lesions in other parts of the body. R.

A Case of Merycism.—The literature of merycism, or chewing the cud, as a human abnormality, is increasing. Taylor (*Brit. Med. Journ.*, March 14th, 1908) reports a case occurring in a native boy of 14 in the Punjab. He had been subject to the condition for some four years, the food beginning to return to his mouth immediately after a meal. It came up quite soft, and, without re-chewing, he again swallowed it. The action was quite automatic, and went on regularly till he began to feel hungry for the next meal. There was no family history of merycism, and the health of the boy was good. R.

Cancer of the Vermiform Appendix.—McWilliams (*American Journal of the Medical Sciences*, June, 1908) publishes a careful study of 90 cases of primary carcinoma of the appendix, while Kelly adds notes on a few cases which came under his observation. The following are the principal conclusions arrived at by McWilliams:—Of the patients operated upon for known reasons, 83 per cent. suffered from some variety of appendicitis. Eleven primary cancers were found in appendices removed in the course of operations undertaken for other purposes, and 10 primary cancers were found in the course of autopsies. In 60 per cent. of the cases the patients were under 30 years of age. The condition was somewhat more frequent in women than in men. In only 5 per cent. of the cases were there concretions in the appendix. The site of the growth was most commonly near the tip of the appendix. It was rare to find the lymph-glands involved. In many of the cases no tumour was observable to the naked eye. The type of cell differed in different cases—in 22 per cent. it was columnal, in 53 per cent. sphenoidal, in 9 per cent. transitional. The spread of the cancer is slow, the appendix being infiltrated through all its coats in only half the cases. In 22 pe cent. the meso-appendix was affected. There is little tendency to the formation of metastases, secondary growth being present in only 6 per cent. of the cases. In 62 per cent. there were chronic inflammatory changes in the appendix, but it was impossible to say whether they or the cancer were primary. R.

The Effect of Muscular Exercise ou Temperature.—Flack (*Brit. Med. Journ.*, April 18th, 1908) publishes observations on the rectal temperature of athletes taken immediately after severe muscular exercise. One set of observations was made on competitors in the London Hospital and Inter-Hospital Sports. The lowest record is 100° F., in the case of a man who had run one mile, and again when he had run nearly two miles. The other records varied from 100.2° F. to 105° F., the average being between 101° F. and 102° F. Speaking generally, the longer the effort the higher the temperature rose. The man whose temperature reached 105° F. was carefully observed and examined afterwards, and he was regarded as perfectly healthy. Another set of observations was made on players in the Inter-Hospital Rugby Final Match, with similar findings. The records varied from 101.2° F. to 103.40 F. R.

Rhabdo-myo-Sarcoma of the Prostate.—Greig (*Brit. Journ. of Children's Diseases*, May, 1908) reports a case of this rare condition occurring in a child of four years. The tumour was an irregular fungating growth, the size of a Tangerine orange, projecting into the bladder round the urethral orifice. It was quite friable. Microscopically it was found to be a sarcoma, possessing in parts a fair number of striped muscle fibres. The sarcoma cells were spindle-shaped, with marked variations in size. Greig has only been able to find a record of three other cases of the condition, all of them reported by Socin and Burckhardt. R.

Alcohol and Protoplasm.—Kesteven (*Brit. Med. Journ.*, April 18th, 1908) records some interesting experiments as to the effect of supplying live amœbæ with alcoholic solutions. Several different specimens of amœbæ were employed, and various strengths of alcohol from 1 to 7 per cent. in water. In the weaker solutions the amœbæ at once became motionless, but after a varying time, from seven minutes upwards, motility was again apparent. In the stronger solutions the amœbæ were at once killed. The observer concludes that, though the animals could live in solutions not exceeding 5 per cent. of alcohol, the effect in every case was one of paralysis, only differing in degree. There was no sign of any stimulating effect. R.

MEDICAL NEWS IN BRIEF

Proposed New Irish Universities.

The following have been nominated as Commissioners to discharge the duties of Commissioners under the Irish Universities Bill. For the Belfast Commission:—The President of Queen's College, Belfast, His Honour Judge Shaw, Professor Symington, Professor Dill. In addition, Mr. Birrell hopes to secure two gentlemen of great academic authority, experienced in University matters in Great Britain, and possibly a seventh person will be nominated.

For the Dublin Commission:—The Presidents of the three Colleges, the Most Rev. Dr. Walsh, Roman Catholic Archbishop of Dublin, the Lord Chief Baron, Sir John Rhys, Dr. Henry Jackson, Regius Professor of Greek in the University of Cambridge, the hon. member for Galway (Mr. Gwynn). The hon. member for Cambridge University (Mr. Butcher), whose assistance was hoped for, is unable to undertake the duties. One or more additional members will probably be asked to serve.

Royal College of Surgeons.—Annual Election to the Council.

The forthcoming election to the council of the Royal College of Surgeons will take place at the college between the hours of three and five on July 2nd. The retiring members of coucil this year are Mr. Pearce Gould, Mr. Ward Cousins, and Mr. W. Harrison Cripps. Mr. F. Howard Marsh has also resigned his seat on the council. There will thus be four vacancies to be filled. It is understood that Mr. J. Ward Cousins will not offer himself for re-election. The following is the final and full list of candidates:—Mr. Pearce Gould and Mr. Harrison Cripps (who offer themselves for re-election), Mr. George Eastes, Mr. W. Arbuthnot Lane, Mr. Bilton Pollard, Mr. C. B. Lockwood, Mr. G. F. Haslam (Birmingham), and Mr. J. Lynn Thomas (Cardiff). Voting papers will be sent by post to all Fellows of the College on the 19th instant, whose addresses in the United Kingdom are registered at the college, and Fellows are not required to apply for them.

Northampton Consumptive Sanatorium.

The well-known Northampton firm of Messrs. C. and E. Lewis have already subscribed over £400 towards the Building Fund of the County Consumptive Sanatorium, and now they promise a further £300 upon the following conditions:—£100 provided four similar sums are collected, a further £100 on the same conditions; £50 provided that four more £50 are subscribed; and another £50 on the same conditions.

This announcement was made by Mr. James Lewis at the monthly meeting of the Sanatorium Committee on Thursday, and the offer was very gratefully accepted. There has been a great revival of interest in the scheme, and Messrs. Lewis feel that in order to secure a large measure of support building operations should be commenced as soon as possible. Up to the present about £3,100 has been raised, and that another £3,000 is required before the work in all probability is commenced, because the committee does not wish the institution to be saddled with a mortgage.

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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O. E. CLUB TRIENNIAL DINNER AT EPSOM.

To the Editor of The Medical Press and Circular.

Sir,—According to the minute made at the Annual Meeting, December, 1907, it has been arranged to hold the Triennial Dinner of the Club at Epsom College, on Tuesday, July 7th. The cricket match against Surrey Club and Ground will be in progress. The Head-master and Mrs. Smith Pearce have asked us to tea, about 4.30. The Council will entertain us to dinner at 7 p.m. Chapel is at 8.45. There are trains back to Waterloo at 9.36, and to Victoria and London Bridge at 9.25.

Owing to the accommodation, the number of those dining must be limited to 50. All members intending to dine must send me notice before *Thursday, June 25th*. If the number of those desirous of dining exceeds 50, a ballot must be held; in which case, notice of the result will be sent to all who have signified their desire to come.

I am, Sir, yours truly,
Edred M. Corner,
Hon. Sec.

37, Harley Street, W.

K. (College of Surgeons).—A private letter has been sent to you.

Meetings of the Societies, Lectures, &c.

Wednesday, June 10th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. L. Mummery: Clinique (Surgical). 5.15 p.m.: Lecture:—Dr. H. French: Points in connection with Intercurrent Medical Illnesses during Pregnancy.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—Clinics:—2.30 p.m.: Medical Out-patient: Dr. Whipham. Skin: Dr. Meachen. Eye: Mr. Brooks.

Thursday, June 11th.

Royal Society of Medicine (Obstetrical and Gynæcological Section) (20, Hanover Square, W.).—7.45 p.m.: Specimens:—Mr. J. D. Malcolm: (1) A Uterus with Cancer of the Cervix removed by Wertheim's method; (2) A Cystic Ovary and Hydro-salpinx removed from a woman, æt. 58. Dr. T. W. Eden: A Case of Bilateral Papillary Carcinoma of the Ovary. Dr. Cuthbert Lockyer: (1) Sarcoma of the Uterus; (2) Tubal Gestation with Unusual Pathological Features. Dr. F. McCann: (1) Grape-like Sarcoma of the Cervix; (2) Bilateral Tuberculous Salpingitis. Short Communications:—Dr. Kedarnath Das: Gastroschisis. Papers:—Dr. J. H. Teacher: The Embedding and Development of a very Young Human Ovum. Dr. J. W. Munro-Kerr: Clinical History and Microscopical Description of an Early Ovarian Pregnancy.

Ophthalmological Society of the United Kingdom (11, Chandos Street, Cavendish Square, W.).—8 p.m.: Mr. Lawford, Mr. Winfield-Roll, and others: Card Cases. 8.30 p.m.: Mr. P. E. H Adams: An Epidemic of Contagious Conjunctivitis due to the Pneumococcus. Mr. E. Nettleship: (1) Senile Cataract in Husband and Wife, Condition of Lenses in Children and Grandchildren; (2) Lamellar Cataract, Discoid ("Coppock") Cataract and Retinitis Pigmentosa in the same Family; (3) A Colour-blind Family. Lieut-Col. H. Herbert: (1) Lower Corneal Plaques; (2) A Factor in the Production of Parenchymatous Xerosis.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.:—Mr. Hutchinson: Clinique (Surgical). 5.15 p.m.: Lecture:—Prof. T. Hewlett: The Diagnosis of Syphilis, etc., by the Antigen Method.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Special Demonstration of Gynæcological Operations: Dr. Giles. Clinics:—Medical Out-patient: Dr. Whiting. Surgical: Mr. Carson. X-Rays. 3 p.m.: Medical In-patient: Dr. Chappel. 4.30 p.m.: Throat Operations: Mr Carson.

Friday, June 12th.

Royal Society of Medicine (Laryngological Section) (20, Hanover Square, W.).—5 p.m. Cases and Specimens:—Dr. Watson Williams: (1) A Case of Malignant Growth of the Septum and Naso-pharynx removed by an External Osteoplastic Operation; (2) A Case of Laryngeal Disease for Diagnosis; (3) Skiagrams of the Accessory Sinuses. Dr. Herbert Tilley: (1) Specimen of a Large Post-Nasal Polypus removed from a boy, æt. 14; (2) Spectroscope Slide showing well-marked development of the Orbito-ethmoidal cells; (3) A Case of Subglottic Hyperplasia with considerable Narrowing of the Tracheal Air-way. Mr. Clayton Fox: A Case of Paralysis of the Right Vocal Cord in a Man with Myopathia. Mr. S. V. Cargill, Mr. William Turner, Dr. St. Clair Thomson: Orbital Cellulitis, Abscess of Left Frontal Cerebral Lobe, consequent on Acute Left Frontal Sinusitis; Operation; Cure. Dr. St. Clair Thomson: (1) Radiographs of the Sphenoidal Sinus; (2) Cases of Submucous Resection of the Nasal Septum. Mr. Stuart-Low: A Case after Operation for Angina Ludovici. Dr. Dan McKenzie: A Case of Malignant Disease of the Larynx. Dr. Jobson Horne: Preparations demonstrating the Exhibitor's Explanation of the Characteristic Appearances of Pachydermia Laryngis.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.:—Mr. R. Lake: Clinique (Ear).

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinic:—Surgical Out-patient: Mr. J. H. Evans. 2.30 p.m.: Surgical Operations: Mr. Edmunds. Clinics:—Medical Out-patient: Dr. Auld; Eye: Mr. Brooks. 3 p.m.: Medical In-patient: Dr. R. M. Leslie.

Vacancies.

Borough of Crewe.—Medical Officer of Health. Salary £230 per annum. Applications to Frederick Cooke, Town Clerk, Municipal Offices, Crewe.

Kent County Asylum, Maidstone.—Fourth Assistant Medical Officer. Salary £175 per annum, with furnished quarters, attendance, coal, gas, garden produce, milk, and washing. Applications to the Medical Superintendent.

City of Chester.—Assistant Medical Officer of Health. Salary £250 per annum. Applications to J. H. Dickson, Town Clerk, Town Hall, Chester.

Bucks County Lunatic Asylum.—Senior Assistant Medical Officer. Salary £175 per annum, with board and furnished apartments. Applications to Wm. Crouch, Clerk to the Visiting Committee, County Hall, Aylesbury

Lord Mayor Treloar Cripples' Home and College, Alton, Hants.—Resident Medical Officer. Salary £150 per annum. Applications to Sir William Treloar, 122-3 Mansion House Chambers, E.C.

County Borough of Salford.—Assistant Medical Officer. Salary £350 per annum. Applications to L. C. Evans, Town Clerk, Town Hall, Salford.

Appointments.

Campbell, Janet M., M.D., B.S.Lond., Member of the Medical Department of the Board of Education.

Farquharson, David A., M.B., F.F.P.S.Glasg., to the Chair of Physiology in the Royal (Dick) Veterinary College, Edinburgh.

Gardiner, Peter, M.D., C.M.Glasg., D.P.H.Lond., Medical Officer to the Camborne (Cornwall) Nursing Association.

Hawker, George Poole David, M.B., B.C.Cantab., Medical Officer to the Exeter Dispensary.

Jones, F. Emrys, L.M.S.S.A., Resident Pathologist at the Birmingham General Hospital.

Leighton, G. R., M.D.Edin., F.R.S.E., Professor of Pathology and Bacteriology at the Royal (Dick) Veterinary College, Edinburgh.

Ramsay, Jeffrey, M.B., B.S.Lond., Junior House Surgeon at the Blackburn and East Lancashire Infirmary.

Stewart, A. H., M.B., M.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Queensbury District of the County of York.

Thomas, Josiah Telfer, L.R.C.P.Lond., M.R.C.S., Medical Officer to the Camborne (Cornwall) Nursing Association.

Walker, Cyril H., M.B.Cantab., F.R.C.S.Eng., Additional Lecturer on Ophthalmology in the Faculty of Medicine of University College, Bristol.

Wright, J. A., M.D.Cantab., Clinical Assistant to the Chelsea Hospital for Women.

Births.

Sandford.—On June 6th at 1, Collingwood Villas, Devonport, the wife of George C. Sandford, M.D., of a daughter.

Marriages.

Dobson—Anderson.—On June 4th, at St. Mary Abbotts, Kensington, William Greswell Dobson, ,Barrister-at-Law, eldest son of W. Dobson, of Plymouth, to Ella Kingdon, youngest daughter of Izett Anderson, M.D.Edin., of 22, Arundel Gardens, London.

Somerville—Ekin.—On June 6th, at St. Andrew's Church, Westminster, D. Gerald, only son of the late A. T. Somerville, Esq., F.R.C.S.E., Edinburgh, to Dora Wentworth, elder daughter of Mrs. Ekin, Brighton.

Deaths.

Nuttall.—On June 4th, at San Francisco, California, John Robert Kennedy Nuttall, eldest son of the late Robert Kennedy Nuttall, M.D., and brother of Professor George H. Falkiner Nuttall, F.R.S., aged 53.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JUNE 17, 1908. No. 25.

NOTES AND COMMENTS.

Bag or Body?

THE man, "Bertram Mortimer," whose doings have already been commented on in these columns, and who has come to be known as the "Gold Dust" specialist, was convicted recently of stealing a Gladstone bag at Victoria Station, and sentenced to fifteen months' imprisonment in the second division. The fact that this crime was the only one pushed home is interesting, for he was committed for trial on two other counts of obtaining money by false pretences by posing as a medical specialist. The revelations made in evidence at the police courts, if they had been credited by a jury at the Assizes, would have established crimes of a far more cruel nature than that for which he was ultimately brought to book. To have a travelling bag stolen is an inconvenience, but to have the bodily health played with by a swindler is disaster of the first magnitude. Nevertheless, the Treasury carried the former crime to conviction, and apparently have dropped the others. The old-fashioned notion of the heinousness of crime against property is still very strong in legal circles.

Increased Sentence.

MORTIMER'S sentence produced an appeal under the New Act, and is notable for being the first case in which the Court adopted the plan of increasing the sentence awarded by the judge in the lower court. This very wholesome precedent is one that we hope will be largely followed, as it will deter scoundrels from trying to get off more lightly by appealing against their conviction, without impairing the value of the Court to wrongly-convicted persons. The Lord Chief Justice remarked that the prisoner had been sentenced in the first place to fifteen months' hard labour, but that this was subsequently reduced to fifteen months' imprisonment in the second division. Personally, he did not see why the sentence should be reduced, and Mr. Justice Phillimore remembering having tried Mortimer before, they agreed that the sentence should be altered back to fifteen months' hard labour. This incident served to illustrate the character of the men who go in for the quack business. They are protected in the lowest and meanest form of swindling by the anomalies of the law, which visits severe punishment on them when they commit such trivial crimes as stealing a bag, and they are supported by a considerable amount of public sympathy and not a little newspaper eloquence. To set up as a healer without having the necessary endowment in the shape of training is *primâ facie* evidence of swindling; it is more, it is definite evidence, for it is not possible for people so circumstanced to understand the nature of illness nor the efficacy of treatment in diseased conditions. The swindle is as great as if a man who knew nothing about electricity obtained money for promising to set up an installation.

Hospital Officers and Compensation Cases.

THE trouble we apprehended—not that a great amount of foresight was need for the prediction—in connection with medical evidence under the Workmen's Compensation Act is considerable, especially as regards hospital residents. With every desire to see justice done, and with every sympathy with injured workmen, we cannot but feel that it is not the duty of house surgeons and honorary medical officers who give their services to charitable institutions, to be called upon to absent themselves from their routine work to hang about county courts in these cases. Hospital work must go on, and there is always as much to be done as the officials can possibly do. Moreover, injured workmen, especially if their applications are unsuccessful, are not in a position to pay for expert medical evidence, and it is most unfair that medical men should be summoned to give evidence for inadequate fees or no fees at all, when their expert knowledge and their time is their stock-in-trade. The position is one that will have to be faced some time or another. At present the usual method adopted by solicitors is to summon the doctor as a common witness, and when he is in the box to ply him with expert questions. If a doctor is summoned as a common witness, he must attend, but if as an expert, of course he can demand his proper fee before doing so.

A Way They Have at the Bar.

A MOST disagreeable incident happened at the Shoreditch County Court the other day, and was reported in many of the daily papers. A medical man from an ophthalmic hospital was summoned to give evidence in an arbitration of a workmen's compensation case, and when called on to give evidence he informed the judge that he had been treated with very scant courtesy; that he had prepared a statement, but that if he was to be asked expert questions he was entitled to a fee before going into the box. Thereupon counsel, who was doubtless sure of his own remuneration, turned sharply upon him and informed the medical man that his attitude was scandalous, adding the unfair stroke, "The complaints continually made about hospital doctors by poor people appear to be well founded." The doctor thereat left the court, the judge not making any comment. Insult of this kind is intolerable. The more the medical profession does for nothing, the more is demanded from it. A way out of the difficulty must be found, and that way, as we have said before, is for the trades unions to employ their own medical officers and pay them adequately. Members of the unions could then get medical support in genuine cases, and the proportion of the fee they would pay would be inconsiderable.

Welsh Medical School. After all that has been going forward in the domain of Welsh education, especially as regards the University of Wales, it is not surprising that Cardiff is looking forward to the early establishment of a complete medical school in its midst. The recent visit of Professor Osler to the Infirmary of that town has stimulated interest in the project, and from what is being said it appears that only questions of ways and means stand in the way. When Cardiff was made a centre for scientific and intermediate medical studies, and the Welsh student arrested there before migrating to London hospitals, the spirit of national emulation was naturally roused. To this the only logical outcome was a demand for a fully equipped medical department. The necessary authority to grant medical degrees has been obtained, and doubtless we shall soon see the school in working order. The greatest practical difficulties at the moment is the necessary endowment for the more purely scientific chairs, the occupants of which could not practise their profession, but in so prosperous a place as South Wales, and with so many philanthropic Welshmen of large means this need not prove a grave hitch.

LEADING ARTICLES.

CAN THE LORD CHANCELLOR REFRAIN?

We make no apology for returning to the subject of Mr. Troutbeck and the recent inquest, to which we referred briefly last week, because now that the full facts are before the public, together with the comments of the people chiefly concerned, a state of things dangerous in the highest degree to the public interest is revealed. We will go further and say that a scandal pertaining to the administration of justice,—greater and more insidious than any we remember,—is suggested by these recent events. The facts may be briefly recalled. A lady living near Wandsworth Common had been for three years under the care of Dr. Biggs, one of the oldest practitioners in South-West London, a man universally admired, respected, and trusted by the public and his colleagues. As the symptoms in this lady's case developed, she was taken by Dr. Biggs to different leaders of the profession for consultation. Eventually, a diagnosis of cerebellar tumour was made, and the alternative of blindness and death, or of possible relief by a dangerous operation, placed faithfully before her and her relations. The latter course was decided upon, and after a searching clinical examination by Sir Victor Horsley, she was operated upon by him in one of the paying wards of the Bolingbroke Hospital. A tumour was found and scraped out, the false capsule and its attachments of course being left behind. Three days later, as so frequently happens in cerebellar disease, death occurred suddenly. The relatives, who felt nothing but gratitude to Sir Victor Horsley, Dr. Biggs, and the other medical men concerned, made their arrangements for the funeral, and a certain day was fixed. Suddenly like a thunderbolt came an order from Mr. Troutbeck for an inquest on that very day. Following this coroner's usual practice Dr. Biggs was not called, and Dr. Freyberger was put on to do the *post-mortem* and give evidence. Sir Victor Horsley protested at the inquest that the inquiry was perfectly unnecessary, Mr. Troutbeck replying that the public as represented by the coroner should be informed as to the cause of deaths following operations, and that he intended to inquire into such deaths. Dr. Freyberger made a gross blunder, asserting that he had found a tumour not removed by the operation—the tumour being merely blood-clot which had collected in the false capsule, and Mr. Troutbeck directed the jury to return a verdict, not of "Natural Death," as indicated by Sir Victor Horsley's evidence, but of "Accidental Death." Sir Victor Horsley went home and wrote to the *Times*, and was replied to by Mr. Troutbeck, other gentlemen taking part in the controversy. Various allegations and counter-allegations were made, and the editor, as the result of the controversy, in a leading article discussed the position taken up by Mr. Troutbeck, finishing with the words of Dr. McManus, who had contributed a letter, "Surely it is high time for the Lord Chancellor to intervene."

Lord Loreburn has proved himself to be a man possessed not only of great ability and a high sense of public duty, but of reforming zeal where abuses which he can control occur in the sphere of his jurisdiction. We appeal to him to consider if it is not urgently necessary to hold an inquiry into Mr. Troutbeck's public acts as coroner. The points to which we submit inquiry should be directed are as follows: (1) Is Mr. Troutbeck by temper and temperament fitted for a judicial position? It is publicly asserted by leading practitioners in South-West London that he is actuated by animus against the medical profession. It is plain he is obstinate, but he is actuated merely by wrong-headedness or by motives improper in a man holding his office? (2) Why did Mr. Troutbeck single out the particular case cited above as one in which to start a new policy, namely, that of holding inquests on all patients who die after operation? Mr. Troutbeck has been a full coroner for five or six years. Many deaths after operation have occurred in his district during that time: he says himself that fourteen have occurred this year at the Bolingbroke Hospital. Why did he select the fifteenth as the one for the first inquiry? We have no special knowledge, but we presume that the case under notice is probably the first and only time that Sir Victor Horsley has had a patient in the Bolingbroke Hospital, or, at any rate, the only time he has had a death after operation there. Sir Victor Horsley was the protagonist in the impeachment of Mr. Troutbeck before the late Lord Chancellor in 1904. Was it merely a coincidence that he should have been the surgeon who first came under the rule, or were there other motives? The latter has been publicly suggested ,and if correct the matter is of the utmost gravity. (3) Why does Mr. Troutbeck always employ Dr. Freyberger, who lives in North-West London, to do post-mortems and give evidence at inquests in the South-West? The seven other London coroners found it necessary to call in special pathologists in forty-six cases in the two years 1903 to 1905. whereas Mr. Troutbeck called Dr. Freyberger in 816 times during the same period? Instances of miscarriage of justice are freely alleged, owing to the system, and Dr. Freyberger's attainments as a pathologist are called freely into question. We say that matters having got to this pass, the restoration of public confidence in the administration of the South-West London Coroner's Court can only be restored by a judicial inquiry by the Lord Chancellor, or some independent tribunal appointed by him, and we appeal to him to take the matter into his serious consideration. No other avenue is open except that of personal appeal to him. His predecessor expressed disapproval of Mr. Troutbeck's methods, and since then they have been developed in new or alarming directions. Indeed, we cannot see how Lord Loreburn, consistent with the respect due to his high office, can any longer refrain, and we believe that he will not allow matters to drift on now that his attention has been specifically directed to them.

CURRENT TOPICS.

The Council Election at the Royal College of Surgeons, England.

The time having expired for the nomination of candidates for election to the vacancies on the Council of the Royal College of Surgeons, we are now enabled to publish the full list of those who will compete for the suffrages of the Fellows. The retiring Councillors are Mr. Pearce Gould and Mr. Harrison Cripps—the former, of the Middlesex Hospital, the latter, of St. Bartholomew's Hospital will seek re-election, while the names of the other candidates, in alphabetical order—seniority is not an element of much concern in these elections—are Mr. George Eastes (date of Fellowship, 1868), Mr. W. F. Haslam (1881), Mr. Arbuthnot Lane (1882), Mr. C. B. Lockwood (1881), Mr. Bilton Pollard (1881), and Mr. Lynn Thomas, C.B., J.P. (1892). Thus it will be seen that for the four vacancies declared there will be eight candidates, all but two of whom, namely, Messrs. Haslam and Lynn Thomas, belonging to the metropolitan district. Particularising the new candidates, Mr. George Eastes is presenting himself in the interests of the Fellows of the College who are in general practice, and we hope he will be warmly supported on that ground. Hitherto the occasion has been a very exceptional one on which a representative of the general body of the profession has been elected to the Council. The last election of the kind was that of the late Mr. Septimus Sibley, who was a member of the Council between the years 1886-1891. Mr. W. F. Haslam is the well-known Birmingham surgeon, who, as a representative of the provincial Fellows, should secure a large measure of support. Mr. Arbuthnot Lane, of Guy's Hospital, will appeal to a large constituency of Guy's Fellows, as a prominent metropolitan surgeon; and the same may be said of Mr. C. B. Lockwood, whose connection with St. Bartholomew's Hospital will doubtless secure him many votes. Mr. Bilton Pollard, of University College Hospital, is another Metropolitan surgeon, who also undoubtedly will command a large following. There is also Mr. Lynn Thomas, C.B., J.P., the well-known surgeon of Cardiff, for whom the profession has recently felt a good deal of sympathy in the result of the unfortunate trial in which he was involved at the High Court. This sympathy and the fact that he is a representative of the Provincial Fellows, should tell greatly in his favour at the coming election. The result of the poll will be looked forward to with some interest, owing to the large number of candidates competing. It will not, however, be attended with any political significance, inasmuch, since the Association of Fellows suspended their work, no questions of policy directly affecting the Fellows has disturbed the even tenor of the Council's deliberations. This being the case, therefore, the suffrages of the Fellows in these elections are now chiefly disposed of in favour of the various candidates upon private grounds and considerations of friendship. The election will take place in the library of the Royal College of Surgeons, Lincoln's Inn Fields, on Thursday, July 2nd, previously to which every fellow of the College, whose address is known, will have received a voting paper for the purpose of recording his vote for transmission by post, instead of requiring him to attend personally at the College.

The Prevention of Puerperal Mortality.

The President of the Irish Medical Association, Sir William Smyly, rendered a valuable service to the country at large when he called attention in his inaugural address to the present condition of midwifery practice. He showed that in spite of the fact "that the old type of medical practitioner and trained midwife, actively hostile, or aggressively scornful, with regard to antiseptic precautions, had passed away, and the modern practitioner and midwife were fully convinced of their value," "the mortality of childbirth was nearly double in private practice what it was in well-managed hospitals." The President further said that he considered the Midwives Act was a good one, and that its extension to Ireland would benefit poor lying-in women. There is no doubt that, in private obstetrical practice there is still not only room, but urgent need, for improvement. Much has been gained by the diffusion of the knowledge of antisepsis and asepsis, but on the other hand, the knowledge that they provide a comparative immunity from septic infection when strictly practised, has led perhaps to an undue freedom in performing obstetrical operations. Prevention is better than cure, and the avoidance of unnecessary vaginal manipulations and operations during labour is a far safer mode of avoiding infection than is the more or less perfunctory carrying out of aseptic precautions. Perhaps the best advice that can be given to the country practitioner or midwife on the conduct of labour cases is not to use the strictest aseptic and antiseptic precautions and to wear rubber gloves, but to manage their cases in such a manner that the patient would be safe even if they neglected both these precautions—that is to say, to avoid all intravaginal manipulations. Such a course is possible in every normal case of labour.

The Irish Universities' Bill.

The Irish Universities' Bill has been in a comparatively dormant condition during the past week owing to the Whitsuntide recess, and any public references to it have been, not in Committee, but at different public meetings which have been held through the country and in the columns of our lay contemporaries. One of the most interesting of the latter references is to be found in a letter from the Roman Catholic Bishop of Limerick, which appears in the *Freeman* of Saturday last. It has been very obvious up to the present that the Catholic Hierarchy have not, as a body, pronounced any opinion on the Bill. This omission is all the more noteworthy inasmuch as in the past they have been most prominent in keeping the condition of University education in Ireland before the public. The Bishop of Limerick's letter is therefore certain to attract attention, and, if it is to be taken as representing the opinions of his episcopal brethren, it may well make the Committee of the House of Commons consider whether all its labours are in vain. Its general gist may be judged from its last sentence:—" . . . It weighs very much on our minds that this University Bill, which, within the limits even of the Nonconformist conditions, might be made a tolerable useful measure, is, whether through the unavowed anti-clericalism of some of our politicians, or more political subserviency, being carried through in a shape which will doom it to failure."

The Dangers of Spiritism.

Father Bernard Vaughan has lately devoted one of his characteristic discourses to the subject of "Spiritism." He describes it as a growing evil, and gives his personal experiences—"convincing and distressing proof"—of the dangers to spiritual, moral and physical health which are incurred by many votaries of the fashionable cults of the day. It is too much to hope that Father Vaughan's warning will have any appreciable effect. It is astonishing that at this period of the twentieth century vast masses of the people of every rank should display a credulity as gross as that existing in the days of witchcraft and mediæval thaumaturgy. We are at the present day witnessing the apotheosis of the quack. No pretentions of the most blatant impostor fail of acceptance if only advertised and be-puffed with sufficient impudence and persistence; and no fanatic protagonist of a new religion remains long without a following if he possesses the strength and the means to proclaim his pretensions with enough noise and excitement. The game of curing disease by miracle-mongering engages the abilities of numbers of impostors, and there can be no doubt their practices in many cases lead to the results that Father Vaughan deplores. The emotional debauches which the cure by miracle provide for the neurotic and hysterical, and for the class who may be said to have made the first step towards the lunatic asylum, often lead those wretched sufferers to the terrible destination from which judicious treatment might have saved them; and with this fact most practitioners, and probably all specialists in mental disease, are nowadays too familiar. Much medical imposture, including that masquerading under the cloak of religion, might be put an end to by legislation. Perhaps this may be done some day when the whole story shall have been unfolded before our responsible statesmen.

Clumsy Milk Adulteration.

Since the introduction of the three per cent. standard for fat in milk, there has been some temptation to a small class of men engaged in the milk trade to add sufficient water to their milk to enable it just to scrape through the test. Should a farmer or milkman be desirous of knowing the amount of fat in his milk, he need not go to any considerable expense over the matter, as certain agricultural colleges will give him this datum for the very professional fee of sixpence. Far be it from us to suggest that such cheap analysis is abused in the manner indicated, we merely suggest that it might be. At all events, however, the amount of the milk fat is obtained, a simple rule of three sum, such as most highly educated people can worry out in time, will give the precise amount of water that can with safety be added. We will not waste time over a lament on the way in which the higher mathematics and analytical chemistry can be used for base purposes, but will pass on to the consoling reflection that the addition of water lowers the percentage of non-fatty solids in milk, and the composition of milk is such that the reduction of the fat to three per cent., has on occasion so reduced the amount of non-fatty solids, that despite the mathematical and analytical aid, the finer susceptibilities of the milkman have been pained to receive an intimation that his milk has been certified as adulterated by the public analyst. According to Mr. C. G. Moor, the Public Analyst for Dorset, a brilliant thought has struck a London milkman. The latter genius added to his milk a mixture of sugar and starch paste which had the effect of keeping up the non-fatty solids figure. Unfortunately for the sophisticator's ingenuity starch paste can readily be detected by the addition of iodine solution, and he must now find some less readily detectable substance for his purpose. In justice to the milk trade generally, we must admit that such clumsy adulterators are comparatively rare, and probably if cases of milk adulteration were traced home it would be found that a very large proportion of them are due to dishonest employees.

The Administration of Anæsthetics.

In our last issue we made reference to the administration of anæsthetics by persons who are not qualified medical men, and we are glad to find that the same subject was matter of discussion at the recent session of the General Medical Council. That body had previously taken the important step of recommending to the licensing bodies the inclusion of the art of administering anæsthetics among the subjects of instruction in the medical curriculum. We have to deplore the tendency to cram any more subjects into an already over-crowded curriculum, and while we regard instruction in anæsthetics as a necessity, we must wish that some of the more useless subjects of the course were dropped. At the recent session, in reply to a communication from the Medico-Legal Society the Council promised its support to any measure which would limit the administration of anæsthetics to qualified and registered practitioners

In the protection of the public some legislation to this effect seems necessary. At present anæsthetics are given with impunity by quack dentists or, what is almost more scandalous, by the mechanical assistants of qualified dentists. When a patient is killed, as not infrequently happens, the perpetrator of the crime is usually acquitted, the judge and jury accepting suborned statements of his experience as proof of his competence.

The British Dental Association.

The meeting of the British Dental Association held last week in Belfast was one of much interest, whether judged from the scientific or the social side. The importance of the care of the teeth to the health of the body is becoming more widely recognised day by day, both by physicians and by dentists. The physician knows that in many diseases he cannot hope to effect a cure until the mouth has been put into a hygienic condition. On the other hand, the dentist is no longer a mere mechanic, but has become a scientific worker, and he regards his art as part of the general art of surgery. Amid the other work of the meeting last week there was found for the public a lecture on "The Teeth of the People: A National Asset," delivered by Mr. Leonard Matheson. It was clearly shown to what a degree the health of the nation depends on the condition of the teeth, and the simpler prophylactic measures to prevent caries were detailed. Other papers of less general, though not smaller, interest were read in the general session, and so active were the discussions that several papers were crowded out through lack of time. On the social side there were many pleasant re-unions, including a party to the Giant's Causeway. Those who were present at the meeting will, we believe, carry away pleasant recollections of Belfast.

The Irish Medical Association.

The annual meeting of the Irish Medical Association, held last week in Dublin, was fairly well attended, and considerable business of importance was transacted. The report, however, showed a deplorable falling off in the membership. There were only eleven new members elected, whereas eighteen old members resigned, and thirteen died, showing a decrease of twenty in the membership. There are something like 2,500 medical men resident in Ireland, and of these only 726, a little more than a fourth, are reckoned as members of the Association. Moreover, of these 54 are two years' subscription and 104 one year's subscription in arrears. The true membership, therefore, can hardly be regarded as more than 650. It is necessary to ask for the reason of this, and for the great falling off during the past few years. Undoubtedly, on the one hand there is considerable apathy on the part of the rank and file of the profession as to any united action. On the other hand, we cannot acquit the present executive of mismanagement and carelessness which has contributed to this apathy. The organisation of the Association is obsolete, the expenditure has been injudicious, and all attempts at reform are blocked. Unless the Association seriously takes the matter in hand, and that speedily, we see nothing before it but gradual extinction.

PERSONAL.

Princess Louise Augusta, of Schleswig-Holstein, presided at the annual meeting of the supporters of Friedenheim Hospital (Home of Peace for the Dying), on Saturday last.

Mr. J. Rymer Young, of Warrington, has been re-elected President of the Pharmaceutical Society of Great Britain.

Princess Christian, attended by Mrs. Dick-Cunyngham, visited Caxton Hall, Westminster, and presided over the annual meeting of the Royal British Nurses' Association

The Executive Committee of the Council of University College. Bristol, have conferred the Associateship of the College on Philip G. Stock, M.R.C.S., L.R.C.P., D.P.H., Assistant Medical Officer of Health and Justice of the Peace, Johannesburg.

Sir William Whitla, M.D., LL.D., has consented to deliver the Cavendish Lecture before the West London Medico-Chirurgical Society on the evening of June 26th, in the Town Hall, Kensington. Subject: "The Ætiology of Phthisis." A *conversazione* and exhibition will follow the lecture.

The Committee of the Liverpool Royal Infirmary announce a gift of £10,000 from the executors of the late Mr. E. R. Bickersteth, their Senior Honorary Consulting surgeon. In accordance with the donor's wishes, the money is to be devoted towards the provision of an improved and extended out-patients' department.

Dr. Theodore Charles Mackenzie, Senior Assistant Physician, Royal Asylum, Aberdeen, has been appointed Medical Superintendent of the Inverness Asylum.

The Right Hon. Sydney Buxton, M.P., Postmaster-General, is to be the guest of the British Postal Medical Officers' Association at their annual banquet at the Hôtel Métropole on July 14th. Dr. George A. Mason, President of the Association, will be in the chair.

Mr. John Hayward will open a discussion on the recent memorandum of the Board of Education on the medical inspection of school children, at the annual general meeting of the Medical Officers of Schools Association in London to-morrow night.

Sir James Sawyer, M.D., F.R.C.P., will preside at the dinner at the Grand Hotel, Birmingham, on the evening of Saturday, June 20th, to celebrate the provincial meeting of the Society for the Study of Disease in Children, to be held in the city that day.

On the recommendation of the Secretary for Scotland, His Majesty has approved the following appointments:—Professor Samson Gemmell, M.D., Professor of Clinical Medicine in the University of Glasgow, to be Professor of Practice of Medicine in that University, in the place of the late Sir T. McCall Anderson; and Mr. Francis Mitchell Caird, Lecturer on Clinical Surgery in the Royal Infirmary, Edinburgh, to be Regius Professor of Clinical Surgery in the University of Edinburgh, in the place of the late Professor Annandale.

A CLINICAL LECTURE

ON

HOW TO DISTINGUISH THE DIFFERENT VARIETIES OF CHRONIC DEAFNESS.

By PROFESSOR ARISTIDE MALHERBE, M.D.,

Surgeon to the National Institute for Deaf Mutes, Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

IT is often of great advantage to the practitioner to be able to identify the principal ear diseases instead of contenting himself with a vague or merely symptomatic diagnosis. It is the same in respect of ear diseases as with diseases of other organs. A doctor who, when confronted with a case of tubo-tympanic catarrh, for instance, merely describes it as "deafness," is on a par with one who, in the presence of typhoid, diagnoses "fever." I propose in this lecture to explain how, by simple clinical examination, without the aid of any instruments save those that every practitioner almost of necessity possesses, among which the tuning fork must be included, it is possible to arrive at an exact diagnosis of chronic affections of the ears, the principal symptom whereof is diminution or loss of hearing.

In chronic maladies of the auditory apparatus there are a certain number of symptoms which are common to many of them, viz., deafness, noises in the ears, and vertigo. Deafness, or rather some diminution of the faculty of hearing, is, however, the most common, and is the first to attract attention. What we require to know is how and why the patient is deaf. The future of the patient's hearing depends on this diagnosis, and every practitioner can elucidate this point easily enough without being obliged to have recourse to the technical methods employed by specialists.

When we are consulted by a patient who comes complaining of not being able to hear, how are we going to determine what affection he is suffering from? Before any examination, just as in any other disease, we must question him. And what must we ask? There are two principal questions that must be put forthwith. The replies to these two questions will teach us at once whether or not we are dealing with an inflammatory affection. First of all we must ask him what he has been suffering from either at the time or previously, and under the term of suffering must be included noises in the ears, which may be very troublesome, although not strictly speaking of the nature of "suffering."

Next we must ask whether or not there is, or has been, any running from the ears. If the patient replies in the affirmative we know that we are dealing with an inflammatory affection of the ears. With that I do not propose to deal on this occasion. If, on the contrary, he replies in the negative, his affection is non-inflammatory. The next step is to diagnose the kind of deafness he is suffering from, and with this object in view we ask him whether the deafness is of long standing. If the deafness came on suddenly, more or less suddenly after a bath, after the introduction of a liquid into the ear, or from any other cause, the likelihood of an accumulation of wax will suggest itself, and this point can be cleared up at once by direct examination.

If the patient states that he is deaf, but not always to the same degree, that he sometimes hears better or worse than at others, we must proceed to investigate the state of the Eustachian tubes. We must make a careful examination of the thoat, looking out for evidence of rhino-pharyngeal catarrh, with or without secretion, or adenoid vegetations. We must also examine the nose to ascertain whether he has had repeated attacks of coryza, or hypertrophic or atrophic rhinitis, simple or multiple deviations of the septum, the turbinates, and other causes of permanent obstacle to nasal respiration. In these cases the lesions of the nasal mucosa are propagated to the Eustachian tubes very slowly, by recurrent attacks, but in the long run the result is certain.

Then we examine the tympanum by the aid of a speculum. It may be more or less depressed (concave), with the handle of the malleus raised and a salient external apophysis, all of which admit of recognition with a little attention. Depression of the tympanum is due—the Eustachian tube being obstructed—to the pressure of the column of air and also to adhesions in the tympanic cavity which fix the ossicles. The classic test introduced by Valsalva, blowing air into the ear by means of Politzer's bag, will confirm the diagnosis. (I purposely avoid mentioning catheterism of the tube, in spite of its practical importance, because it can only be employed by persons with considerable experience.) There are cases to which the term tubo-tympanitis my be applied, *i.e.*, affections in which the lesions are mostly located in the Eustachian tube and tympanum, such lesions being characterised by thickening and the formation of adventitious fibrous bands that hinder the free play of the ossicles, and may degenerate into sclerosis. These cases of tubo-tympanitis ultimately merge into secondary tympanic sclerosis, of catarrhal or infective origin, which spreads from the rhino-pharynx to the tympanic cavity *viâ* the Eustachian tubes. In their simplest form they constitute ***tubo-tympanic catarrh,*** while in the old-standing fibro-ankylosing variety we are dealing with ***hyperplastic otitis.***

Let us assume that we are dealing with a patient who presents no obstruction of the external auditory canal or Eustachian tube, who has been deaf for several years—ten years and upwards. He tells us that there are places where he hears better than in others—in the train or omnibus, for instance. This stamps it as a chronic affection of the tympanic cavity.

We must then ask our patient at what age he began to be hard of hearing. If he tells us that it was in early life, say, between 18 and 30 years of age, especially if the patient be a woman, we must question her closely as to her hereditary antecedents, and we shall often find out that her father or mother, brothers or sisters, have suffered from rheumatism or have died of tuberculosis. With respect to the patient himself, we may find that there have been attacks of pain in the fifth nerve, fugitive or persistent headaches, auditory hyperæsthesia, or there may have been pseudo-rheumatic manifestations (intercostal or sciatic pain, lesions of bone, scoliosis, etc.).

On examination, the tympanum, as a rule, presents little alteration, at most a little redness of the inner part of the tympanic cavity. The Eustachian tube is patent. What, then, is our patient suffering from? It is one of the commonest affections, one that was long confused with sclerous otitis, and which is known as early adhesive otitis. Its principal feature is true ankylosis of the stapes, a typical articular synostosis of the same kind as ankylosing tuberculous rheumatism.

Following up our inquiry, we find that the affection began with deafness and noises in the ears or, it may be, quite insidiously without any noises, and without any pain. In some cases these symptoms are accompanied by pseudo-rheumatic manifestations. The disease runs a more or less rapid course, there being periods of arrest, followed by sharp outbreaks associated with headache. The noises in the ears and the deafness then increase in intensity, and these recrudescences are specially apt to supervene at the menstrual periods, or during pregnancy. The process of ankylosis progresses little by little, the diminution of hearing becomes more pronounced, and the deafness affects both ears, though possibly in different degrees. These are the principal signs that enable us to identify this affection, so often overlooked.

Let us now take the case of a patient somewhat advanced in years. He complains of noises in the ears and deafness, or deafness only. In his hereditary antecedents we get a history of neuro-arthritism or arthritism, arterio-sclerosis or gout. On examination we find that the lesions are essentially of vascular origin, involving, so to speak, the whole ear, external, middle and internal. The external ear is often very flat, not much convoluted, parchment-like, angular, and with little in the way of a lobule. The external auditory canal is large and straight, and its walls are persistently dry. The tympanum is sometimes thickened, opaque, sometimes greyish and translucent. It may be infiltrated with calcareous salts and be remarkably rigid, while in other instances it is relaxed and thinned. Inside the cavity there are incrustations or calcareous deposits. The Eustachian tube is abnormally wide, owing to atrophy of the mucous membrane. This affection is almost always bilateral and runs a slow insidious course. In the long run it ends in sclerosis of the labyrinth when the panotitic process is complete and deafness is absolute. This variety, which we may call scleromatous otitis *ab origine,* to distinguish it from the preceding variety, is easy to identify by the signs just described. These two last forms of deafness—adhesive and scleromatous tympanitis—belong to the group of the tympano-labyrinthian affections, which are distinguished from tubo-tympanitis by the fact that the lesions, instead of spreading through the Eustachian tube, start within the ear itself, and involve at or about the same time the tympanic cavity and the labyrinth, whence their special gravity.

There is one other category of deaf people who do not present any of the symptoms previously described. These are cases of labyrinthian deafness. They can be distinguished by means of the tuning fork. If patients hear nothing when we apply the tuning fork to the skull the deafness must be due to some cerebral lesion (meningitis, tumour, etc.). If they still hear, but perception is almost abolished, this is a sign that the mischief is in the labyrinth. This is what used to be called "nervous otitis." An inquiry into the disturbances of which these patients complain will put us on the track. Moreover, in otitis of the labyrinth the noises in the ears are very loud and there is vertigo.

These, then, in synoptic form, are the principal signs that enable every practitioner who will take the trouble to identify the particular form of deafness from which a patient is suffering, and this, too, by means of the simplest possible clinical examination without any unusual skill or special instruments.

The synoptical table hereunder comprises the various forms of deafness just described:—

External Ear	**Auditory Canal**	**Wax**
		Foreign Bodies
Middle Ear	**Tubo-Tympanitis**	**Tubo-Tympanic Catarrh**
		Hyperplastic Otitis
	Tympano-Labyrinthitis	**Early Adhesive Tympanitis**
		Scleromatous Tympanitis *ab origine*
Internal Ear	**Labyrinthitis**	**Tumours**
		Syphilis
		Meningitis, &c.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Robert A. Fleming, M.A., M.D., F.R.C.P.Ed., Physician to the Edinburgh Royal Infirmary, Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School, Examiner in Medicine, Aberdeen University. Subject: "Sciatica."*

ORIGINAL PAPERS.

ON THE DANGERS AND TREATMENT OF MYOMA OF THE UTERUS.(a)

By CHRISTOPHER MARTIN, M.B.Edin., F.R.C.S.Eng.,
Surgeon to the Birmingham and Midland Hospital for Women.

LECTURE II.

In my first lecture I discussed the various dangers of myoma, and the complications that may arise. I also pointed out the slender hope there was of a natural cure, by extrusion of the growth per vaginam, by absorption after confinement, or by atrophy at the menopause. To-day I propose to direct your attention to the treatment of the disease.

We may divide the various remedial measures into the medical and the surgical. Let us first consider the medical (or non-surgical) methods of treatment.

I.—Non-Surgical Treatment.

If a patient has only a small myoma, which is not growing, not causing pain, severe hæmorrhage, or interference with her health or comfort, we are not justified in advising her to undergo an operation. The case should be watched, and the growth examined, at regular intervals, to see if it be really quiescent. A fibroid which is not actively growing, may yet vary in size from time to time, being larger and more vascular just before the period, and smaller after it. This is most noticeable in those cases where there is much menorrhagia. Hence, to ascertain if the tumour be really growing or not, it should be examined at the same time after each period—say one week after the cessation of menstruation.

Rest.—It is important that a patient, with a troublesome myoma, should rest as much as possible. During the period, she should stay absolutely in bed. If there be a tendency to flooding, the foot of the bed should be raised, from twelve to eighteen inches, on blocks. In the intervals between the periods, she must avoid all strain and fatigue. Any physical exercise, if at all violent, may bring on sudden and alarming bleeding. Hence dancing, horse-riding, and cycling must be forbidden. One of my myoma patients lived in the country and used to cycle a good deal. She found that, whilst walking never brought on hæmorrhage, cycling frequently did so; and, on one or two occasions, caused such a severe flooding that she fainted on the road, and had to be carried home.

(a) **Abstract of the Ingleby Lectures delivered at the University of Birmingham on May 7th and 14th, 1908.**

If the patient be married, she should be warned of the dangers of pregnancy. In these cases, I think it is our duty to tell the woman and her husband to take suitable measures to prevent conception. In all cases of polypus, in most sub-mucous, and in many interstitial fibroids, it will be found that sexual intercourse is apt to start hæmorrhage. In such cases, coitus must be forbidden.

Supporting the Uterus.—The patient should be forbidden to wear corsets, as they tend to press the tumour down into the pelvis. At the same time, by obstructing the abdominal veins, they keep up a condition of chronic venous congestion in the uterus, and so favour hæmorrhage. On the other hand, the wearing of a light abdominal belt is sometimes beneficial, especially where the tumour is subserous, of large size, and is pressing on the bladder, the pelvic veins and nerves. Here, a well-fitting belt may comfort her, by taking some of the weight of the tumour off these structures.

It is sometimes useful to support the uterus from below by means of a pessary—especially in those cases of small myomata which cause retroflexion and retention of urine. In such cases, the urine should be drawn off with a catheter, the patient placed in the genu-pectoral position, the impacted tumour pushed up out of the pelvis, and a large ring pessary adjusted.

Drugs.—The treatment of myoma by drugs is unsatisfactory, and resolves itself into the alleviation of symptoms. By far the most important of these is hæmorrhage.

Ergot is our chief remedy for the control of the bleeding; and, in many cases, is of great value. It excites the contractions of the uterine muscle, and, by pressing together the opposing surfaces of the mucosa, checks excessive bleeding. To some extent, it also acts by causing contractions of the small arterioles. I know of many cases, where patients have taken ergot in drachm doses thrice a day for years; and I have never seen it produce ergotism. Its use, however, is not free from objection. As Dr. Thomas Wilson has pointed out, when the heart muscle is degenerated, ergot is contra-indicated. It contracts the arterioles all over the body, and so increases the resistance to the left ventricle. The liquid preparations of ergot sometimes upset the digestion. In such cases, it will be found that ergotine, given in pill or tablet form, agrees better with the stomach. It may be given hypodermically; but there are many objections to this as a regular mode of administration. It is painful, and, if not given with aseptic precautions, may give rise to small abscesses at the seat of puncture. In emergencies, however, as when a patient is flooding severely and prompt action is necessary, a sterile preparation of ergot, given hypodermically, is of great value. But, beyond controlling the hæmorrhage, I doubt if ergot has any good effect on a myoma. The uterine contractions, which it excites, tend to convert an interstitial fibroid into either a subserous or submucous one. If the latter, whilst it is true that the growth becomes more accessible from the vagina, the tendency to flooding is increased. In any case, I think the prolonged use of ergot predisposes to degeneration and necrosis of the fibroid, by interfering with its blood supply.

Hydrastis is often prescribed with ergot in the form of tablets. It is an astringent to the uterine mucosa, and so helps to check the menorrhagia and leucorrhœa due to the endometritis so often present. As far as I know, it has no direct effect on a fibroid.

Cotarnine is a derivative of morphia, and, in the form of styptol, has been recommended in cases of myoma. I have tried it in several cases; but I cannot say I have seen much benefit result.

Calcium chloride has the property of increasing the coagulability of the blood, and in this way favours the natural arrest of hæmorrhage. It is thus undoubtedly of service in bleeding fibroids.

Bromide of potash, iodide of potash, and chlorate of potash have all been advised in myomata, but I doubt if any of them do real good. Lawson Tait, following Sir James Simpson's teaching, was in the habit of treating most cases of metritis, subinvolution, and small myomata with chlorate of potash combined with ergot. He claimed that it was a sedative to the uterus, and caused absorption of chronic inflammatory deposits. All the potassium salts are muscle-poisons, and tend to weaken the uterine contractions. But, for the same reason, they are also heart depressants; and, where the heart is failing, may do positive harm. Bromide of potash may be of service in allaying nervous irritability, and in promoting sleep. I have never seen any benefit result from the administration of iodide of potash, or indeed any of the preparations of iodine. I am sceptical, therefore, as to the virtues of the iodine and bromine waters of certain spas, such as Woodhall, Kreuznach, etc. Undoubtedly, many patients return benefited from a visit to such health resorts—especially if there was not much the matter when they went. The change of air and scene, the freedom from home worries, the mental and physical rest enjoyed, and the regulation of the patient's diet, bowels, and habits of life—to these factors we must give the credit of whatever improvement takes place.

Tonics.—When a patient is anæmic, weak and exhausted, it is customary to give her tonics, especially iron. Whilst iron picks the patient up, and stimulates the blood-forming organs, it may prove a dangerous remedy by exciting alarming hæmorrhage from the uterus. It often does far more harm than good. The organic preparations of iron—such as the peptonate—seem to be less hurtful than the inorganic metallic salts. In cases of profound exhaustion, it is safer to give strychnine, strophanthus, easily assimilated preparations of phosphorus, and, above all, the various preparations of hæmoglobin.

Laxatives.—A myomatous woman should keep her bowels well open, as constipation tends to increase congestion of the uterus, through scybala pressing on the ovarian veins. Straining at stool may bring on hæmorrhage from the uterus. Further, fibroids frequently cause piles from pressure on the rectum; and these, as a rule, are aggravated by constipation. Some mild laxative, such as cascara, sulphur, compound liquorice powder, or a saline aperient water, should be ordered.

Vaginal Plugging.—Plugging the uterus and vagina is of great help in controlling dangerous bleeding. It may tide a patient over a bad flooding, and allow her to gain some strength before undergoing an operation. When called to a patient collapsed, blanched, and nearly pulseless from uterine hæmorrhage, it is madness to attempt a big surgical operation such as hysterectomy. The best treatment is to put her on her side, pass a Sims speculum, and draw down the cervix with vulsella. If the cervix be found dilated, the uterine cavity should be firmly plugged with a long strip of iodoform gauze. The first few inches of gauze may be soaked, with advantage, in a solution of adrenaline. The rest of the vagina should then be firmly plugged with some antiseptic material, such as iodoform gauze, or dry boracic lint. A firm abdominal binder should be applied to exert counterpressure on the uterus. The plugging should be removed from the uterus and vagina every 48 hours, and fresh material re-applied. In this way the bleeding is controlled, and the patient given time to rally. Should the myoma be submucous (and these are the cases in which there is most bleeding), the gauze packing slowly dilates the cervix, and renders easy the subsequent removal of the growth.

It is most unwise to apply styptics, such as alum or perchloride of iron, to the interior of the uterus to check bleeding. They lead to the formation of hard clots, which, decomposing, cause sepsis, and precipitate the onset of necrosis.

Electrolysis.—There is a mystery—a glamour—about electrolysis, which allures patients who have a horror of the knife, and who grasp at any alternative which promises relief. As a means of treatment, it has been given a careful trial by scores of gynæcologists, and has now been abandoned as futile and dangerous. Vineberg analysed Keith's and Engelmann's statistics, and found that, out of 372 cases, there were 5 deaths and only 9 cures. Martin and Mackenrodt report 36 cases, of which 16 were distinctly made worse, and 3 died—one from pulmonary embolism, one from necrosis, and one from suppurative peritonitis. In some cases temporary benefit was obtained in the arrest of hæmorrhage from the congested endometrium. But when the treatment was stopped the symptoms returned. In other instances, especially where the electrode was thrust into the growth, acute necrosis of the tumour occurred, and endangered the patient's life. It seems to me just as rational to thrust a red-hot poker into the heart of a myoma and expect a cure to result.

II.—SURGICAL TREATMENT.

Bearing in mind the manifold dangers and complications that threaten the myomatous woman, the slender hope there is of a natural cure, and the inadequacy of non-surgical remedies, we are driven to look for help from surgery. I admit it is a choice of evils—no woman wishes to undergo an operation if she can be cured by milder measures. In the early days of abdominal surgery, the major operations for the removal of a fibroid resulted in such a frightful mortality that they were only undertaken as a *dernier ressort*. But now, thanks to a more perfect asepsis and an improved *technique*, modern surgeons can show such a low death-rate that, in the great majority of cases, a radical operation can be conscientiously advised.

Before discussing the merits and de-merits of the various operations for myoma, let me briefly state the indications for and against surgical interference.

Contra-Indications to Operation.—I would not advise an operation:—

(1) Where the tumour is smaller than an orange, is causing no symptoms, and is not growing.

(2) Where the patient is past the change of life, and the myoma is quiescent and causing no trouble.

(3) Where the patient is gravely ill from some other condition—such as phthisis, heart disease, or kidney disease—which will of itself prove fatal before long.

Indications for Operation.—On the other hand, an operation is called for:—

(1) Where there is severe bleeding, uncontrolled by rest and ergot.

(2) Where there is rapid or persistent growth of the tumour.

(3) Where there are signs of degeneration, necrosis, or malignant disease.

(4) In many cases complicated with pregnancy.

(5) In cases complicated with gross lesions of the ovaries and tubes.

(6) Where there are marked symptoms of pressure on the urinary organs.

(7) Where the tumour is very large, and from its great bulk and weight becomes a burden.

(8) In some single women where the tumour, from its size, leads to unfounded suspicions of pregnancy, and causes the patient much unhappiness.

(9) In cases of sterility due to the presence of a myoma, which can be removed without sacrificing the uterus.

No hard and fast rule can be laid down. Each case must be considered on its merits, and the question of operation decided only after due consideration of the condition of the tumour, its rate of growth, the gravity of the symptoms caused by it, and the state of the patient's general health.

The operations for myoma may be divided into: (1) those performed per vaginam; and (2) those that involve abdominal section. Let us first consider the vaginal operations.

Curetting.—Curetting should be performed, after the removal of a fibroid polypus or a submucous myoma, in order to cure the endometritis which generally accompanies these conditions. In some interstitial tumours, if done cautiously and aseptically, it may also do good by checking the leucorrhœa and menorrhagia, and so giving a feeble patient time to regain her strength. It is seldom, however, of more than temporary benefit, and is not without risk. If the tumour be submucous, it may cause necrosis by opening the capsule of the growth, and allowing germs to get access to its structure. Further, in cases complicated with pyosalpinx or ovarian abscess, curetting may be positively dangerous, by the manipulations causing the pus sac to burst into the peritoneum.

Removal of Polypi.—A fibroid polypus should be removed as soon as discovered. It is an easy and safe operation. In most cases, it is enough to seize it with vulsella and twist it off. If the growth be large and the pedicle broad and vascular, it is safer to control the bleeding with a ligature. I usually crush the pedicle with strong Spencer-Wells' forceps, and then tie a fine silk ligature in the groove left by the forceps. Occasionally a fibroid polypus is met with of colossal size, filling the pelvis, and lifting the uterus up into the abdomen. In such cases the growth must be cut away piecemeal, before the pedicle can be reached. Patients with fibroid polypi are often quite blanched from long continued hæmorrhage; but if there be no other complication, they make a rapid recovery.

Vaginal Myomectomy.—Vaginal myomectomy was first performed by Amussat in 1840. The *technique* was developed by Atlee, Emmet, and Thomas, and perfected in recent years by Pean and Doyen. It is the operation, par excellence, for the removal of submucous growth. These are usually, but not invariably, single. They cause very severe bleeding; and, if of large size, block the pelvis, and cause retention of urine. The uterine contractions tend to force the growth downwards, to dilate the cervix, and to convert the tumour into a fibroid polypus. During this process, there is a great risk of necrosis occurring. Hence every submucous tumour should be moved without delay. Where the cervix is dilated, it is usually easy to enucleate these growths, after the mucous membrane and thin remains of the capsule have been divided. If the cervix be insufficiently dilated, it may be split with scissors vertically in the middle line. The growth then becomes accessible, and may be removed either whole or piecemeal (morcellement). The cervical wound may then be closed with catgut, and the uterus preserved entire. It is an ideal method in sterile women anxious to have children; and it is the one always indicated in cases of necrosing submucous fibroids. It is, however, sometimes a long and difficult operation; and the patient may lose much blood before it is finished. It is usually unwise to attempt it, if the tumour be larger than the fœtal head at term. During the years 1892 to 1908, I find that, at the Birmingham Hospital for Women, the operation of vaginal myomectomy was performed in 34 cases, with 2 deaths—a mortality of 6 per cent.

Ligature of the Uterine Arteries.—This operation was introduced by Dr. Franklin Martin, of Chicago; but it has not found much favour in this country. The object is to cut off most of the blood supply of the uterus, to check the menorrhagia, and cause the tumour to atrophy. But there is such a free anastomosis between the uterine and ovarian arteries, that the latter rapidly enlarge; and soon the womb is as well supplied with blood as before. Moreover, a sudden and very marked decrease of the blood supply may cause necrosis of the growth. It is quite an easy operation. An incision is made in each lateral fornix, the enlarged uterine arteries are felt for, exposed, and tied with stout silk—taking care, of course, to avoid including the ureter. I have performed it in two cases, but without any benefit to the patients.

Vaginal Hysterectomy.—It is the best operation to perform in cases of small myomata—other than those which can be enucleated without sacrificing the uterus. It removes the whole of the disease; it does not involve an abdominal scar, and it is attended with but moderate risk to life. In my own practice, hospital and private, I have, up to date, performed the operation for myoma 73 times, with 3 deaths, a mortality of 4 per cent. It may be a dangerous operation when the uterus, with its myoma, is larger than a three months' pregnancy, if it be fixed by adhesions, if the case be complicated by pyosalpinx or ovarian abscess, or if the vagina be very narrow and rigid. In such cases, it is safer to open the abdomen, and remove the uterus from above.

Some years ago, I lost a case by not following these rules. The woman was exhausted by long continued hæmorrhages from a big submucous myoma. I split open the uterus, enucleated the growth piecemeal, and then removed the rest of the uterus by vaginal hysterectomy. The operation, which took about two hours, was a long, difficult and bloody one; and the patient never rallied from the shock. Had I opened her from above, and performed abdominal hysterectomy,, I feel sure I should have saved her.

Abdominal Operations for Myoma.—We now pass to the considerations of the more important abdominal operations for myoma. These fall under three headings:—

(1) Removal of the uterine appendages (where the ovaries and tubes are removed, but the uterus with the tumour is left behind).

(2) Hysterectomy (where the tumour, together with most or all of the uterus, is removed).

(3) Myomectomy (where the tumour is removed, but the entire uterus is saved).

Removal of the Uterine Appendages.—This operation was first performed by Lawson Tait in this city in 1872, and to the day of his death he was its leading exponent. It was, par excellence, "Tait's operation"; and, for nearly a quarter of a century, it held the field against all rivals. It was a fairly safe operation when the tumour was a small one; but a risky and unsatisfactory one when it was large. I find that, during the years 1882 to 1908, it was performed, at the Birmingham Hospital for Women, 300 times with 15 deaths—a mortality of 5 per cent. In my own practice, I have removed the appendages for small myomata 20 times with 1 death (a mortality of 5 per cent.), and for large myomata 8 times with 2 deaths (a mortality of 25 per cent.). I have not performed the operation myself since 1896. In about 90 per cent. of the cases that recovered, menstruation ceased, and the tumour shrank—though I doubt if it ever completely disappeared. But in the remaining 10 per cent. the patient was not cured, the floodings continued, the tumour grew, pressed on the bladder, rectum, and pelvic nerves, and rendered the patient's life a burden to her. Moreover, it was found that, even when the operation removed the symptoms due to the myoma, it often led to others, of a nervous character, equally distressing. Such were intense heats and flushes, palpitation, headaches, nervous depression, and pelvic neuralgia. Some of these patients became neurasthenic wrecks. These sequelæ were no doubt due to the sudden cessation of the internal secretion of the ovaries—something which they manufacture, and add to the blood circulating through them, and which is essential to the well-being of the nervous system.

It was these failures, and bad after-effects, that shook the faith of surgeons in the operation, and led them to search for some more excellent way. When it was found that, by improved methods, we could reduce the mortality of hysterectomy and myomectomy to under 5 per cent., the operation of removal of the appendages was abandoned. None the less should we honour Lawson Tait for his genius in devising this operation, and his courage in advocating it. It was, at the time, a great advance in gynæcology, and it saved thousands of lives that would otherwise have been sacrificed.

Extra-Peritoneal Hysterectomy.—The extra-peritoneal operation was that always performed by Lawson Tait in those cases in which it was impracticable to remove the uterine appendages. The uterus, with the tumour, was delivered through the abdominal wound, transfixed with steel pins as low down as possible, and strangulated, below the pins, with an iron wire drawn tight by means of the serrenœud or "clamp." In some cases, a rubber tourniquet replaced the wire. The tumour beyond the pins was then cut away, and the wound above it closed. The stump underwent acute necrosis, and in about a week became a black, gangrenous, horribly offensive mass. This sloughed off in from ten to twenty days, leaving a huge gaping septic chasm, which took many weeks to close. It was a murderous operation, and those who recovered did so only by the skin of their teeth. They had to run the gauntlet of secondary hæmorrhage, septicæmia, peritonitis, and rupture of the septic wound with extrusion of the bowels. The death-rate was terrible—so great indeed that, in the annual report of the Birmingham Hospital for Women for 1891, the medical staff announced that they had practically abandoned the operation.

On looking over the statistics of the hospital I find that, from 1879 to 1900, extra-peritoneal hysterectomy for myoma was performed 58 times with 20 deaths—a mortality of 34 per cent. In my own practice I have done the operation only 8 times with 2 deaths—a mortality of 25 per cent. My last case was in 1895, after which I adopted the intra-peritoneal method.

Intra-Peritoneal Hysterectomy.—Under this heading we include: (1) pan-hysterectomy, where the whole of the uterus, including the cervix, is removed; and (2) supra-vaginal hysterectomy, where the cervix is left behind. Both methods have their advocates. For some years I clung to pan-hysterectomy as the better operation. Increased experience, however, has convinced me that in most cases supra-vaginal hysterectomy is preferable. It is safer for the patient, and less difficult for the surgeon. The ureters and bladder are less in danger, the germ-laden vagina is not laid open to the peritoneum, and there is less interference with the integrity of the pelvic floor. The chief argument urged against supra-vaginal hysterectomy is that the cervix, which is left behind, may become the seat of cancer. But I do not think statistics support this objection. Therefore, contrary to what I taught in 1896, I now hold that, whenever possible, supra-vaginal hysterectomy should be performed in preference to pan-hysterectomy. The latter should be reserved for cases where the cervix is involved in the myoma, or otherwise diseased.

It is an easy operation, if the patient be thin, and the tumour be confined to the body of the uterus. It may be a very difficult one in a fat woman, or where the myoma has invaded the broad ligament, or developed in the cervix.

Whenever possible, one or both ovaries should be left behind, so as to preserve for the patient their "internal secretion." If one or both can be saved, removal of the uterus causes practically no climacteric disturbances, whilst if both be removed the patient suffers severely. Of course, if both ovaries be diseased, they must be taken away.

The after results of intra-peritoneal hysterectomy are excellent. The patient usually makes an uninterrupted recovery, and gets up, with a soundly healed wound, at the end of a fortnight.

The mortality of the operation is small. In my own practice, private as well as hospital, I have done 51 pan-hysterectomies for myoma, with 2 deaths—a mortality of 4 per cent. I have performed 142 supra-vaginal hysterectomies, with 3 deaths—a mortality of 2 per cent.

Abdominal Myomectomy.—By this we mean the removal of one or more myomata from the uterus by abdominal section, without removal of any part of the uterus. It was first performed by Atlee as long ago as 1844, but I believe this was only the removal of a pedunculated subserous fibroid. The modern operation (in which the tumours are enucleated from the substance of the womb, followed by suture of the uterine incisions and conservation of the whole organ), we owe chiefly to Martin of Berlin, Olshausen, and Kelly. It is the ideal operation for myoma, and will, I believe, ultimately supersede hysterectomy for all but a small minority of cases. It removes the tumour, and leaves the uterus intact. It causes no climacteric symptoms, and, most important of all, it does not sterilise the patient. It may, indeed, cure sterility by removing a tumour, which was preventing conception or interfering with pregnancy. It may be performed during pregnancy without necessarily interrupting the gestation, or adding to the risks of the subsequent labour. In 1891 I was called in to see a case by Dr. Langsford Clay. The patient was æt. 37, and three months pregnant. She had also two large fibroids which were causing great suffering. She had been married for many years without having been pregnant before, and she was very anxious to have a child. I opened her abdomen, made incisions over the tumours, shelled them out of the uterine wall, sewed up the incisions, and closed the wound. The patient made a good recovery. She did not abort, but went to term, and was safely delivered of a living boy.

Here I must draw to a close. Much has been accomplished, but more remains to be done. The end of the nineteenth century witnessed a great advance in gynæcology, notably in the treatment of myoma. In the coming years I look forward to still more glorious achievements by our brethren—those workers for humanity seen in the poet's vision—

> "Ever reaping something new:
> That which they have done but earnest of the things
> that they shall do."

ALCOHOLISM AND CRUELTY TO CHILDREN. (a)

By ROBERT J. PARR,

Director of the National Society for the Prevention of Cruelty to Children.

Amongst the many evils to be attributed to an excessive indulgence in intoxicating liquor, neglect of and cruelty to children is one of the most terrible in its effects. First in sapping the character of parents, whilst killing by slow and insiduous processes the protective instinct of parenthood; then in endangering the life and happiness of a host of children who are being surrounded with an environment corruptive and unhealthy in respect to their physical and moral upbringing; and equally serious as affecting the desires and habits of future generations, as shown by the recurring and increasing deterioration in families of children born to drink-sodden and partially demented parents.

These results are sufficiently grave to excite the careful attention of all intelligent and patriotic people. The man of business, the scientist, the true temperance reformer—all these are concerned, for the evil touches our public and natural life at every point. I have purposely excluded the politician, for he has his own ideas both as to the evil and to the remedy.

The National Society for the Prevention of Cruelty to Children has long since given over trying haphazard methods of reform, and has settled down to what may be described as the application of a scientific system of remedies that are fortunately proving effectual. During the year ended March 31st, 1908, the Society dealt with 46,212 cases reported to it, affecting 134,252 children. Of these cases, 39,867 were due to neglect, and the children neglected numbered 125,674.

There is no exaggeration in the estimate that 90 per cent. of those cases are due to the drinking habits of one or both parents. To all concerned in the treatment of inebriety, it will be encouraging to learn that reform is not only possible, but that it is frequently secured. The Society's records teem with illustrations where under the direct influence of good advice and some watching, parents have given up their habits of drinking, and have resumed normal conditions of life.

The chronic inebriate has also proved to be subject to reform. In England, Ireland and Wales, owing to the action of the Society, 358 inebriate mothers have been committed to detention in Inebriate Reformatories from January, 1901, to March, 1908. Rather more than half of these cases have been reformed. The proportion would have been larger but for the fact that many women were sent away for short periods. Nearly all the women detained were wives whose husbands were earning regular wages, the average ranging from 23s. to 35s. per week.

As in the other class of cases, much depends on the spirit in which the work of reform is undertaken. The personal element is all important as contrasted with the official. Speaking from an experience that justifies testimony, it may be said that though the evil is great, and the difficulties of dealing with it are many, there is boundless hope for ultimate success if only a sufficiently large number of people could be persuaded to give up the pleasure of theorising for the practice of personal help.

(a) Abstract of a Paper introductory to a Discussion before the Society for the Study of Inebriety, held in the Rooms of the Medical Society of London, Tuesday, June 16th, 1908.

CLINICAL RECORDS.

CASHEL UNION HOSPITAL.

SOME SURGICAL CASES UNDER THE CARE OF

THOMAS LAFFAN, M.R.C.P.I., M.R.C.S.Eng.,

Physician to the Hospital.

Case of Fracture of the Right Humerus.

This occurred in P. C., a boy, æt. 9, who was admitted to hospital in February. The fracture was simple, and was through the surgical neck. The point I wish to emphasise is that the splints, which were ordinary ones, were taken off on the tenth day, and passive motion employed. The splints were taken down and re-applied on each tenth day, and light passive motion used. The little patient was discharged on April 2nd with united bone and entire mobility of proximal joints.

Case of Intractable Neuralgia.

C. M., æt. 29, was admitted on January 15th. She had suffered for months from intolerable neuralgia near the outer half of the lower lid. Every possible medicine, both local and constitutional, was tried in vain. At last I resolved on cutting down on the nerves, and commenced with the temporo-facial, where it crosses the lower maxillary condyle, and excised a portion of the nerve. The result was most gratifying. The pain in great part disappeared, and though some remnant remained for a time, the patient was rendered comfortable, while after a little time it disappeared altogether.

Case of Impermeable Stricture.

The patient was æt. 50. It followed an attack of gonorrhœa which he had had many years before. The retention for which I was summoned to him in 1901 was the second of its kind. The other had occurred a few years before. No instrument could be passed, no matter how small. I then used the aspirateur, and emptied the bladder above the pubis. This was repeated at daily intervals for an entire week. At the end of this a delicate whalebone bougie was got into the bladder. Then a minute catheter was slipped in, and the patient in a short time had the stricture fully dilated by the gradual process, and was relieved of all further trouble. He remained well from this affection till his death, which occurred some three years afterwards from Bright's disease.

Excision of Enlarged Glands.

M. S., æt. 25, gardener, was admitted in March, 1904. A number of glands were enlarged on the right half of the neck in the parotid and adjacent portions of the sub-maxillary spaces, posterior superior and posterior inferior triangles, and that portion of the neck covered by the sterno-mastoid. A couple were as large as a hen's egg, and there were all manner of sizes from that downwards. The disease had existed for many months, and a variety of treatment had been tried prior to his coming under my care. On admission his condition was very feverish. On March 20th he was operated upon, and about half of the glands were removed. No untoward symptoms followed. The remainder were removed on May 4th, and the patient was discharged cured in June. I last saw him some twelve months after. In the interval he had been actively engaged in farm work, and he had enjoyed perfect health. On his visit to me his pulse and temperature were normal, and his health excellent. Three glands had enlarged to the size of peas, and, of course, these offered no guarantee against further enlargement. This is the chief drawback of these operations, but, on the other hand, the patients are saved from the exhaustive drain of prolonged suppuration. Even if other glands do enlarge, it seems to me that further operations can be employed without either risk or much ground for grumbling.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Impacted Stone in the Ureter.—Mr. **Arthur Edmunds** operated on a woman, æt. 35, who had been suffering for about 14 days from a swelling in her left loin. This swelling had been increasing steadily in size and had become tender on deep pressure. The accompanying symptoms were largely negative and yielded but little information as to the nature of the swelling. Thus there had been no definite frequency of micturition, no urgency, only once a little scalding, no hæmaturia. There had been, however, signs of severe septic intoxication with rigors, the temperature rising as high as 103° on several occasions. On examining the abdomen a movable swelling could be felt in the left lumbar region, extending upwards under the ribs and backwards towards the spine. The colon could be demonstrated in front of it. There was no rigidity of the abdominal muscles, and the tumour could be moved quite easily for a short distance in all directions. The right kidney was definitely palpable, but not tender, and only slightly more mobile than normal. Per vaginam the pelvic viscera were normal. The diagnosis, therefore, narrowed itself down to some enlargement of the left kidney, complicated by septic infection. The absence of any appreciable quantity of pus in the urine suggested the presence of an obstruction in the pelvis of the kidney, or in the ureter. Accordingly, the kidney was exposed through the ordinary lumbar incision, which was extended downwards into the iliac region; the kidney was brought up into the wound and examined. It was found to be about twice the normal size and extremely congested. On exposing the ureter the fat and connective tissue were found definitely infiltrated about an inch below the junction of the pelvis of the kidney and ureter, and here a definite hard nodule could be felt through the thickened peri-ureteral tissues. Gauze was next packed into the lower portion of the wound to prevent any displacement of this nodule, which was believed to be a stone, and to absorb any pus which might be discovered. The pelvis of the kidney was now opened through an incision about an inch and a half long just behind the convex border of the organ, and about a couple of ounces of purulent urine were let out. The pelvis of the kidney was then thoroughly explored to ascertain if there was any calculus, and an attempt was made to remove the ureteral stone *viâ* the pelvis of the kidney. This was found to be impossible, and accordingly the wound in the kidney was temporarily sutured to arrest hæmorrhage. The ureter was now exposed more fully, and the stone fixed by the finger and thumb of the left hand; a longitudinal incision was then made over the calculus, which was removed, and after the passage of a probe upwards and downwards along the course of the ureter demonstrating that there was no other obstruction the ureteric wound was sutured. The wound in the substance of the kidney was now re-opened to allow a drainage tube to be passed into its pelvis so as to carry off the urine for the first few days, and allow the incision in the ureter to heal. The kidney substance was then sutured firmly around the tube by mattrass sutures of catgut. A convenient instrument for passing such sutures, Mr. Edmunds said, in the neighbourhood of veins is the ordinary fully curved needle passed eye first, thus avoiding much of the hæmorrhage which is caused if the needle be employed in the usual way, the blind end displacing vessels which would otherwise be divided. Drainage tubes were then inserted into the cellular tissue around the kidney, and the incision in the abdominal parietes closed. Mr. Edmunds said that the diagnosis of a kidney tumour was fairly apparent, but it was not clear at first whether there was any perinephric suppuration or not. The absence, however, of any abdominal rigidity and the comparative mobility of the tumour negatived the idea of any such inflammatory mischief, and suggested that the whole of the trouble would be found within the kidney. It was generally worth while, he pointed out, to endeavour to close an incision in the ureter, for although leakage is common, final union is undoubtedly hastened, especially when the urine can be deviated from its normal track for a few days.

The patient bore the operation well, and for the first three days the urine which escaped from the kidney was caught in a vessel by the bedside. When this ceased the amount of urine passed by the urethra suddenly increased from 32 to 50 ounces, proving that the affected kidney was working well, and that there was no obstruction to the passage of the urine. Urotropine was given so as to render the urine as sterile as possible. The septic complications were trivial. The wound healed normally, and a fortnight after the operation the urinary fistula had completely closed, and there was only a slight discharge from the openings of the drainage tubes.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Meeting held Thursday, June 11th, 1908.

Mr. R. Marcus Gunn, F.R.C.S., President, in the Chair.

Mr. Priestley Smith showed a small instrument, consisting of a series of lenses arranged in a frame, for use with the shadow test. The feature of the apparatus was the close packing of the lenses, about 16 of them being contained in a linear foot, and it enabled very rapid examinations to be made.

Mr. Leslie Paton showed a case with connective tissue in front of the optic disc.

Mr. Edridge Green exhibited an improved lantern for testing colour-perception. There was an arrangement consisting of three slides in a vertical column, each slide being fitted with variously coloured glasses, which could be brought opposite an aperture with an iris diaphragm.

Mr. J. H. Tomlinson showed a Nernst lamp projecting lantern.

Mr. Sydney Stephenson showed a patient with a curious congenital anomaly of the iris.

Mr. G. W. Roll showed a patient with sky-blue sclerotics, and one with double papillitis.

Mr. Hudson showed a case of Thiersch grafting.

Mr. G. Coats showed a case of exudation in the retina.

Mr. P. E. H. **Adams** read a paper on

AN EPIDEMIC OF CONTAGIOUS CONJUNCTIVITIS DUE TO THE PNEUMOCOCCUS.

He said the epidemic occurred in the spring, in a small school of 37 boys, 21 of whom were attacked. The eldest boy affected was 14, the youngest nearly 10. All the smears taken, except one, showed numerous Gram-positive diplococci. Most of them were typically flame-shaped pneumococci with capsules, though a few of them were rounder in shape, and in some the capsules were not evident. This agreed with the description given by Schmidt ("Archiv. of Ophth.," XXXVII., No. 2) of smears taken from cases of pneumococcal conjunctivitis. On blood agar the colonies were typical slow-growing pneumococci, and there was no growth on agar. Only three of the cases were at all acute, most of them being subacute or quite mild. Four cases of relapse were reported. The condition found on examination was fairly constant: general congestion of the lower palpebral conjunctiva, with slight injection of the ocular conjunctiva, and in the acute cases a thin line of muco-pus in the folds of the conjunctiva of the lower lid. The upper lid showed slight enlargement of follicles at the angles, and a row of minute follicles along the everted edge. The whole epidemic lasted about five weeks, and spread in spite of isolation. It agreed in almost every respect with previously reported outbreaks, the chief difference being the generally mild nature of the cases.

Mr. **Nettleship** read notes of three cases of

HEREDITARY EYE DISEASES.

Case 1 was that of a husband and wife who had senile cataract at an advanced age, and both were operated on with success. They had ten children, and 7 had cataract in various degrees, 2 of these having had them "matured" and operated upon at a much earlier age than in their parents. There were also slight lenticular changes in the grandchildren of the original couple. The second family showed the occurrence of "Coppock," or discoid cataract, and lamellar cataracts of various sizes, and likewise of retinitis pigmentosa. Among about 250 persons the author had been able to trace, belonging to the family, 32 with family cataract, and 15 with retinitis pigmentosa. The sex incidence and mode of descent was shown to be different, for the cataract and retinal disease respectively. The third case was that of a family containing colour-blind individuals. Mr. Nettleship had examined all the available members; and of 33 males 14 were found to be colour-blind: and of 36 females only one was affected, and she slightly. There were 40 others in the pedigree who were either dead or inaccessible.

Lieut.-Col. H. **Herbert** read a note on

SECONDARY (PARENCHYMATOUS) XEROSIS.

He drew attention to the part played by pannus in the development of xerosis after trachoma, and pointed out that old pannus rendered the corneal surface insensitive. Hence, with both corneas covered with pannus, the blinking movements of the lids tended to be imperfect, and thus lead to exposure of the globe. This appeared to be an important factor in the dryness which followed: for in such cases xerosis of the cornea and conjunctiva was often very marked when the cicatricial degeneration of the conjunctiva was much less advanced than in other old trachomatous cases in which the eyes remained moist and the corneas clear. The exposure of the cornea rendered it more opaque and insensitive, so that the blinking movements might amount to only very infrequent and slight twitches of the lids. Similarly inactive lids were seen in India in a few cases of severe primary (epithelial) xerosis. In these cases the exposed cornea became not only opaque, but pigmented, like the degenerate conjunctiva. Here the primarily defective reflex action of the lids seemed to be attributable to malnutrition only. Another factor in the production of cicatricial xerosis was the reduced transudation of fluid from the palpebral conjunctiva. If the upper lid were everted in any case of ordinary acute conjunctivitis, a free flow of watery fluid was readily demonstrable from the exposed conjunctiva. But a similar flow was not obtainable from a cirrhosed or cicatricial conjunctiva, however much inflammation might be present.

Lieut.-Col. **Herbert** also read a paper on

LOWER CORNEAL PLAQUES.

These, he said, were slightly raised, feebly vascular, grey patches with rough surfaces, close to the lower margin of the cornea. Their opacity varied with their thickness. They were often of curious shapes, and were mostly multiple and binocular. They were not very uncommon in India, and appeared to be due to slightly defective closure of the lids, together with more or less chronic conjunctivitis, trachomatous or otherwise.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, JUNE 3RD, 1908.

The President, Dr. **James Ritchie**, in the Chair.

Mr. F. M. Caird showed:—(1) A boy, æt. 14, who had received a crush in the lumbar region causing hæmorrhage into the mesenteric sub-peritoneal tissue and kidney. Paresis of the bowel supervened, necessitating laparotomy and appendicostomy. (2) A patient, æt. 25, who was sent into hospital about 12 hours after rupture of a gastric ulcer. The ulcer was large, situated near the pylorus, and because it was found impossible to secure it very thoroughly, as well as because the operation involved some narrowing of the pylorus, it was deemed advisable to perform a gastrojejunostomy in addition. Until the third day all went well. Then the patient wakened up suddenly from his sleep with severe abdominal pain, and very rapidly passed into a condition of extreme collapse, with cold extremities and an enormously swollen abdomen. Laparotomy was at once performed, and a large volvulus of the ileum, with blackened bowel, was found. Over 10 ft. of intestine were resected, and the patient made a good recovery.

Mr. **Cathcart** showed a woman who was admitted to his ward on account of inability to open the jaws. There was a history that on two previous occasions—1901 and 1904—an operation had been performed to relieve the condition. The case was thought to be one of ankylosis, and injections of fibrolysin having proved ineffectual, operation was determined on. He proposed to remove a wedge from the right side, and possibly from the left. Under chloroform, however, he found that the jaw could easily be opened. A gag was therefore inserted, and the operation was not proceeded with. The patient could now open the jaws perfectly well. The case was looked upon as hysterical.

Dr. W. M. **Russell** read a paper on

CONGENITAL STENOSIS OF THE PYLORUS IN THE ADULT.

Reviewing the history of the subject, he enumerated the various causes of pyloric obstruction. Ulcer, cicatrix, and malignant disease were, of course, by far the most frequent. In many cases an element of spasm was added, and doubtless cases occurred in which there was pyloric spasm alone, apart from any organic narrowing. Lauder Brunton had drawn attention to a group of cases in which pyloric spasm was associated with, and formed one of the symptoms of, an attack of migraine. The chief symptoms of pyloric obstruction were dilatations of the stomach, ptosis of the organ, and in many cases peristaltic waves. If the latter were present it was proof that there was no atony of the stomach wall. An atonic condition was most likely to supervene either when there was a long-continued history of simple stricture, or in malignant cases of short duration associated with much wasting. In some cases a definite pyloric tumour could be felt, and in these the diagnosis of pyloric stenosis was obvious.

Congenital pyloric narrowing has not hitherto had any definite clinical position given to it, although it has been suggested that it may occur. The speaker's attention had been drawn to the subject through reading of the cases reported by Maylard, of Glasgow. Historically, the earliest references to the condition were in the papers published by Landerer in 1879, and

Maier in 1885. The former reported 10, and the latter 31 examples. In these cases there was simply a narrowing of the pylorus, and Maier differentiated two groups of cases—(1) the simple form, and (2) the combined form, in which there was an associated hypertrophy of the muscular coat. Of late years congenital hypertrophic stenosis of the pylorus in infants had aroused a great deal of attention, and its clinical symptoms, thanks to the number of papers on the subject which had been published, were now so well known as not to require mention, and, indeed, were so characteristic that it was a wonder the disease had passed so long unrecognised. He noted that there was little unanimity of opinion as to the treatment of this disease. Some physicians (*e.g.*, Pfaundler) thought operation to be unnecessary; others believed almost every case ought to be treated surgically. He thought those who had opportunities of seeing many infants ought to be on the look-out for a simple form of stenosis, as well as the hypertrophic type. At present there was no definite explanation of the occurrence of simple stenosis in the adult.

He read notes of three cases in adults which were believed to be of this nature; all had been dealt with surgically. An important point in the diagnosis was the history, which extended back into childhood. (Owing to the exigencies of time, Dr. Russell was compelled to greatly curtail the latter part of his communication.)

Mr. **CAIRD** said that the difficulty was to prove that such cases actually were congenital. The histories were not reliable as to the events of infancy unless they were obtained from the parents, as well as from the patients themselves.

Dr. **JOHN THOMSON** agreed with Mr. Caird, and stated that, although he had looked out for years for simple stenosis in infants he had never seen a case; this was also the experience of others.

Mr. **MAYLARD** believed that these cases did exist. He dwelt on the variability of the symptoms, and said they were often diagnosed as ulcer, etc., the true condition being only detected at the time of operation. Formerly he advocated gastrojejunostomy; now he considered pyloroplasty much better.

Dr. **DAWSON TURNER** read a paper on the

TREATMENT OF ANEURYSM BY ELECTROLYSIS.

One could not fail, he said, to be struck by the diversity of methods which had been recommended. Ciniselli inserted one electrode into the aneurysm and reversed the direction of the current every five minutes or so. The late Mr. John Duncan, who gave so much attention to electrolysis, inserted both poles, and latterly adopted the expedient of allowing the point of the positive pole to play against the wall of the aneurysm and cauterised it here and there. The negative pole caused a great deal of frothing, from the gas which was set free, the positive pole caused a firm coagulum of albumin. Moore and Corradi employed the positive pole, using electrodes of gold, platinum, silver, copper, zinc, etc., and passing a current of 50 m.a. for an hour. Dr. Turner then demonstrated the effects of electrodes of various metals on serum, by means of a projection lantern. In all cases the negative pole presented a very striking appearance by reason of the quantities of gas given off. The appearances at the positive pole varied much according to the metal used. With gold, silver, platinum, the serum appeared to undergo little change; when copper, and particularly zinc, was employed, a firm coagulum of albumin was quickly developed. Several conclusions were drawn from the experiments. In the first place, Dr. Turner thought that, as it was ordinarily practised, electrolysis was of very little value indeed. Secondly, apparently the fear of gas bubbles entering the circulation was nothing but a bogey. As carried out in many cases quantities of gas were set free, and apparently did no harm. Thirdly, the most efficient means of producing a coagulum was by using zinc as the positive pole. With the normal 50 m.a., for an hour only, 5 centigrammes of the metal were dissolved. A firm coagulum of albuminate of zinc was formed. It was probably most likely to do good when it was combined with the introduction of a coil of wire into the aneurysm. The wire so introduced might be zinc, and employed as a terminal. It would be very desirable to try and ascertain whether the albuminate of zinc so deposited favoured the formation of fibrin clot which was capable of organisation, and also to discover the action of the zinc electrode on whole blood, not serum.

Mr. **CAIRD** said that the surgical treatment of large aneurysms which were inoperable by the usual methods was extremely disheartening. He was not impressed by the benefits of electrolysis, and thought that much of the good was due to the scratching of the aneurysm walls by the electrodes, just as had been found by McEwen in using needles.

Dr. **J. S. FRASER** read a paper on "Chronic Inflammatory Œdema of the Submucous Tissue of the Nose." Instead of delivering his paper *in extenso*, he demonstrated a number of microscopic preparations of the turbinals. These specimens showed that chronic hypertrophy of the turbinals was due to œdema; in one specimen appearances suggestive of thrombosis of a vein were present, suggesting that this might be the cause of the œdema. A strong point was made of the similarity in structure of the œdematous tissue and the ordinary mucous polypus. The opinion was expressed that a polypus was nothing more than an exaggeration of the condition found in hypertrophy. When the hypertrophy affected the middle turbinal the œdematous tissue from the action of gravity came to hang down more and more and gradually formed a polypus. When the lower turbinal was affected the force of gravity did not come into play in the same way, the œdematous tissue rested on the floor of the nose, and consequently there was no polypus. Polypus was rare compared with hypertrophy; and it was never met with in children, in whom hypertrophy is so common. This, in Dr. Fraser's opinion, showed that a long period was needed for the development of a polypus.

Dr. **LOGAN TURNER** and the **PRESIDENT** discussed the communication.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MAY 29TH, 1908.

Sir A. V. MACAN, and subsequently the **PRESIDENT**, in the Chair.

TWO UTERI REMOVED FOR ADENO-CARCINOMA OF THE BODY.

Dr. **GIBSON** exhibited specimens as above. The first was from a young woman, æt. 26, who had been married for one year, and had not yet become pregnant. She only complained of irregular uterine hæmorrhage. The uterus was apparently quite normal, but examination of the curettings revealed adeno-carcinoma. In the second case the woman, æt. 42, had had three children. This patient, like the first, only complained of irregular hæmorrhage, but the case was more marked than the first, as she had an enlarged uterus. The diagnosis was made from the curettings. Except for the attacks of hæmorrhage every two or three weeks, both women were in apparently perfect health. He brought the specimens forward as showing the importance of curetting in all such cases, and of the absolute necessity of routine examination of the curettage.

Dr. **HOLMES** said that 26 was an early age at which to find carcinoma, although he had known a case at 18. He agreed as to the importance of routine examination in all cases where curetting was done.

The **CHAIRMAN** said the youngest case of carcinoma he had seen was at 27, and if it occurred as early as Dr. Holmes said—18—it might occur at any time.

DERMOID TUMOURS.

Dr. **HORNE** exhibited two specimens of dermoid tumours which had occurred in one patient, a condition he had not met before. The girl was suffering severe pain eight or ten days before menstruation. Last October menstruation ceased, and the pain lessened, and she came to him to know what was wrong. By vaginal examination he found one tumour in front of the uterus; uterus was pushed to the right, and through the fornix a certain amount of bony hardness was found. On going into the posterior *cul-de-sac,* he found it occupied by a semi-resistant tumour, which felt in size like an extra-uterine pregnancy, but in one part there was a hard nodule. At the operation he found the tumour in front completely covered by the omentum, which passed over it and was adherent to the bladder. He then came on a slight pedicle, and in trying to keep close to the tumour some of the contents—typical yellow fluid—escaped. He removed the tumour in front, and shelled out the second from behind the uterus.

Dr. **Rowlette** asked if Dr. Horne had established any connection between the second tumour and the ovary.

The **Chairman** said it was a wise thing not to run any risks with dermoid cysts, as their contents were sometimes very septic.

Dr. **Horne**, in reply, said the second tumour lay altogether behind the peritoneum, and he could find no trace of the ovary. On account of the escaping fluid he provided drainage into the vagina, and packed the cavity with iodoform gauze. The case had run a most satisfactory course

ECTOPIC GESTATION, WITH OVARIAN CYST.

Sir A. V. **Macan** exhibited a specimen of ectopic gestation, with ovarian cyst. The patient came to him in July last, when he found a tender tumour behind the uterus slightly to the left side. In November he enucleated a small fibroid that had been undergoing calcareous degeneration, and he removed the left ovary, which was degenerated. She made a good recovery, and went home in December apparently quite well. About the middle of May she came to him again, miserably thin and pale. She had been in bed for a month, and had had a red discharge for three weeks, as well as severe abdominal pains. He examined her and found the uterus dislocated to the left, and a large elastic swelling filling the right side of the pelvis. The whole abdomen was very tender. He could make no other diagnosis than that of extra-uterine fœtation. He operated last Monday, and found considerable adhesions. There was hardly any blood in the peritoneum. He enucleated a large lump in the right side of the pelvis which he thought was part of the fœtation. Careful examination showed a rupture in the tube.

Dr. **FitzGibbon** said the specimen was particularly interesting as showing the rapidity with which the ovary could grow, and the possibility of growth at that rate being malignant.

THE OBSTETRICAL REPORT OF THE ROTUNDA HOSPITAL, 1907-1908.

The obstetrical report of the Master of the Rotunda Hospital for 1907-1908 was read by Dr. W. Bell.

Dr. **Horne** said they were delighted to see the improvement in the morbidity, though he would prefer to see some one definite method of calculating it adopted. The mortality was also extremely good, yet two deaths out of nine eclampsia cases seemed high in view of present-day methods.

Dr. **Gibson** had great pleasure in congratulating the Master of the Rotunda Hospital and his assistants on the large amount of work done. He regretted that he had not yet had an opportunity of reading the report, as a copy had not been sent to him. Dr. Bell had drawn special attention to the fact that one woman, for whom pubiotomy was necessary on a former labour, had now delivered herself spontaneously. This was, of course, one of the greatest advantages of pubiotomy, that they could give the patient every opportunity of delivering herself, and only perform the operation when it is indicated.

Dr. **FitzGibbon** said that when he was at the Rotunda cases of venereal disease in pregnancy were looked upon with abhorrence, and a large percentage of them died of septic infection afterwards. It was interesting, and apparently inexplicable, that there had never been a death after childbirth in the Lock Hospital, which was saturated with venereal disease, yet in the Rotunda, where there were the very best conditions, deaths occurred. In a recently reported autopsy the results of a previous pubiotomy were examined, and the bone showed no attempt at osseous union which might explain some cases of easy delivery after pubiotomy, as the fibrous union gave greater space.

Sir **Arthur** V. **Macan** said that the great majority of obstetricians abroad recognised 38° C. as the limit of morbidity, and he thought they should adopt it unless there was some very great objection to it. Statistics on different standards were useless, and they must use a standard that others understood if they were to compare the Rotunda with other places. He was convinced of the ease and simplicity of pubiotomy, but it had been shown that serious accidents might occur in the hands of the most skilled men, and, therefore, he could not consider the operation one to put before a man in ordinary country practice as the most suitable and certain. At the same time, it was better to perform the operation in an emergency than to let the woman die without any attempt to save her. He thought that cases of convulsions should not be allowed to go on where the sight was already affected; everything—even Cæsarean section—should be done. He thought that the case of death from shock immediately after the removal of adherent placenta was worthy of more detail, as the operation was the most dangerous one in midwifery.

THE GYNÆCOLOGICAL REPORT OF THE ROTUNDA HOSPITAL, 1905-1907.

Dr. A. **Holmes** read the above for the Master of the Rotunda. The Gynæcological Report of the Rotunda Hospital covers two years, beginning November 1st, 1905, and ending October 31st, 1907, and deals only with those cases in which operative measures were undertaken. In many instances several operations were necessary, and were performed at the same time. Each operation is counted under its own heading. The number of patients admitted to the hospital during the two years amounted to 981, of these 110 were cases where no operation was performed or operation was refused. The total number of operations performed comes to 1,153, of which 468 come under the heading of curettage. Operative measures for rectifying backward displacements of the uterus were undertaken in 94 cases. The Alexander-Adams' method was elected on five occasions, vaginal fixation twenty-three, and ventro-suspension on the remaining sixty-six. Myomectomy was performed whenever possible, and was adopted on fourteen occasions. Hysterotomy was necessary once for overcoming the symptoms associated with an irreducible retroverted gravid uterus. Hysterectomy was performed in all sixty-seven times, malignancy being the indication in twenty. The mortality following upon extirpation of the uterus for malignancy is represented by seven, showing a percentage of 35. Fibroid condition of the uterus accounted for thirty-seven of the other cases; pyosalpinx, intraligamentous cysts and severe hæmorrhage the remainder. Forty ovariotomies are recorded, with a mortality of five, in two of which malignancy was the indication for operation, and probably in a third case, the pathological findings not being definite. The two other cases were in a hopeless condition of sepsis on admission. Many operations in minor gynæcology were performed for repair of torn perinæum, cervix, etc. The total mortality is represented by twenty-one. Twelve deaths occurred in cancerous patients, two followed hysterectomy for fibroid condition—one of which cases succumbed to congestion of the lungs, and the other to shock. A pyosalpinx which ruptured during removal accounted for another. Two women died who suffered from irreducible retroverted gravid uteri; both were moribund when accouchement *forcé* was resorted to. Another death occurred in a woman pregnant four months, and with an ovarian cyst whose pedicle was twisted and gangrenous. Cerebral symptoms pointing to tubercular meningitis arose in a patient who was suffering from ovarian cyst associated with a very high temperature, and proved fatal. The remaining two cases died before operation—one from peritonitis, the other of pneumonia.

Dr. **Seymour Stritch**, adverting to the question of mortality, said that there had not been a death in the Lock Hospital of any sort following confinement during the last twenty-eight years, and only one death occurred in the London Lock Hospital, he was informed, in twenty-five years. In the Dublin Lock Hospital there were about twenty cases of delivery annually. Douching was constantly done. An account of these cases would be found in THE MEDICAL PRESS AND CIRCULAR for July 4th, 1906.

Dr. ASHE said that shortening the round ligaments, in his experience, had been most unsatisfactory, and he would like to know if anything had afterwards been heard about the cases operated on.

Dr. KIRKPATRICK suggested the inclusion of a statistical table in connection with the administration of anæsthetics as a matter of considerable importance which would make a valuable addition to both reports.

Dr. BELL said that the measurements of the true conjugate of the patient who had delivered herself after pubiotomy were 7 cm. last year, and 8 cm. this year. No one who has had much practice with Skutsch's pelvimeter will believe that such a discrepancy could be possible, and the fact remained that the woman delivered herself this year in six hours. Last year she was in labour forty-two and a half hours, with the head balloting freely above the pelvic brim, when forceps were applied. They failed to fix the head in the brim. Three hours later pubiotomy was performed. Walcher's position was tried for one and a half hours without success before pubiotomy was performed.

Dr. HASTINGS TWEEDY said he did not think any apology was necessary for the method of ascertaining morbidity which had been adopted at the Rotunda. Reference had been made to the Queen Charlotte Hospital report, where a morbidity of 20 per cent. was shown when estimated by the rigid methods adopted at that institution; and yet, when this morbidity was calculated by the rules laid down by the British Medical Association and by those which obtain at the Rotunda, it showed a marked decrease. It was unfortunate that the British Medical Association and Rotunda estimations of morbidity in the Queen Charlotte Hospital report were estimated from only a small number of their cases—*i.e.*, 300 British Medical Association and 89 Rotunda. Needless to say it is impossible to draw any comparison between their percentage morbidities, as the different calculations did not deal with the same number of cases. We at the Rotunda could easily show a hundred consecutive cases without any morbidity. Thirty-eight degrees was a purely arbitrary line, and it was futile to take temperature in the axilla and compare them with those taken in the mouth or rectum. The British Medical Association suggested that the thermometer be placed in the mouth; the temperature be taken twice daily—at 8 a.m. and 5 p.m.; and in these suggestions they were far ahead of any plan generally adopted on the Continent. A greater number of temperatures would be found in four-hourly records than in bi-daily records. He was not interested in these rises of temperature save as an indication of disease, and it was misleading to schedule every patient as diseased (morbid) who showed some slight transitory rise. What we really want are statistics of the health of the various hospitals, and to this end the plan of the British Medical Association is worthy of much wider recognition than it has yet received. Two women on whom he performed pubiotomy last year had since delivered themselves naturally. Those cases had been carefully measured by Skutsch's pelvimeter, had had the head balloting above the brim of the pelvis for several hours before operative interference was adopted, and had shown marked pelvic contractions, measurements of which will be seen by referring to the report. One of these showed a marked increase in the pelvic measurements when examined before the birth of the second child. In conclusion, he expressed his admiration of the way in which the work of the reports had been done by Dr. Bell and Dr. Holmes. The former had omitted the reading of the paragraph referring to himself and Dr. Holmes, an omission which Dr. Tweedy supplied.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 14th, 1908.

HYPERHYDROSIS OF THE FEET.

FOR the treatment of this troublesome affection, Hebra proposed a treatment which he considered as heroic. He enveloped the foot with a plaster composed of equal parts of diachylon and linseed oil. After 12 hours the dressing was removed, the feet dried, and the application renewed, and so on for 10 or 12 days. At the end of that time the plaster is replaced by some absorbent powder.

Kaposi recommends the employment of naphthol in lotions morning and evening:—

Naphthol, 5,
Glycerine, 10,
Proof spirit, 100,

and powdered with—

Naphthol, 3,
Starch, 100.

Salicylic acid has been employed by Broca. After rubbing the feet with a spirit lotion, he employs the following powder:—

Salicylic acid, 3,
Starch, 10,
Fuller's earth, 87.

Or,

Powdered alum, 45,
Salicylic acid, 5.

Perchloride of iron has been used with advantage.

Glycerine, 2 dr.
Perchl. of iron, 1 oz.
Ess. of bergamot, 20 drops.

During two days the feet are bathed in some astringent decoction, and on the third day the above mixture is painted on the feet morning and evening.

In the German army chromic acid is the current treatment.

A complete cure is effected in 42 per cent. of the cases, improvement in 50 per cent., and only 8 per cent. are rebellious to the treatment.

The chromic acid is employed in solution (5 to 10 per cent.), and rubbed on the soles of the feet and between the toes with a piece of cotton wool after the feet have been thoroughly washed. The operation is renewed at an interval of a week or fortnight.

STICKING PLASTER.

M. Kogaul indicates a simple and practical method of applying adhesive plaster without heating it over steam or fire. It is sufficient to pour a little benzine into a plate, and pass the straps through it before applying them. To remove the plaster a plug of cotton wet with the benzine is passed over it, when it peels off with the greatest facility.

CHRONIC APPENDICITIS IN CHILDREN.

Appendicitis, frequent in children, is essentially, says Prof. Comby, a chronic affection. How it commences is unknown, and in this it resembles adenoid vegetations, hypertrophy of the tonsils or ganglions, and all other morbid affections of slow and prolonged development.

When one is put on the track of appendicitis by such symptoms as local pain, nausea, vomiting, etc., it has already a long time existed, having progressed insidiously in the midst of the vaguest and most deceptive symptomatology.

When an acute attack has suddenly appeared, it is regarded as one of those accidents that could not have been foreseen; but acute appendicitis is only an episode of the chronic form.

In many cases the cause of chronic appendicitis in children escapes notice; the patients are well nourished, never suffer from troubles of digestion, never had an attack of enteritis, and seem to have always enjoyed good health. Here heredity, lymphatism, arthritism, might be invoked as exciting causes.

In another class of cases may be noticed rhino-pharyngeal manifestations, adenoid vegetations, with or without otitis. These children have a weak throat, are easily seized with inflammation of the tonsils after the slighest cold or an attack of grippe, accompanied by cervical adenitis. After one or several of these attacks, the first symptoms of chronic appendicitis appear.

Others have suffered from attacks of gastro-enteritis or entero-colitis in their infancy. M. Comby observed a large number of children who were treated first for entero-colitis and in whom the malady terminated in chronic appendicitis. The coincidence of these two maladies is very frequent in children.

Among the infectious maladies, there is one which plays a principal *rôle* in the ætiology of appendicitis. Influenza presents a predilection for the lymphatic apparatus, and determines engorgement of the ganglions. The appendix might be assimilated to a ganglion.

Next in order comes typhoid fever, measles, scarlatina, mumps, and generally all infectious maladies which in children affect specially the lymphatic system. Abuse of certain foods, meat, raw vegetables, and all indigestible foods play an important *rôle*, by irritating the intestines and provoking abnormal fermentations.

Rare in infancy, chronic appendicitis becomes more and more frequent as the child advances in age; it is common between the ages of 5 to 15, and may be prolonged to the adult age.

The symptomatic tableau of chronic appendicitis is exceedingly complex. Sometimes the latent affection is mirrored on the physiognomy of the child, which attracts attention, at other times none of the features betray the cause; on the contrary, the face has all the appearance of health. In general, however, the children are pale, complexion waxy, eyes sunken, face emaciated. At the same time the whole body participates more or less in this wasting, the limbs are slight, the abdomen hollow, the ribs protuberant, etc. This external habitus is seen, above all, in children who have suffered from enteritis or dyspepsia.

The patient has little or no appetite, he eats by force, or his appetite is capricious and irregular; good to-day, bad to-morrow.

Some children, on the contrary, eat ravenously, and too much, they digest with difficulty, are swelled after meals, and present signs of dilatation of the stomach, and flatulent dyspepsia. With this dyspeptic condition constipation almost always coincides, while others suffer from diarrhœa, or from diarrhœa and constipation alternately.

Several present a saburral condition of the tongue, with fœtidity of the breath, especially in the morning They are subject to gastric disturbance. All these digestive troubles are vague, ill-defined, and of difficult interpretation. They are generally considered as symptoms of ordinary indigestion.

GERMANY.

Berlin, June 14th, 1908.

At the Hufeland Society, Hr. Kraus showed a case of

BRONCHIAL CALCULUS.

The patient was a man between 40 and 50, whose father had died of phthisis. He himself had previously suffered from cardiac trouble. For six years he had suffered from cough, night sweats, and emaciation. More recently there had been paroxysmal attacks of coughing, with severe pain in the shoulder region, burning in the trachea, with vomiting at the height of the attack. There was also expectoration of small, linseed-shaped, calculi with prickly processes; after this improvement took place. The sputum contained bacilli. Röntgen illumination showed the outlines of calculi disseminated through the chest. Cases of expectoration of calculi had very rarely been described.

Hr. Kraus also showed a lady, in good health, who was the possessor of cervical ribs, as shown by the X-rays. The ribs were causing some inconvenience, however, as by pressure on the brachial plexus, pain was caused in the shoulder and arm of the side affected. As in other cases the pain was a long time before it appeared. It would be easy to give relief by operation.

Hr. Senator said he had frequently found cervical ribs, as, in order to discover any possible cervical glands, he was in the habit of palpating the side of the neck in all cases.

Hr. Kraus next showed a case of

ECHINOCOCCUS.

It was remarkable that it had started from the posterior margin of the liver, and the diagnosis was difficult as the situation was unusual. It gave the operator a good deal of trouble to arrest the hæmorrhage.

Hr. Mosse showed preparations from a case of

LYMPHÆMIC CIRRHOSIS OF THE LIVER.

The patient was first examined three years ago, and a diagnosis was then made of chronic lymphatic leucæmia. In 1905, and later in 1906, the X-rays were applied. The result was that the lymph tumours and the spleen were reduced in size, the blood also improved. In January, 1907, there was a good deal of ascites. As displacement of the portal vein was supposed to have taken place through enlargement of the lymph glands the treatment was renewed. The patient then left the hospital. The autopsy showed chronic peritonitis, no enlargement of the lymph glands of the abdomen whatever, but excessive cirrhosis of the liver. This and the peritonitis might be a result of the X-ray treatment. The cirrhosis of the liver and the leucæmia might here be accidental concomitants, but cases of the kind were described by other authors.

Hr. Kraus did not think that the liver disease was caused by the Röntgen treatment. Cirrhosis of the liver often occurred with pseudo-leucæmia.

DEMONSTRATION OF PANCREATIC DISEASE.

Hr. Ewald showed some microscopic preparations, pointing out that they showed the action of the pancreatic secretion. This digested the nuclei of muscles. Where such were recognisable in the fæces the pancreas could not have been acting. He showed small particles of flesh which had been swallowed by the patient wrapped up in gauze, as these were quickly found in the fæces the examination was rendered more easy.

Hr. Strauss spoke on

PROCTITIS SPHINCTERICA.

He said the disease was characterised by redness and swelling in the region of the sphincter, with tendency to excoriations and ulcerations, and frequently set up considerable disturbances. It was often overlooked if the rectal speculum was not made use of. Not infrequently a nervous spasm of the rectum was diagnosed, which on more careful examination proved to be sphincteric proctitis. Considerable hæmorrhages were also not rare, so that one thought of carcinoma. As regarded treatment, besides sitz baths and suppositories, applications of silver nitrate through the speculum were called for, or injections or ointments applied through a syringe. The speaker had become more backward in making a diagnosis of rectal spasm the more his experience had increased in the use of the rectal speculum.

AUSTRIA.

Vienna, June 14th, 1908.

TALLOW CANDLE IN BLADDER.

At the Gesellschaft der Aertze, Lenk showed the remains of a tallow candle which he had removed from the bladder by what he called a new method, and which we may now call "Lenk's method." For some time past the patient had suffered from severe attacks of hæmaturia and cystitis, which persisted in spite of heroic treatment. The cystoscope revealed ulcerous cystitis in the lower part of the bladder with an encrusted foreign body. When the bladder was filled the foreign body floated and sank when it was emptied. Further examination proved it to be stearin, but how was it to be removed—by the lithotrite or section. Owing to ulceration the sectio alta was entertained, but the cystitis was dreaded.

After consultation it was decided to dissolve the foreign body if possible by means of benzine. The first step was to inject 13.0 cubic centimetres of sterilised water into the bladder which floated the candle; after this 60 cubic cm. of benzine was injected, which remained on the surface of the water in contact with the stearine. This device protected the lower ulcerated part of the organ, and prevented further aggravation of the cystitis. The benzine was only allowed to remain 20 seconds, and was then drawn off, at the same time washing out the bladder well with sterilised water. After the action of the benzine the stearine, with the heat of the body, commenced to break up, and was passed with the urine as a thick oily substance. Five more injections of benzine and washings were applied, but none of these exceeded 20 seconds before the oily discharge ceased. The next difficulty was the removal of the cotton wick, which was done with the lithotrite. Mastubation was the original cause of the accident.

IMPERFECT VISION AND PREGNANCY.

Meissner presented a woman in pregnancy three months, with greatly impaired vision. According to her history six years ago she suffered from a severe attack of neuritis optica, the result of syphilis. After this illness her eyesight remained fairly good for two years till she became pregnant, when her sight was greatly impaired. After the confinement her vision improved, but never came up to the clearness it was before the confinement. Later she again became pregnant with the same result, improving after the confinement, but still worse than before it.

She is now three months gone in the present pregnancy with the eyesight again impaired, which she thinks would be better if the pregnancy could be ended. The right eye can distinguish fingers at 3 metres or 9 ft. 9 in., the left at 3¼ metres. The ophthalmoscope revealed signs of neuritis optica in both eyes with regular and irregular astigmatism. Vision is concentrically limited, and the only colour distinguished red. No trace of syphilis to be found now, and no albumin in the urine; notwithstanding iodide and syphilitic treatment was adopted without success, indeed the vision became rapidly worse during the administration of the drug.

There is no doubt in this case that the pregnancy is the cause of the reduced vision which raises the important question of inducing premature labour as suggested.

Königstein said he had had the opportunity of examining this patient a few weeks ago, and was impressed with the idea of inducing abortion, but one must always take into account the amount of hysteria present in these cases which the other functions verified.

Bäringer thought if no simulation could support the case it was grave, but his own opinion from the history of the case was that no attempt at abortion should be made. He believed that the woman's danger would be greatly increased by such interference.

Hirschl thought that Meissner should have treated the case with mercury, as iodide alone was not proper anti-syphilitic treatment.

Hochenegg said he sympathised very much with the patient's grief concerning her blindness, and from the history of the case vision was very much disturbed. As a cause of this defect he should remind his hearers of the recent facts noted by French authors as well as Erdmann and Stumme, who have all found changes in the hypophysis. Meixner reminded Hochenegg that the characteristic hemianopsia which is usually associated with the disease of hypophysis was not present in this case.

Teleky said that in his long practice he had never met with a case where the ætiology was due to pregnancy pure and simple, but with albuminuria he had often met with retinitis.

Stejskal thought that atrophy of the optic nerve might be present, and that the organic changes occurring in the gravid state might be due to exostosis or periostitis in the ocular orbit. Such exostosis during pregnancy is not an uncommon associate.

CONTINENTAL HEALTH RESORTS.

AIX-LES-BAINS.

A VISIT to Aix-les-Bains (that ancient thermal resort famous alike for its treatment, its gaiety, and the delightful character of its surroundings) ought to form part of the curriculum of medical study. It is, so to speak, the mother of thermal stations, its early history going back to the dawn of Christianity, and it has served as a model for similar establishments all over the world. Not every spot where hot springs are available can command the lovely scenery and the bright genial climate of Savoy, which, by the way, was Italian territory until 1860, when it was annexed to France after a referendum of the inhabitants. It is a remarkably fertile soil, every inch of which is diligently cultivated by a thrifty, hard-working population.

The facilities for entertainment and promenades in and around Aix are almost unrivalled. The country roads are kept as only French roads are kept, and they provide miles and miles of leafy avenues which are delightful on foot or on wheels, or viewed from the cushioned indolence of the local fiacre, which again is a marvel of primness and comfort Then, too, there are two Casinos, probably the largest, and certainly among the most beautiful, in Europe, where we are treated to theatrical representations by metropolitan troupes, open-air opera, orchestral and vocal concerts, not to speak of gaming rooms, attractive lounges and gardens, in which Art and Nature have joined hands to produce most striking effects. The gilded saloons are nightly thronged by a cosmopolitan assembly of all nationalities and of all ages, clad in the height of fashion, a truly democratic institution, where social differences seem to be obliterated in the pursuit of pleasure.

But we must not lose sight of the fact, especially in a medical journal, that Aix-les-Bains is essentially a thermal station, whither thirty or forty thousand specimens of suffering humanity find their way every year for the purpose of undergoing a course of treatment. These include the victims of rheumatism, gout and arthritic states in general, obesity, neurasthenia, gouty eczema, varicosity, and stiff joints, the result of traumatisms or chronic inflammation. The best testimony to the usefulness of the treatment is that its reputation has been maintained for about twenty centuries. Mere fashion would long since have spent its force, so we are compelled to believe in the curative effects, if not of the waters *per se*, at any rate of the mode or rather modes—for they seem to be innumerable in their variety—in which they are applied. We may remind our readers that the Aix water issues at a temperature of about 110° F. to the tune of a million gallons a day, its principal component being sulphur in the form of sulphuretted hydrogen and *baragene*, an unctuous substance that greatly facilitates massage.

The bathing establishment, which is on a palatial scale, is the property of the State, which turns it to national account by according its benefits to the sick poor and underpaid employees at a nominal cost, or even free of charge. Even "paying guests" find the charges very reasonable, varying, as they do, from a franc per bath (douche-massage) in the older part to 2f. 50c. and 4f. in the more luxuriously installed departments. It is hardly necessary to add that, apart from the Aix treatment proper, which is known all over the world as douche-massage, every variety of hydropathic treatment is available, including the treatment of diseases peculiar to women, of intestinal affections, not to speak of the throat, nose and air passages. It is quite a department of therapeutics in itself, and must require no small experience to master in all its details. Every year witnesses some additions in deference to the representations of the local medical society, and, thanks to the kindness of Mr. Durand-Desmond, the director of the establishment, and of Mr. Marillet, the assistant director, we have been enabled to inspect some of the more recent improvements which comprise an installation for intestinal irrigation, special douches for women, especially the so-called "marine douche" (vaginal douche taken in the ordinary mineral water bath), and a very elaborate horizontal douche-massage table for patients who are too weak or too infirm to avail themselves of the stool that is usually employed.

Municipal enterprise is shown in the tarring of the streets, a matter largely due to the personal initiative of M. Mottet, the popular and quasi-permanent Mayor of Aix. The streets present a smooth surface free from dust—a point of immense importance in view of the hundreds of powerful cars that daily pass through or arrive at Aix every day during the season. The tarring is carried some distance out into the country, so that *promeneurs* can take their walks abroad without being smothered.

We may mention, too, that, in order to attract medical men hither, and induce them to become personally acquainted with the resources of the bathing establishment, they and their families are accorded the treatment free of charge, and on presentation of their cards they are admitted to the casinos and other entertainments.

There is a charming public park, on one side of which is a well-installed Zander Institute, under the direction of Dr. Guyenot. Aix is half-buried in verdure, and the air is redolent of the perfume of acacias, magnolias, polonias, and other scented flowering trees. Hotel accommodation at Aix is excellent, the establishments most favoured by English folk being the Grand Hotel d'Albion (very select and comfortable), the Hotel Bernascon, and the Hotel Splendide.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Chair of Clinical Surgery, University of Edinburgh.—The King has been pleased, on the recommendation of the Secretary for Scotland, to approve of the appointment of Mr. F. M. Caird as Regius Professor of Clinical Surgery in the University of Edinburgh. Professor Caird, who graduated in 1877, is one of the best known surgeons in Edinburgh, and is extremely popular, both personally and as a teacher. The branch of surgery in which, perhaps, he particularly excels is abdominal work generally, and he was one of the first surgeons to take full advantage of and apply modern methods to the operative surgery of the abdomen. As an undergraduate he was trained by Lister, and witnessed the revolution in surgical science and practice which resulted from the labours of his teacher. He subsequently studied pathology under von Recklinghausen, and taught anatomy under Dr. (now Professor) Cossar Ewart. He then acted as assistant to Mr. Chiene, and in 1886 was elected assistant surgeon to the Royal Infirmary. He lectured on systematic surgery in the extra-mural school of medicine for nearly twenty years, and his class was regarded by the students as one of the best in Edinburgh; its popularity is evidenced by the fact that the average attendance throughout these years was 106. In 1900 Mr. Caird became a full surgeon to the Infirmary and began to lecture on clinical surgery. The appointment, which was announced in the beginning of last week, has been received with very general satisfaction.

Chair of Medicine, University of Glasgow.—The King has been pleased, on the recommendation of the Secretary for Scotland, to approve of the appointment of Professor Samson Gemmell as Professor of the Practice of Medicine in the University of Glasgow. Dr. Gemmell graduated in 1872, and for a time acted as assistant to the late Prof. Sir William Gairdner. From 1873 to 1876 he acted as resident physician at the Glasgow Fever Hospital, and in 1887 he was appointed physician to the Royal Infirmary. Since 1892 he has been physician at the Western Infirmary, Glasgow. In 1900, on the appointment of Sir Thomas McCall Anderson, then Professor of Clinical Medicine, to the Chair of Practice of Physic, he was appointed to the former chair. In his new post, therefore, he has again succeeded the late Prof. McCall Anderson.

Sir Henry Littlejohn's Retirement.—The Local Government Board, in a letter accepting, with deep regret, Sir Henry Littlejohn's resignation, refer to his work in most appreciative terms. They recall the fact that long as has been Sir Henry's period of service as Medical Officer of Health for Edinburgh, his connection with the board has been longer still, dating, as it does, from 1859, when as a Commissioner, Dr. Littlejohn investigated the epidemic of Asiatic cholera then visiting the country. The appreciation of his services as a Commissioner from time to time led the Board in 1873 to attach Dr. Littlejohn permanently to its staff. The value of this unique record of half a century's strenuous work cannot well be over estimated. The terms of the appreciation are to be officially communicated to the Secretary for Scotland for his information.

Fatal Assault on a Medical Man.—A lamentable occurrence is reported from Ardrishaig, whereby Dr. Duncan Shaw Morrison lost his life. It seems that the deceased gentleman left Loch Gilphead for home about 11 o'clock on Wednesday evening, and on the way was overtaken by two men who have been working in the district for some time. What led to the assault is not yet known, but a dispute arose, with the result that Dr. Morrison was knocked down. Almost immediately afterwards two cyclists came on the scene and challenged the assailants. Seeing the state of matters, with Dr. Morrison lying on the roadside bleeding profusely and apparently unconscious, they compelled the two men to accompany them to the nearest village, where they were handed over to the police. Meanwhile help was sent to Dr. Morrison, but by the time it arrived the victim of the assault was *in extremis*, and expired a few minutes later. The deceased was about fifty years of age, and was unmarried. The prisoners were brought before Sheriff Penney on the capital charge, and after emitting a declaration were committed for further examination.

Chancellorship of Glasgow University.—The new Chancellor, Lord Rosebery, was formally installed in office on June 12th, additional interest being lent to the occasion by the fact that the first duty of the new Chancellor was to confer the Doctorate of Laws on the Duke of Argyll, Lord Elgin, and Lord Newlands. Following upon his induction to the office of Chancellor, Lord Rosebery delivered an eloquent address, contrasting the spirit and work of individual Universities, and speaking especially of the self-reliance which the Scottish Universities fostered in their students. The proceedings were brought to a close by a luncheon party, at which the Chancellor, the Duke of Argyll, and Lord Elgin gave addresses.

Memorial to the Late Professor Annandale.—A sum of £231 15s. has now been subscribed towards this object, leaving £168 5s. still to be found before the sum of £400, at which the Committee aim, is raised.

Mr. F. H. A. Marshall, Assistant to the Professor of Physiology, and Lecturer on the Physiology of Reproduction in the University of Edinburgh, has been appointed to a newly-instituted Lectureship in Agricultural Physiology in the University of Cambridge.

BELFAST.

Meat, Milk, and Tubercle.—At the last monthly meeting of the Corporation, a statement was made by the Chairman of the Public Health Committee, Dr. King-Kerr, regarding the occurrence of tubercle in cattle. He said that, of 3,452 milch cows examined by their veterinarian, only one was found affected with tubercle, and of 27,446 cattle slaughtered in the city abbatoir, only 384 showed tubercle, or about one animal in 70. For three months Professor Symmers had been making elaborate examinations of milk from city dairies, but had never found tubercle bacilli in any sample. In discussing these figures it was made clear that in the case of the milch cows the tuberculin test had not been applied.

Typhoid Fever.—In spite of all efforts to stop the consumption of cockles—the supposed source of typhoid infection in Belfast—there is no abatement in the number of cases, but rather the reverse. Last month there were notified 29 cases of typhoid and 14 of "simple continued fever," which may be counted as typhoid, making 43 cases in all. Apart from this, the general health of the city shows distinct improvement.

AMENITIES OF HOSPITAL LIFE.—Much interest and amusement have been roused in medical circles in Belfast by the announcement of the engagement of a prominent surgeon, supposed to be a confirmed bachelor, to the matron of one of the hospitals to whose staff he belongs. The special interest lies in the fact that it is just a year since his surgical colleague on the staff married the late matron, and it is felt that the Board of Management have a responsible task before them in selecting the next, as there are still several bachelors on the staff!

LETTERS TO THE EDITOR.

THE STUDY OF TWINS AND DOUBLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you kindly allow me once again to appeal to your readers for additional information on the above subject, which the consideration of my present evidence has rendered advisable.

My object is to determine the greater or lesser importance of the constitutional factor in disease, and while still relying mainly on data derived from information respecting twins and doubles, I wish to draw upon all subsidiary sources, so as to obtain as complete an outline of the subject as is possible.

I have now evidence, though I should be glad of more, on the following points:—

(*a*) Similar particular diseases and definite constitutional conditions in true twins like and unlike in respect to: melancholia, broncho-pneumonia, chorea, splenic anæmia, diabetes, hernia, influenza, quinsy and tonsillitis, conjunctivitis, bronchitis, convulsions, thrush, typhoid fever, scarlet fever, measles, cyclical vomiting, pulmonary tuberculosis, peritonitis, caries of similar teeth.

From the literature of the subject instances of suicidal insanity, exalted delusions, melancholia, mania, idiocy, imbecility, congenital deformities, conjunctivitis, and most of the commoner specific fevers.

(*b*) Cumulative evidence of several similar diseases contracted nearly or quite simultaneously, sometimes in twins not living together.

Confirmatory evidence from literature of the subject:

(*c*) Cumulative evidence in triplets.

(*d*) Reference to insanity in triplets.

(*e*) Other characteristics shared in common in twins and triplets.

Confirmatory evidence from literature of the subject:

(*f*) Twins not of the same sex. Much less similarity, but not unlikeness of constitution.

(*g*) "Doubles," two cases of particular diseases—diabetes, tetanus.

(*h*) "Doubles," one case of cumulative evidence.

(*i*) Dissimilar diseases in twins, one doubtful case.

For help in collecting these instances together, I wish specially to thank Drs. D. Biddle, C. and H. Campbell, S. Davies, R. Glass, Goring, R. Hutchinson, A. D. Lewis, H. Maudsly, George Murray, H. Rayner, W. J. Rutherford, W. C. Sullivan, F. W. Ewart, Urquhart, and others of Great Britain; Drs. M. J. Conlin, C. Hedger, H. Lyons, Hunt, J. Ratcliffe, Milton Sturges, J. M. Trigg, and H. Yoder of America, and Dr. H. Rugg of Australia for useful suggestions and valuable particulars kindly given, and all others who replied to my inquiries. I am also much indebted to the various medical journals which kindly afforded me space for my inquiries.

Further data required:—

1.—SIMILAR DISEASES IN

(*a*) *Twins and triplets of the same sex.*

Like twins and triplets: Instances of one disease; or, if possible, of several diseases.

Unlike twins and triplets: Instances of one disease; or, if possible, of several diseases.

(*b*) *Twins and triplets not of the same sex.*

Like twins and triplets: Instances of one disease; or, if possible, of several diseases.

Unlike twins and triplets: Instances of one disease; or, if possible, of several diseases.

(*c*) "*Doubles*" *same sex, preferably adults.*

Instances of one disease; or, if possible, of several diseases.

(*d*) *Husband and wife.*

Like, the likeness consisting in similar eye colour, similar complexion, similar height characteristics, allowance being made for the fact that women are about four to five inches shorter than men.

Unlike in above particulars.

(*e*) *Parents and children.* Like. Unlike.

(*f*) *Brothers and sisters.* Like. Unlike.

2.—DISSIMILAR DISEASES IN

(*a*), (*b*), (*c*), (*d*), (*e*), (*f*), as quoted above.

I should be glad, as the evidence is often difficult to interpret rightly to have as many particulars in each case as possible.

I cannot find satisfactory evidence for the statement that true uniovular twins are *always* of the same sex, if any of your readers could supply me with references to detailed series of observations on this point I should be still further obliged.

I am, Sir, yours truly,
J. LIONEL TAYLOR.

8 Adys Lawn,
Willesden Green, London, N.W.

MEDICAL INSPECTION OF CHILDREN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The majority "of us" are grateful for the attitude you are taking up over the appointment of county M.O.H.'s as medical inspectors of schools.

The chief point is—"Are practitioners and specialists in medicine, surgery and diseases of children to be permanently barred from the posts because, forsooth, they have not the Diploma in Public Health?" If so, the posts are available only to a very small fragment of the profession, and that small fragment not specially trained and experienced in the diagnosis and treatment of children's diseases—congenital or acquired. A point apparently overlooked by the "powers that be" is that in the curriculum for D.P.H. a course in children's diseases is conspicuous by its absence.

Had it been a question of ventilation and inspection of school buildings alone, then there could be no doubt as to the value of such a diploma. But the county M.O.H.'s do this already, and then the children are to be inspected. So much have the majority of these diplomates laid aside the duties of everyday medicine and surgery (in many cases never writing even a simple tonic prescription or advising as to a suitable regimen) that instead of them being eligible to the exclusion of general medical practitioners, the reverse might with more justice be laid down, namely, that men in active practice should be eligible, and D.P.H.s not in general practice almost barred.

The Government are being led by the M.O.H.'s—they having no others to advise them, and unless we act the appointments will fall into the hands of a limited number of medical men.

Trusting you will give this important question your kindly consideration,

I am, Sir, yours truly,
MEDICUS.

June 11th, 1908.

SIR VICTOR HORSLEY ON MR. TROUTBECK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Sir Victor Horsley's latest public utterance should go some way towards promotion of amendment of the peculiar methods of "crowner's quest" which have been for so long displayed in the inquiries conducted by Mr. Troutbeck. Of these methods Sir Victor Horsley's criticism constitutes an indictment the force of which is not diminished by the moderation of the language in which it is expressed. Sir Victor furnishes exemplifications of the results of Mr. Troutbeck's system such as have been so often illustrated and commented upon in your columns, and points out that the system has for years led to a widespread miscarriage of justice. Mr. Troutbeck has systematically abstained from calling before the jury the medical practitioner actually in charge of the case, and has employed an outside pathologist who has never seen the patient during life, and has mostly had no communication whatever with the practitioner in charge. Sir Victor's specific complaint of the moment refers to a case in which Mr. Troutbeck held an inquiry into the death of a hospital patient who was dying, and did die, from the effects of a cerebellar tumour. The case was a perfectly simple one, and if it really called for an inquest, such an inquiry must be deemed necessary in every case of death during medical treatment of any kind. This is the absurdity to which Mr. Troutbeck's method, pursued to its logical end, must lead. Some means of putting Mr. Troutbeck under sufficient official restraint will be no doubt devised before much further approach is made towards so grotesque a consummation. That he has been allowed to go on so long without effective interference manifests once more the political impotence of the profession, its incapacity to make its voice heard in denunciation of a grievance even when of much greater importance to the community than to the medical practitioners.

I am, Sir, yours truly,
S. W.

IS THE TREDELENBURG POSITION ORIGINAL?

To the Editor of The Medical Press and Circular.

Sir,—While looking over some volumes of the *Provincial Medical Journal*, I observed the following, by Dr. H. Del Agémère, copied from *Le Progrès Médical*, Paris, June 1st, 1891:—"One of the difficulties in operations on the uterus and appendages is the presence of the intestines and their tendency to obscure the view of the operator. The author has got over this difficulty by placing the patient over an inclined plane; when so placed the knees and half the trunk are raised to a considerable height above the head. The bowels thus fall away by their own weight from the pelvic basin. The patient is rendered insensible before being placed in the inclined position." If this is not the Tredelenburg position I should like to know how it differs?

I am, Sir, yours truly,
Alexander Duke.
London, W.

THE OLDEST HOSPITAL FOR SICK CHILDREN IN THE UNITED KINGDOM.

To the Editor of The Medical Press and Circular.

Sir,—To prevent misconception such as has occasionally arisen in the past and which might arise again in the future from the recent letter to the papers from the secretary of the Royal Waterloo Hospital, may I ask you to state that the first hospital for Sick Children to be established in this country was the Hospital for Sick Children, Great Ormond Street.

The treatment which the Royal Waterloo Hospital afforded before 1852, the year of the foundation of the Great Ormond Street Hospital, and for many years after that date, was dispensary treatment only.

How great was the need of a children's hospital at that time may be gathered from the fact that in January, 1842, out of 2,363 persons in all the London hospitals only 26 were children under the age of 10, while of 50,000 persons dying annually in the Metropolis 21,000 were children under that age.

I am, Sir, yours truly,
Stewart Johnson, Secretary.
Hospital for Sick Children,
Great Ormond Street, London, June 9th, 1908.

A memoir of the late Edmund Symes-Thompson, M.D., F.R.C.P., physician 40 years to the Brompton Hospital for Consumption, by his wife, with a preface by the Bishop of Wakefield, has just been published.

OBITUARY.

JOHN DUNLOP, M.D.Aberd., L.R.C.P. and S.Ed.

We regret to have to record the death of Dr. John Dunlop, of Bradford, which took place on June 5th after a somewhat long illness. Dr. Dunlop was of Scottish birth, but he had resided in Bradford so long that he had almost come to be looked upon as a native of the city. In everything in which he bore a part he was enthusiastic, and the cause of enthusiasm in others, and his death will consequently create a gap in the friendships of many men in Bradford. Born on August 28th, 1840, at Dolphinton, Lanarkshire, Dr. Dunlop as a youth received his medical education at the school attached to the Royal College of Surgeons, Edinburgh, and took the diplomas of L.R.C.P. and L.R.C.S., Edinburgh, in 1863. He then proceeded to Marischal College, Aberdeen, where he studied under his friend and teacher, the late Sir John Struthers. In 1864 he became M.D. of that University. For many years Dr. Dunlop had held the appointment of medical officer to the Bradford Post Office, and he was one of the oldest members of the Bradford Medico-Chirurgical Society, being for many years treasurer of that body. He was also a very active member of the Bradford Medico-Ethical Society, now merged in the British Medical Association. For the long period of thirty years he was a member of the committee of the Bradford Nurses' Institution, and at the time of his death he occupied the position of Chairman.

EDWIN RICKARDS, M.A.Oxon., M.B., F.R.C.P., F.R.C.S.

We regret to record that the death took place at Edgbaston, Birmingham, on June 11th, of Dr. Edwin Rickards, one of the leading physicians in the Midlands. He was President of the British Medical Association in 1880, and in 1902-4 was President of the Birmingham Medical Institute. In his early career Dr. Rickards was House Surgeon at University College Hospital, London. Subsequently he was connected in an honorary capacity with the General Hospital, Birmingham, and other medical charities of the city. He was a Justice of the Peace for the county of Warwick, and one of the best-known medical leaders in Birmingham.

JOHN O'NEILL, L.R.C.P. and S.Edin., L.F.P.S. Glasg.

Dr. John O'Neill has died somewhat suddenly at his residence, Beckett Cottage, Burmantofts. On May 30th broncho-pneumonia set in, and death took place on June 1st. Dr. O'Neill, who was 41 years of age, was a native of Glanworth, County Cork. After studying at Queen's College, Cork, he went to the Universities of Glasgow and Edinburgh, and gained the degrees of L.R.C.P., L.R.C.S., and L.F.P.S. in 1889. For a short period he acted as an assistant at Halifax, and then began on his own account in the East-end district of Leeds. He built up a large practice among the poorer classes, by whom he was greatly respected. When the recent re-arrangement of the districts of the Leeds Union was made, Mr. O'Neill was appointed Medical Officer of the No. 11 district, which comprises a large portion of the East-end of the city.

SIR JAMES ARTHUR HANBURY, K.C.B., M.B., Hon. F.R.C.S.Eng. and Irel.

We regret to report the death of Sir James Arthur Hanbury, K.C.B., Hon. F.R.C.S. Sir James, who had reached his 76th year, was a retired Surgeon Major-General. He entered the Army Medical Department fifty-five years ago. He became Surgeon 1863, Surgeon-Major 1873, Brigadier-Surgeon 1879, Deputy Surgeon-General 1881, and Surgeon-General 1887. His first services were in China, India, and America; but his greatest distinction was gained in connection with the Afghan campaigns of 1878-80. In the Khyber in 1879, when cholera was raging in the pass, Dr. Hanbury was the principal medical officer, and his services were of such sort that he was several times mentioned in despatches, and especially thanked by the Governor-General in Council and by the Indian Commander-in-Chief. He served on the march from Cabul to Kandahar, and was present at the battle of Kandahar, September 1st, 1880. He also served as principal medical officer in the Egyptian Campaign of 1882, with the rank of Surgeon-General, and took part in the battle of Tel-el-Kebir. Sir James received the distinction of K.C.B. after this campaign, and the Distinguished Service Award in 1905.

REVIEWS OF BOOKS.

DISEASES OF THE NERVOUS SYSTEM. (*a*)

This work on "Diseases of the Nervous System" is one of unusual interest to British readers, for it presents a series of articles—monographs, we might almost say—by German neurologists of eminence. As confirmatory of, and supplemental to, the works on the subject in this country, it will be found to have a high practical value, and we warmly commend its perusal to all interested in the topics of which it deals. The language and expressions used are a little different to what we are accustomed, for the translation of German articles by an American produces as a result a compound of sententiousness and modernism with a touch of pedantry, and we do not find the mixture a very convenient medium for conveying the thoughts of the authors. In a word, the style is heavy, and not very lucid, and the reader has to follow every word closely to be sure he catches the exact drift of the author's mind. Even then he is not always successful. But, as was said above, this work is evidently not intended for the tyro, and the instructed will find so much good matter in it that he will not be deterred by the style from delving deeply. It is very good to look at our daily problem again from a fresh point of view, and no British neurologist will read this work without having his mind stimulated by fresh thought, fresh criticisms, and fresh facts. For ourselves, we are particularly struck by Dr. W. Erb's articles on locomotor ataxy and Parkinson's disease; by Dr. P. Schuster's very clever dissertation on traumatic neurosis; and a refreshing account of sexual neurasthenia by Dr. A. Eulenburg. A very high standard, however, is maintained throughout, and it is somewhat invidious to particularise, and detailed criticism of so important a work by so many contributors could only be attempted in much more space than is here at our disposal. The book represents a high achievement, for which we are grateful to authors, editors, and publisher alike, and we have no hesitation in saying that no English-speaking neurologist can afford to be without it.

THE PHILOSOPHY OF DISEASE. (*b*)

In all the ages there has been, on the part of those whose minds turned to speculative pursuits, a desire to arrive at first principles. Among other principles, that unifying the phenomena of disease was and is, naturally, an object of search. The present portentous volume sets out at great length one of the oldest theories of the philosophy of disease. The plan of the work is a peculiar one. The author might have taken as his motto the words of Montaigne, "I have culled a bouquet of flowers, and brought nothing of mine own but the string that binds them." Not only in arrangement, indeed, does the work seem to belong to the era of "Elegant Extracts," but also in its knowledge, for few authorities are quoted later than those of the early Victorian age. Nevertheless, Mr. Russell has a wide taste. He quotes largely from the father of medicine, from Boerhaave, from Sydenham, and from the great men of the past, but he does not exclude an extract from the *Family Herald*, "a leading article, probably written by a University man," nor various cuttings from the *Athenæum* of the first half of the last century.

Mr. Russell's extracts are sorted out under various headings, "Indigestion," "Consumption, etc.," "Headaches," "Epidemics," and some score or more of others, each, however, being introduced by a few lines of his own. One might think that it would be a matter of difficulty to discover in this large mass the kernel of medical philosophy. Fortunately, Mr. Russell, however he may like to support his position by the opinions of others, is himself the tersest of philosophical writers. He sums up his principle in one line in a quarter-page introduction—"He now proposes that 'putrefaction' and 'bacteria' are synonymous." As stated at more length in the opening paragraph of many of the chapters, his doctrine is:—"All disease is the same in all parts of the body; its cause, morbid humour; its source, indigestion and constipation, or the putrefaction arising therefrom; . . . its remedy, purgatives" (p. 125). We cannot but reflect that in this quotation Mr. Russell accurately describes the ætiology and genesis of his own volume.

MANUAL OF PRESCRIBING. (*a*)

The art of prescription-writing is, we have good reason to believe, falling into disuse. It has, therefore, become necessary within recent years to call the attention of teachers in medical schools to the importance of giving instruction in this important subject to their students. Accordingly, Dr. Marshall's little manual appears very opportunely. It deals with the various orthodox modes of administering medicines, with solubilities, incompatibilities, and dispensing. The section on incompatibility is one which will be studied most closely by readers of this volume, for this is a subject concerning which a great many students, and practitioners, for that matter, have very confused ideas. Another very useful chapter is the one on the forms in which medicines may be administered. This chapter contains a number of excellent illustrative prescriptions, characterised for the most part by their simplicity of construction, and always by their accuracy. This chapter occupies one-third of the entire volume.

The section which deals with dispensing will be found valuable by students and also by practitioners who dispense (*i.e.*, in the strict sense) their own medicines. Here we find a very clear account given as to the making of suppositories, and even of capsules, which we fancy few medical men take the trouble to make for themselves. The author maintains that the only royal road to efficient prescribing is through the portals of dispensing. With this we heartily agree. There is no doubt that many mistakes in prescription-writing are made simply from a lack of the practical knowledge of dispensing.

An appendix is added which contains an account of the Latin used in prescribing, and a very full English-Latin vocabulary. This we consider is by no means the least useful part of this admirable manual. The teaching given is throughout sound and practical, and we can unhesitatingly recommend this volume for use either as a students' text-book or as a work of reference for the practitioner. The writer's wide experience as a teacher has enabled him to produce a work which is at the same time scientifically accurate as well as easy of comprehension. It will certainly take its place as a standard text-book on the subject with which it deals.

THE POLICE SURGEON'S EMERGENCY GUIDE. (*b*)

A very useful little book of tips for police surgeons, tips also which may be of great service to any medical man if called upon by the police in his professional

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(*a*) "Diseases of the Nervous System." By Archibald Church M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence, North-Western University Medical Department, Chicago. An Authorised Translation from "Die Deutsche Klinik," under the general Editorial Supervision of Julius Salinger, M.D. One hundred and ninety-five illustrations in the text and five coloured plates. London: Sidney Appleton. 1908. Price 25s. net.

(*b*) "Medical Philosophy; Man's Peculiarities, Weaknesses, Diseases, Degeneration, and Remedies." By W. Russell. Pp. xiv, and 504. London: Henry Kimpton. 1907. Price 21s. net.

(*a*) "A Manual of Prescribing for Students and Practitioners." By C. R. Marshall, M.D., Professor of Materia Medica and Therapeutics in the University of St. Andrews. London: J. and A. Churchill. 1908. Price 5s. net.

(*b*) "Police Surgeon's Emergency Guide." By C. Graham Grant, L.R.C.P. and S.Edin. Pp. 77. London: H. K. Lewis.

capacity. We quite agree with the modest words of the author in his preface, especially when he says:—“. . . This little book may rest unseen in the pocket, and perhaps justify its existence by saving its owner from making the little slip that leads to trouble,” and, we might add, “from cutting the sorry figure seen in the person of some medical men when giving professional evidence in the coroner's, police, or law courts.” This handy little volume should therefore form part of the *armamentarium* of all police surgeons, and also of any medical man who may be called upon to give skilled evidence in the courts. It is a pity the author does not facilitate the finding of the various tips by an index.

THE OXFORD PHYSIOLOGISTS. (a)

JUST two hundred and forty years ago the Oxford University Press published the celebrated “Tractatus Quinque” of John Mayow, and we gladly welcome Professor Gotch's lecture, issued by the same press, and drawing attention to the truly wonderful work which Mayow accomplished. The middle of the seventeenth century appears to have been the brightest period in the scientific life of Oxford University, and John Mayow stands out as pre-eminently among the great men of the time. Professor Gotch has endeavoured to explain why, not only the men of his own time, but scientists for more than a hundred years afterwards, failed to realise the value of the work contained in this small volume of five essays, but we cannot say that the explanation is very satisfactory. Richard Hook, no doubt, published the very imperfect abstract of Mayow's work which appeared in the “Transactions of the Royal Society,” but Mayow's work was published by the Oxford University Press, and was translated into Dutch and issued at Amsterdam in 1688, and so, at all events, was available in its complete form for the use of scientific inquirers. Mayow died five years after the publication of his work, and it seems to us that this work was overlooked, as the work of many another has been since, simply because the author was unable to insist on its importance by constant reiteration. Whatever may be the explanation, we are glad to think that now, at all events, Oxford recognises the worth of her great son, and our thanks are due to Professor Gotch for the very interesting account which he has given of him. The original editions of Mayow's works are difficult to obtain, but last year the Alembic Club, of Edinburgh, published an English translation of the “Tractatus Quinque,” and we could have wished that Professor Gotch had urged his readers to study for themselves this most interesting volume.

A CHRONOLOGY OF MEDICAL HISTORY. (b)

VERY little attention has ever been paid in these countries to the study of medical history, and there is, perhaps, no subject connected with his profession of which the general practitioner is more ignorant. The works of Freind, Leclerc, Wise, Berdoe, Withington and Hamilton seem to be almost unknown to many medical men, and certainly are not read by most. It has always seemed to us a pity that every doctor has not some general knowledge of the history of his profession; but perhaps the establishment of the Fitzpatrick Lectureship in London may do something to remedy the defect. The little book before us gives a brief epitome, with dates, of some of the chief events in medical history, and of the men who took part in them. It does for English students what Spemann's “Historischer Medicinal-Kalendar” does for Germans, though perhaps not quite so well. There are some curious omissions in the book, such, for instance, as 1846. One would have expected that the date of the introduction of artificial anæsthesia for surgical purposes was of sufficient interest to be mentioned. Graves is mentioned, but there is no record of his greater colleague, Stokes. More care might have been expended in verifying the dates, for we find Clopton Havers described as living from 1550 to 1702. This may, of course, be a mere typographical error, but it is difficult to account in this way for the dates associated with the name of John Howard. The date of his birth cannot be absolutely fixed, but it is generally agreed that it cannot have been later than the end of 1727, while our author puts it at 1766. We lay stress on these, which may seem minor points, because we consider that in a book of the kind accuracy is essential.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE. (a)

WHETHER the union of the Medical Societies of London will prove to be all that its promoters promised it would be, is a matter which only the future can decide. There can, however, we think, be little doubt that the publication of these proceedings will be of the very greatest value to all students of medicine. One has here gathered together the reports of practically all the work of the London School of Medicine, and these reports are presented monthly while the matter with which they deal is still fresh. It is impossible for us in the space at our disposal to even indicate the great mass of material in all branches of medical knowledge contained in these reports, but it is sufficient to say that here we have a full account of the proceedings of all the chief medical societies of London. The form in which these reports are presented, and the excellence of the illustrations, reflects the greatest credit on the publishers, Messrs. Longmans, Green and Co.

HUMAN ANATOMY. (b)

WE have again the pleasure of welcoming a volume of Professor McMurrick's sumptuous anatomy. Volume III. deals with the Vascular System, the Lymphatic System, the Nervous System, and the Sense Organs, and it exhibits the same qualities as its predecessors. That is to say, it presents to the profession a series of diagrams, mostly in colours, which stand unexcelled for beauty and faithfulness of all the important and many of the less important parts of the body, together with accurate, lucid, and unencumbered accounts of regional anatomy. We doubt if pictorial art has ever achieved anything higher in the domain, in human anatomy, than figure 551, showing a dissection of the neck and axilla. It is more than lifelike because it shows the contrasts between the parts even more vividly than the actual subject, alive or dead, does. We need not say more than that to the student this book should prove an “Anatomy without Tears,” and to the practitioner a ready-made dissecting-room ever at his elbow.

AN INTRODUCTION TO DERMATOLOGY. (c)

THE fourth edition of this, the best-known of the smaller works on dermatology, marks an important advance on previous editions. While the size has been greatly increased, the author has nevertheless kept to the condensed yet easy style of treatment that gives a peculiar attraction to his writings. We notice that alopecia areata is treated as a symptomatic malady of multiple origin, and the theory of infection is accepted, as well as a nervous origin, while Mr. Hutchinson's theory that it is a sequel of ringworm is discussed, as well as Sabouraud's specific micro-organism. We note, however, that no mention is made of the syphilitic form described by some observers, nor of the variety associated with myxœdema and other constitutional affections. Lactic acid is advised as an excellent remedy, a point upon which those who have tried that drug will agree. Dr. Walker is emphatic upon the desirability of excluding a child from school when affected with alopecia patches. There is much to support that view both on grounds of prudence and for other obvious reasons. One of the great features of the present edition is to be found in a number of excellent illustrations in three-colour reproduction process. They are of first-rate quality, and greatly add to the value of the book. There is no particular need to criticise at length the contents of a work that has attained the dignity of a fourth edition. Suffice it to say that Dr. Norman Walker has here ably maintained the reputation of the Scotch school of dermatology. For any medical man who wants a crisp, readable, and eminently clear guide to the study of diseases of the skin, we can imagine no more useful volume to place on his bookshelf.

(a) “Two Oxford Physiologists; Richard Lower, 1631 to 1691, and John Mayow, 1645 to 1679.” By Francis Gotch, B.Sc., Waynflete Professor of Physiology in the University of Oxford. Oxford at the Clarendon Press. 1908. 8vo, pp. 39.

(b) “A Chronology of Medical History.” By James Young, M.D. 8vo, pp. 91. Bristol: Edward Everard.

(a) “Proceedings of the Royal Society of Medicine.” Edited by John Nachbar, M.D. Vol. I, Nos. 2, 3 and 4, December 1907 to February 1908. London: Longmans, Green and Co.

(b) “Atlas and Text-Book of Human Anatomy.” By Dr. Johannes Sobotta, Professor of Anatomy in the University of Würzburg. Edited, with additions, by J. Playfair McMurrick, A.M., Ph.D., Professor of Anatomy in the University of Michigan. Vol. III, Vascular, Lymphatic, and Nervous System, and Sense Organs. Two hundred and ninety-seven illustrations, mostly in colours. Philadelphia and London: W. B. Saunders Co. 1907. Price 25s.

(c) “An Introduction to Dermatology.” By Norman Walker, M.D., F.R.C.P., Physician for Diseases of the Skin, Royal Infirmary, Edinburgh. Fourth edition. Edinburgh and London: William Green and Sons. 1908. Price 9s. 6d.

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

Sidney Appleton (London).

Diseases of the Breast, with special reference to Cancer. By W. L. Rodman, M.D., LL.D. Illustrated. Pp. 385. Price 16s. net.

Baillière, Tindall and Cox (London).

Physical Signs of Diseases of the Thorax and Abdomen. By James E. H. Sawyer, M.A., M.D.Oxon., M.R.C.P.Lond. Illustrated. Pp. 188. Price 5s. net.

The Treatment of Gonorrhœa in the Male. By Charles Leedham-Green, M.B., F.R.C.S. Second Edition. Illustrated. Pp. 160. Price 5s. net.

A Manual of Diseases of the Eye. By Charles H. May, M.D., New York, and Claud Worth, F.R.C.S.Eng. Second Edition. Illustrated. Pp. 400. Price 10s. 6d. net.

Diphtheria in Practice. By W. F. Litchfield, M.B.Syd. Illustrated. Pp. 96. Price 3s. 6d. net.

Lectures on Babies: A Course of Lectures delivered at the Infants' Hospital, Westminster. By Ralph Vincent, M.D., B.S., M.R.C.P. Illustrated. Pp. 114. Price 2s. 6d. net.

J. B. Baillière et Fils (Paris).

La Diathese Urique. Par Henri Labbe, Chef de Laboratoire a la Faculte de Medecine de Paris. ("Les Actualites Medicales.") Price Fr. 1.50.

Cassell and Co., Ltd. (London).

Clinical Methods. A Guide to the Practical Study of Medicine. By Robert Hutchison, M.D., F.R.C.P., and Harry Rainy, M.D., F.R.C.P.Ed., F.R.S.E. Fourth Edition, revised. Pp. 632. Price 10s. 6d.

Hygiene and Public Health. By B. Arthur Whitelegge, C.B., M.D., etc., etc., and George Newman, M.D., D.P.H., F.R.S.E. Illustrated. New and Revised Edition. Pp. 650. Price 7s. 6d.

Churchill, J. and A. (London).

A Short Practice of Midwifery. By Henry Jellett, B.A., M.D. Dublin Univ., F.R.C.P.I., with a preface by Sir W. J. Smyly, M.D., F.R.C.P.I. Fifth Edition, revised and illustrated. Pp. 654. Price 10s. 6d. net.

A Manual of the Practice of Medicine. By Frederick Taylor, M.D., F.R.C.P. Eighth Edition. Pp. 1,111. Price 16s. net.

Uric Acid as a Factor in the Causation of Disease. By Alexander Haig, M.A., M.D.Oxon., F.R.C.P. Seventh Edition. Pp. 940. Price 14s. net.

Eliot Boothroyd (London).

Low's Handbook of the Charities of London, 1908. Pp. 278. Price 1s.

Henry Frowde and Hodder and Stoughton (London).

Oxford Medical Publications. Glandular Enlargement and Other Diseases of the Lymphatic System. By Arthur Edmunds, M.B., M.S., B.Sc.Lond., F.R.C.S.Eng. Pp. 230. Price 7s. 6d. net.

Diseases of the Spinal Cord. By R. T. Williamson, M.D. Lond., F.R.C.P. Illustrated. Pp. 342. Price 15s. net.

The Law in General Practice: Some Chapters in Every-day Forensic Medicine. By Stanley B. Atkinson, M.A., M.B., B.Sc., of Inner Temple, Barrister-at-Law. Pp. 239. Price 7s. 6d. net.

The Operations of General Practice. By Edred M. Corner, M.A., M.C., M.B., etc., etc., and H. Irving Pinches, M.A., M.B., B.C., etc., etc. Second Edition. Revised and Enlarged. Pp. 338. Price 15s. net.

A System of Syphilis in Six Volumes. Edited by D'Arcy Power, M.B.Oxon., F.R.C.S., and J. Keogh Murphy, M.D., M.C., F.R.C.S., with an Introduction by Jonathan Hutchinson, F.R.C. Vol. I. Pp. 380. Price £2 2s. net per vol.

Henry J. Glaisher (London).

Hay-Fever, Hay-Asthma, Its Causes, Diagnosis, and Treatment. By Wm. Lloyd, F.R.C.S. Second Edition. Pp. 101. Price 4s. 6d. net.

Wm. Green and Sons (Edinburgh).

An Introduction to Dermatology. By Norman Walker, M.D., F.R.C.P. Illustrated. Fourth Edition. Pp. 332. Price 9s. 6d. net.

Charles Griffin and Co., Ltd. (London).

Forensic Medicine and Toxicology. By J. Dixon Mann, M.D., F.R.C.P. Fourth Edition, revised and enlarged. Pp. 709. Price 21s.

Greening and Co., Ltd. (London).

Education, Personality, and Crime. A Practical Treatise built up on Scientific Details, dealing with Difficult Social Problems. By Albert Wilson, M.D.Edin. Illustrated. Pp. 296. Price 7s. 6d. net.

G. Gillies and Co. (Glasgow).

The Practical Medicine Series. (10 Vols.) Under the General Editorial Charge of Gustavus P. Head, M.D. Vol. I. General Medicine. Edited by Frank Billings, M.S., M.D., and J. H. Salisbury, A.M., M.D. Pp. 408. Price 6s.

The Practical Medicine Series. (10 Vols.) Vol. II. General Surgery. Edited by John B. Murphy, A.M., M.D., LL.D. Pp. 614. Price 8s.

The Practical Medicine Series. (10 Vols.) Vol. III. The Ear, Nose, and Throat. Edited by C. A. Wood, C.M., M.A., A. H. Andrews, M.D., and G. P. Head, M.D. Pp. 355. Price 6s.

H. K. Lewis (London).

Public Health Laboratory Work. By Henry R. Kenwood, M.B., D.P.H., F.C.S. Part dealing with Public Health Bacteriological Work is contributed by W. G. Savage, M.D., B.Sc., D.P.H. Fourth Edition. Illustrated. Pp. 468. Price 10s. net.

Materia Medica and Pharmacy for Medical Students. By Reginald R. Bennett, B.Sc.Lond., A.I.C. Pp. 221. Price 4s. 6d. net.

Rough Notes on Remedies. By Wm. Murray, M.D., F.R.C.P. Lond. Sixth Edition. Pp. 192. Price 4s. net.

Experimental Researches on Specific Therapeutics. By Prof. Paul Ehrlich, M.D., D.Sc.Oxon. (The Harben Lectures for 1907.) Pp. 95. Price 2s. 6d. net.

J. B. Lippincott and Co. (London).

The Diseases of Children. A Work for the Practising Physician. Edited by Dr. M. Pfaundler and Dr. A. Schlossmann. English Translation edited by Henry L. Shaw, M.D., and Linnæus La Fetra, M.D. Four Vols. Illustrated. Price £4 4s. net.

International Clinics. Edited by W. T. Longcope, M.D., Philadelphia, U.S.A., with Collaboration. Vol. I. Eighteenth Series, 1908. Price 35s. net for 4 Quarterly Volumes.

Longmans, Green and Co. (London).

Proceedings of the Royal Society of Medicine. Vol. I., No. 7. May, 1908. Pp. 88. Price 7s. 6d. net.

Rebman, Ltd. (London).

Vitality, Fasting, and Nutrition. By H. Carrington, with an introduction by A. Rabagliati, M.A., M.D., F.R.C.S. Pp. 648. Price 21s. net.

Electric Ions and their Use in Medicine. By Professor Stephane Leduc. Translated by R. W. Mackenna, M.A., M.B., Ch.B.Edin. With an Appendix by the Translator. Only Authorised Translation from the French Edition. Pp. 70. Price 2s. 6d. net.

The Theory of Ions. A Consideration of its Place in Biology and Therapeutics. By William Tibbles, M.D.Chicago, LL.D., L.R.C.P.E., M.R.C.S., L.S.A., etc. Pp. 131. Price 2s. 6d. net.

The Scientific Press, Ltd. (London).

The Heart and Sudden Death. By Theodore Fisher, M.D., F.R.C.P. Illustrated. Pp. 53. Price 2s. net.

"The Pilot" Press (London).

Cancer: Operation not the Cure but a Cause. By John Shaw, M.D.Lond., formerly Vice-President, British Gynæcological Society, and (for upwards of 20 years) Physician for Diseases of Women, North-West London Hospital. Pp. 144. Price 1s. net.

J. Whitaker and Sons, Ltd. (London).

The Holiday Whitaker: A Guide to the Holiday and Health Resorts of the United Kingdom. Illustrated. Pp. 397. Price 1s. net.

John Wright and Co. (Bristol).

Golden Rules of Venereal Disease. By C. F. Marshall, M.D., F.R.C.S. Pp. 90. Price 1s.

Vermin Inquiry.

The Society for the Destruction of Vermin have appointed a special committee to inquire into the various existing laws and regulations concerning noxious insects and animals, to agitate for their more efficient and extended application, and to propose such amendments or promote such new laws as may be necessary to meet requirements in the light of modern knowledge, especially with regard to the all-important and recently ascertained *rôle* played by vermin in the dissemination of disease germs communicable to man and domesticated animals.

WEEKLY SUMMARY OF MEDICAL LITERATURE, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Symptomatology of Gastric Cancer.—Przewalski (*Zentralblatt f. Chiurgerie Leipsic*, April, 1908) calls attention to the contraction of the middle intercostal spaces on the right side of the thorax as an early sign of carcinoma of the stomach. It is probably a reflex contraction from the nerves of that part of the stomach wall most frequently affected with malignant disease. In the later stages all the intercostal spaces are contracted on both sides, as also in case of cancer of the œsophagus. He examines for this contraction with his finger tips between the axillary lines. D.

Chilling as a Cause of Sickness.—Siegel (*Deut. Med. Woch.*, March, 1908) has experimented on dogs, proving that the presence of bacteria *plus* the action of cold does not always cause disease. On the other hand, cold without bacteria is able to produce parenchymatous nephritis under certain conditions. The dogs in his experiments invariably developed a bilateral nephritis, even when only one foot had been immersed in ice water. In most of his experiments the hind legs of the animal were covered with ice water from the knee downwards at a temperature of 39° F. He explains this by the fact that chilling of the feet induces constriction of the renal vessels by reflex action, and if this reflex anæmia persists for a considerable time, it causes disturbances in the circulation and in the nutrition of the kidney cells, followed by degenerative changes, with inflammation as the final outcome. The chief result of these experiments is the proof that an acute kidney affection can be produced by chilling alone, without the presence of bacteria. D.

Müller's Test for the Functioning of the Pancreas.—(*Mün. Med. Woch.*, April, 1908).—This communication reports favourable experiences with Müller's test of pancreas functioning at Von Strumpell's clinic at Breslau. The simplicity and convenience of the test commend it, Schlecht says, while it is thoroughly reliable, and requires only a few drops of fæcal matter. Another advantage is that the material is sterilised by the high temperature. The test is based on the proteolytic action of the pancreatic ferment trypsin. The patient is given a test meal, and two hours later a calomel purge. A few drops of the thin stool then obtained are sown on a plate of Loeffler serum, which is kept for 24 hours at a temperature of 131° to 141° F. If there is any of the pancreatic ferment in the stool, the surface of the Loeffler serum shows pronounced depressions where the proteolytic ferment has been at work. In the absence of the pancreatic ferment the surface of the serum remains smooth, with no tendency to dimpling. D.

Diet in Nephritis.—Louria (*Long Island Med. Journ.*, March, 1908) discusses the physiologic chemistry of renal excretion in regard to diet. His experience enables him to support the French dechloridisation treatment. The salt-free diet certainly seems to cause a general improvement of the patient, the diminution of œdema, and a loss of weight, all of which seem to be parallel phenomena. Indeed, increase of weight in a nephritic may be interpreted as the first symptom of the beginning of an œdema not yet visible. He considers the idea that red meat is more harmful than white as exploded. As regards the quantity of meat, the nephritic should receive a daily ration of 100 grammes of albumin. Assuming that he takes 750 c.c. of milk, containing 26 grammes of albumin, two eggs, with 13 grammes of albumin, and that 20 grammes of proteid are in other food, as bread, vegetables, etc., there still remains 50 grammes of proteid that he can be allowed in the form of meat, which amounts to about half or three-quarters of a pound. D.

Alimentary Poisons and Atheroma.—Loeper (*Arch. des Maladies du Cœur des Vaisseaux et du Sang.*, Paris, 1908) gives illustrations of processes of calcification and atheroma found in the arteries of animals under the influence of certain alimentary poisons. If the diet could be strictly atoxic from beginning to end, then atheroma could be warded off, he says. Oxalic acid was particularly active in inducing atheroma in his rabbits, and he warns that rhubarb, spinach, and tomatoes contain an unusualy large proportion of oxalic acid, which is also present, he says, in large proportions in tea, coffee, kola and cocoa. The latter also contains, he states, from .65 to 2 per cent. of theobromin, and theobromin is another vascular poison, as he shows by the atheroma induced in rabbits by injection of theobromin acetate. Administration of lime salts had also a marked favouring action on the experimental atheroma. The lesions induced in his experiments were always calcification of the middle layer of the vessel wall. No tendency to sclerosis was ever noted. D.

Etiology of Plague in India..—Bannerman gives a critical analysis and summary of the recent researches of the Plague Commission into the etiology of plague in India (*Edin. Med. Journ.*, May, 1908, p. 417). The account itself must be read to gain any connected view of the work upon which the conclusions drawn are founded, but the general conclusions of the writer are of sufficient importance to quote without further comment. They are as follows:—(1) Pneumonia plague is highly contagious, but being rare (less than 3 per cent. of all cases), plays a very small part in the spread of the disease. (2) Bubonic plague in man is not infectious, and is entirely dependent on the disease in the rat. (3) The infection is conveyed from rat to rat, and from rat to man, solely by means of the rat flea. (4) Plague is usually conveyed from place to place by rat fleas, brought by people in their baggage or on their persons. M.

Enlargement of Supraclavicular Glands in Abdominal Carcinoma.—Schellschmidt observes that enlargement of the supraclavicular glands either on the right or left side is by no means a frequent occurrence in abdominal carcinoma (*Centralbl. für Inn. Med.*, No. 23, 1908, p. 585). When present, however, it is of considerable diagnostic value. The enlargement is nearly always caused by metastases, and is only occasionally of an inflammatory nature. The enlargement may also be found in scrofula, syphilis, leucæmia, and in malignant tumours of the mediastinum and lungs. In any doubtful case extirpation and microscopical examination of the suspected gland should be carried out. The metastatic growths are caused either by emboli or by continuous extension of the primary growth along the lymphatics, and glandular involvement in the neck is usually secondary to involvement of other organs, such as the liver. In consequence, gland metastases in the neck are an absolute contraindication to any operation, with the doubtful exception of cases in which the primary growth is in the cardiac end of the stomach. Once involved with cancer, the lymph glands very rapidly increase in size. M.

The Toe-Reflex.—Rossolimo describes a special toe-reflex which he states to be of considerable pathological importance (*Neurol. Centralbl.*, 1908. No. 10). The reflex is obtained as follows:—In individuals suffering from disease of the upper motor neurone, a short, quick stroking movement of the finger is made along the plantar aspect of the toes in the direction from behind forwards: the toes will then, after a variable interval, perform a characteristic movement of flexion or abduction, provided that the calf muscles and those of the foot are kept in a state of complete relaxation. Rossolimo states:—(1) That this toe-reflex is only obtained in cases where the pyramidal tracts are diseased, and is never found in simple neuroses. (2) That it can often be observed in cases where Babinski's sign is absent. (3) Its intensity varies much—from a scarcely perceptible movement, up to a smart contraction. (4) In contradistinction to other tendon reflexes, whose value depends upon an increase above the normal, this reflex, if present at all, is pathognomonic of disease, as it is never found in normal individuals. M.

Poisoning by Thiosinamin.—Thiosinamin and its ally, fibro-lysin, has been so largely used of late to cause absorption of morbid fibrous tissue, that it has become of importance to observe any untoward symptoms caused by its use. Grosse reports a case of poisoning following the injection of six doses of fibrolysin at intervals of five days (*Munch. Med. Woch.*, 1905. No. 17). The symptoms consisted of cardiac weakness, anuria, fever, vomiting, and severe debility. The sickness lasted altogether for four weeks, and was followed by recovery. M.

Treatment of Eczema of Infants by Thyroid.—Eason (*Scottish Med. and Surg. Journ.*, May, 1908) reports five cases of eczema in infants and young children which were treated entirely by small doses of thyroid extract with most excellent results. In each of the cases the children had been ill for some time previously, and had not improved in spite of careful and persistent local treatment. One of the children, æt. 9 months, had shown symptoms of eczema for two months, which persisted, in spite of the use of various ointments. A quarter of a grain of the thyroid was given daily, and in a week the eruption was very much better. A month later, when the rash was almost well, the child developed a severe attack of bronchitis; the drug was then stopped, but the child died of convulsions two days later. There seemed to be no reason to connect the thyroid with the fatal result, and at the time of death the child was practically cured of the eczema. Moussous, Parhon and Urechie have also recorded good results from this form of treatment. K.

X-Rays in the Treatment of Lupus.—Tomkinson (*Practitioner*, June, 1908) details the method which he has for the past two years adopted in the treatment of lupus vulgaris by X-rays. As a general rule this method of treatment is only adopted when the lesion is situated on some exposed part, and when, in consequence, the nature of the resulting scar is of considerable importance. If any crusts are present they are removed by an application of salicylic ointment, and then a tentative X-ray exposure of from three to five minutes' duration is made upon a small area of the lesion. If no ill result follows from this in the course of a few days, daily exposures are given of about five minutes' duration over a wider area until the whole lesion has been exposed some three or four times. It is then plastered with Unna's 50 per cent. salicylic acid and creosote plastermulle, which is renewed daily. If this causes much pain the parts may be swabbed with a 10 to 20 per cent. solution of cocaine previous to its application. In about ten days it is found that much of the tuberculous tissue has come away. The lesion is then swabbed with cocaine solution, dried, and afterwards painted with the following preparation:—Carbolic acid, 50 per cent.; lactic and salicylic acids, of each 15 per cent.; and absolute alcohol, 20 per cent. A few minutes afterwards the lesion is painted with a solution of 80 per cent. carbolic acid in absolute alcohol. In extensive cases it is well to cauterise only part of the lesion at a time, but as much as a whole cheek may safely be done at one time. After cauterisation the part is dressed for a day or so with carbolic oil, and then with a 20 per cent. aqueous solution of ichthyol until healing has taken place. As a rule the healing is rapid, and when it is complete the X-ray treatment is recommenced and continued for about three months. Only short exposures are given, rarely more than three or four minutes. Treatment is then discontinued for a considerable interval, during which time the patient returns periodically for inspection. Sometimes it is necessary to submit the patient to a second course, but this is only done after an interval of some months. Tomkinson states that this method has given excellent results, and the cicatrices resulting from this combined treatment of X-rays and cauterisation are, as a rule, smooth and flexible and show few telangiectases. K.

The Use and Abuse of Digitalis.—Janeway (*Amer. Journ. of the Med. Sciences*, June, 1908) states his belief that there are five chief causes of failure in the employment of digitalis. These are:—(1) The use of inefficient preparations; (2) use in unsuitable cases; (3) improper dosage; (4) improper methods of administration; and (5) neglect of other necessary therapeutic measures. It would appear that good digitalis is not at all plentiful, and that various specimens and preparations of the drug vary very much in their therapeutic activity. Janeway himself favours the infusion, provided it is freshly made from good leaves; but the tincture and the powdered leaves are also both reliable preparations. If the administration of digitalis by the mouth is followed by vomiting, administration by the rectum should be tried. An injection of half an ounce of the infusion three times a day will, as a rule, give as prompt results as administration by the mouth, while if a very rapid effect is needed hypodermic administration may be resorted to. K.

MEDICAL NEWS IN BRIEF

The Management of St. Bartholomew's Hospital.

Lord Ludlow (the treasurer) and the five almoners of St. Bartholomew's Hospital have resigned their posts because a unanimous recommendation made by them, which they considered all important for the future welfare and good management of the hospital, was not adopted by the court of governors. A court of governors was held on Thursday last, when the following resolution was unanimously adopted:—

"That in accepting the resignation of the Right Hon. Lord Ludlow of the office of treasurer, to which he was elected on January 26th, 1905, this court hereby records its deep sense of appreciation of the very valuable services he has rendered to the hospital. The important structural alterations and additions which have been carried out under his treasurership have added greatly to the efficiency of the hospital, and the advantages that have accrued to the institution as the result of the various reforms instituted by him in the management of the estates, and in the internal administration of its affairs, cannot be overestimated, and the court tenders to Lord Ludlow its grateful acknowledgments."

The almoners consented to postpone their resignation until July next, in order that the affairs of the hospital may be carried on whilst the new officers are appointed.

The Dublin Hospital for Diseases of the Skin.

A curious case was heard before Judge Barton during the past week in which the plaintiffs, consisting of one member of the staff of this hospital and one of its governors, sued the remaining member of the staff and the other governors with the object of obtaining an account of all sums of money paid from time to time by the Managing Committee of the hospital to the defendant member of the staff, Dr. C. M. O'Brien. These payments were stated to be made on foot of an alleged agreement between the committee and Dr. O'Brien, by which the committee agreed to purchase certain X-ray apparatus from Dr. O'Brien. These apparatus were to be paid for by instalments, and in the meantime Dr. O'Brien was to receive one-half of the profits of the working of the apparatus. The plaintiffs also asked for an account of all sums of money received by Dr. O'Brien from the South and the North Dublin Unions and other Poor-law Unions in Ireland from which patients were sent for treatment in the Hospital, which funds, it was charged, had never been brought to the credit of the funds of the hospital; also for sums of money received by Dr. O'Brien from patients not brought by him to the credit of the funds of the hospital. The defence was a traverse of the material allegations in the affidavits on behalf of the plaintiffs. The chief points of difference were as to whether the hospital was entitled, under the agreement, to receive half of the amount paid to Dr. O'Brien by the various Poor-law unions for treatment of patients at the private rooms of Dr. O'Brien in Mary Street.

Mr. Justice Barton directed an account to be taken from April 10th, 1902, of all moneys paid to Dr. O'Brien by the Poor-law Unions and other public bodies on foot of the agreement up to the present: also that Sir Robert Gardner should audit the accounts of the hospital, the account to be afterwards taken before the chief clerk, and that payments now being made to Dr. O'Brien should cease. His lordship further said that, if it had not been for Dr. O'Brien there would have been no such hospital in Dublin, and that he deserved much credit for the cures he had effected.

The Annual Meeting of the Royal Medical Benevolent Fund Society of Ireland.

The annual meeting of this Society was held during the past week, the President of the Royal College of Surgeons in the chair.

Sir John William Moore read the report of the Central Committee, which, having dealt with formal matters, noted some changes which had been rendered necessary in the list of the Society's officers, and paid tribute to the memory of members whose death had occurred since the previous annual meeting.

Dr. Joynt read the financial statement, from which it appeared that during the financial year 1907-8 eighty-four grants were awarded by the Central Committee, amounting to £1,127. Dividends on stock realised £785, an increase of £96 17s. 10d. on the preceding year. The Society received £71 9s. 6d. from the Dublin and South-Eastern Railway Company.

On the motion of Mr. Wm. Taylor, seconded by Mr. M'Namara, warmest thanks were passed to the Committee and officers of the parent Society, and the provincial branches for their hearty zeal.

On the motion of Dr. Bradley, seconded by Dr. W. H. Byrne, the Central Committee and other office bearers were re-appointed for the ensuing year.

Interesting Inquest.

On June 11th, at the City Coroner's Court, Dr. F. J. Waldo held an inquest with reference to the death of B. E. Clark, 17, a waiter, who died in St. Bartholomew's Hospital. Clark was crushed across the shoulders while trying to get out of a lift in October last. His spinal column was broken, and he was admitted to St. Bartholomew's Hospital, although he was paralysed from the middle of the shoulders downwards. During seven and a-half months that Clark was in the hospital he was visited by some of the most eminent surgeons, who took great interest in the gradual progress of the case. Everything possible was done to brighten Clark's life, and a special reading desk was fitted up above his bed to enable him to get as much comfort as he could in his helpless state. He died on Wednesday. Dr. Basil Lang, house surgeon at St. Bartholomew's Hospital, stated that Clark was completely paralysed when admitted, as his neck was broken. After a time an operation was performed for the purpose of seeing if the backbone was pressing on the spinal cord, and they then found that the cord was completely severed 2 in. below the brain. He had never had a similar case. The jury returned a verdict of "Accidental death," and added a recommendation that something should be done so that the lift could be worked outside as well as inside.

Charges Against a Medical Man.

The Waltham Abbey magistrates dealt on June 11th with two charges against Frederick Charles Ackland, 34, described as a physician and surgeon, of Brailsford Road, Brixton. In the first case the charge was brought by the N.S.P.C.C., and had reference to Mary McCarthy, 4 years of age. It was alleged that prisoner found the child and her sister Kate, who is two years older, playing in Lincoln's Inn Fields, and that, giving them chocolates and oranges, he persuaded them to go with him to Liverpool Street Railway Station, taking them thence to Epping Forest. The second charge was for contracting a bigamous marriage with Hetty Florence Gertrude Satchell. In her evidence Miss Satchell said she met the prisoner on September 14th, 1907, on board the *Pomeranian*, bound for Canada. She was travelling from London to Montreal, and he was engaged as doctor on the vessel. They became friendly, and on October 3rd they were married at St. George's Church, Montreal, she believing him to be a single man. Evidence was given of the prisoner's marriage on October 5th 1898, to Margaret Hankey at Dalton-in-Furness, and that she is still alive. Prisoner, who asked no questions, was committed for trial at the Essex Assizes.

Death by Compressed Air.

The death of an apprentice, Wilkinson, by name, at the Central Marine Engine Works, Hartlepool, was inquired into by a coroner's jury at Hartlepool on June 9th. Two fellow-apprentices, D. M. Johnson and W. H. Woodward, who have been remanded in connection with Wilkinson's death, were present. To his father, who saw him in hospital, Wilkinson had said: "What a foolhardy trick those boys have done to me. They have filled me with compressed air. I was standing at the bench, when the pipe was put between my legs. I felt myself swelling right out. What a funny sensation I had!" Woodward's story was that he picked up the pipe which serves compressed air to the pneumatic tools, intending to clean the bench with it. Johnson turned on the tap, and when the air came through the pipe the end flew up and caught Wilkinson between the legs. Another witness said that Wilkinson was blown up like a bladder. The stated maximum air pressure produced by the apparatus was 100 lb. per square inch. The jury exonerated the management of the works, and found insufficient evidence to show whether the youth had received the compressed air accidentally or otherwise.

Death under an Anæsthetic.

An inquest was held by Mr. W. Schroder, on June 9th, on Hortense Berthand, æt. 18, single, a French dressmaker. Mlle. Berthand suffered, it was stated, from an affection of the right ear, and after consulting a medical man, it was deemed advisable that she should undergo a surgical operation. For this purpose she entered the Central London Throat, Nose, and Ear Hospital, Gray's Inn Road. She was, M. Jan, her brother-in-law, said, informed before consenting to the operation that "she need not be afraid, as there would be no danger." The operation was being performed on Thursday, when death ensued whilst she was under the influence of an anæsthetic. The witness added that it was an outside practitioner who stated that there was no danger. Dr. D. Mackenzie, Assistant-Surgeon at the Hospital, stated that both Dr. Dundas Grant and he were of opinion that an operation in this case was urgent, and that if it were not performed the patient would certainly die from the disease from which she suffered—an abscess in the middle ear. Chloroform, and also a mixture of alcohol, chloroform, and ether, having been administered, the witness began to operate for the relief of the abscess, when the patient suddenly expired before the operation—which was not very serious in itself—could be completed. There were seven doctors present altogether, and everything possible was done with a view to resuscitation. The Coroner: It is said that she was told that she need not be afraid, as there would be no danger. Is that a statement likely to be made by a medical man? Dr. Mackenzie: I do not think so. If made, it would, perhaps, be qualified. The impression left on the girl's mind nobody can tell. Dr. B. Kingsford, the hospital anæsthetist, said he had administered the alcohol, chloroform, and ether mixture 10,000 times previously without fatal mishap. Dr. Wingrave, pathologist at the hospital, who had made an autopsy, attributed death to syncope whilst the patient was under the influence of the anæsthetics, which were not, he thought, administered in excess. The jury found a verdict of "Death by misadventure."

NOTICES TO CORRESPONDENTS, &c.

☛ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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T. P.—We are glad to see that you value our opinion. You seem as well up in the modern development of surgery as we ourselves.

S. R.—No medical man should refuse to itemise his account if the patient wishes it. There may be far too much standing on dignity, and it is possible that a mistake may have been made. In following the fashion of sending in an account for a lump sum, it is by no means implied that a patient is not entitled to details if he wishes. Some business men do not understand the practice, and rather resent it. Medical men should be thankful they are not compelled to send in accounts as elaborate as that of a solicitor.

CITY OF LONDON CORPORATION MEDICAL EXAMINATION.

In accordance with the Standing Order of the Court, everyone now entering the employment of the Corporation in any capacity has to pass a medical examination. Last year 50 persons were so examined, and of these 7—or 14 per cent.—were reported by the Medical Officer as physically unfit for office. Nineteen officers were also medically examined with a view to their retirement, and of these 9—or 47.3 per cent.—were reported to be unfit for duty.—*City Press.*

G. E.—Thank you for calling our attention to the matter of the letter. We wish you all success.

C. E. R. (Miss).—We have written to you privately. The matter is not one in which we can give more than general advice, and, of course, we cannot recommend private practitioners. There is no need, so far as we can see, for you to come to London.

Scotsman.—Thank you for your interesting communication and enclosure. The matter is so important that we have ventured to make use of the former in the way you will see. We feel sure you will be agreeable.

F. W. L. (Liverpool).—We are much obliged for your letter and newspaper. As you see, we are dealing with this important matter more extensively this week.

Enquirer.—Vacant posts of the nature mentioned are not often announced in the English medical journals. Two such are advertised in our present week's issue at Sanatoria in New South Wales. For details we refer you to the announcement in another column.

Meetings of the Societies, Lectures, &c.

Wednesday, June 17th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. R. Johnson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. C. R B. Keetley: Affections of the Toes, Feet, and Ankles.

Thursday, June 18th.

Royal Society of Medicine (Neurological Section) (20, Hanover Square, W.).—4.30 p.m.: Clinical Meeting (at the Hospital for Epilepsy and Paralysis, 4, Maida Vale).

Royal Society of Medicine (Dermatological Section) (20, Hanover Square, W.).—5 p.m.: Clinical Cases: Dr. Graham Little: (1) Private Case for Diagnosis; (2) Private Case of Urticaria Pigmentosa in an Adult (with sections); (3) Two Cases of Pseudo-pelade (Brocq); (4) Sections of Skin from the Case for Diagnosis and the "Varus Nodulosus" shown at the last meeting.

Royal College of Physicians of London (Pall Mall East).—5 p.m.: Croonian Lecture:—Dr. A. E. Garrod: Inborn Errors of Metabolism.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. W. Langdon Brown: Diseases associated with Cyanosis.

Friday, June 19th.

Society of Tropical Medicine and Hygiene (20, Hanover Square, W.).—8.30 p.m.: Annual General Meeting. Dr. C. F. Harford: Tick Fever of Africa, with Special Reference to its Clinical Manifestations and its Relations to the Relapsing Fever of India and other parts of the World.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. A. Lawson: Clinique. (Eye.)

Vacancies.

Metropolitan Hospital.—Secretary. Salary, £350 per annum. Applications to the Chairman, Metropolitan Hospital, Kingsland Road, N.E., not later than June 20th. Canvassing will disqualify.

Royal Hampshire County Hospital, Winchester.—Secretary-Manager. Salary, £150 per annum. Applications to the Acting Secretary.

London County Asylum, Claybury, Woodford, Essex.—Assistant Medical Officer. Salary, £160 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London, S.W.

London County Asylum, Horton, Epsom, Surrey.—Assistant Medical Officer. Salary, £160 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London, S.W.

Manchester.—Chorlton-upon-Medlock Dispensary.—Resident Medical Officer. Salary, £120 per annum. Applications to the Secretary.

County Borough of Derby.—Medical Officer of Health. Salary, £600 per annum. Applications to G. Trevelyan Lee, Town Clerk, Town Clerk's Office, 15, Tenant Street, Derby.

St. George's Union, London.—Second Assistant Medical Officer. Salary, £120 per annum, with board, residence, and washing. Applications to the Medical Superintendent.

Enfield and Edmonton Joint Hospital Board.—Resident Assistant Medical Officer. Salary, £150 per annum, with rooms, rations, and washing. Applications to T. W. Scott, Clerk to the Board, Public Offices, Enfield.

St. Vincent's Hospital, Dublin.—A Physician and a Surgeon. Applications to Hon. Secretary. (See Advt.)

Incorporated Orthopædic Hospital of Ireland.—An Anæsthetist and an Assistant Anæsthetist. Applications to Captain J. W. Borthistle, Secretary. (See Advt.)

Appointments.

Dennis, A., L.D.S., L.R.C.P.Lond., M.R.C.S., House Surgeon at the Royal Dental Hospital of London.

Fletcher, E. E., L.D.S., to the Appliance Department of the Royal Dental Hospital of London.

Gemmell, Samson, M.D., C.M.Glasg., F.F.P.S.Glasg., Professor of the Practice of Medicine in the University of Glasgow.

Harwood, L. A., L.D.S., House Surgeon at the Royal Dental Hospital of London.

Mackenzie, Theodore Charles, M.B., F.R.C.P.Edin., Medical Superintendent of the Inverness District Asylum.

Murphy, Edward Ernest Albert, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Assistant Medical Officer at the Devon County Asylum, Exeter.

Ovey, W. C., L.D.S., House Surgeon at the Royal Dental Hospital of London.

Skerrett, Frank B., M.B.Lond., D.P.H., School Medical Inspector for the County Borough of West Ham.

Smyth, F. R., L.D.S., House Surgeon at the Royal Dental Hospital of London.

Marriages.

Haig—Thorne.—On June 10th, at St. Mary's, Summerstown, Wandsworth, Francis Murray Haig, M.D., of Trevone, Woking, eldest son of the late Genl. Felix T. Haig, R.E., to Eliza Mabel, daughter of John Mills Thorne, of Burntwood Lodge, Wandsworth Common.

Heywood—Gibbs.—On June 11th, at the Parish Church, Moulsford, William Benjamin Heywood, M.D., M.A.Camb., second son of the late Benjamin A. Heywood, of Beckenham, to Josephine Frances Audrey, fourth daughter of the Rev. Joseph Gibbs, Vicar of Moulsford.

Rabagliati—Bright.—On June 10th, at Christ Church, Harrogate, Andrea H. Rabagliati, M.D., eldest son of Andrea C. F. Rabagliati, M.D., F.R.C.S.E., of Bradford, to Julia, fourth daughter of Frank J. Bright, Bentfield, Rochdale.

Rogerson—Attwell.—On June 9th, at St. Peter's Church, Morley, Frederick Rogerson, M.B., B.S., L.R.C.P.Lond., M.R.C.S.Eng., youngest son of William J. Rogerson, of London, to Jane, youngest daughter of the late George Attwell, of Portsmouth.

Smallhorn—Forster.—On June 10th, at Sevington Church, Ashford, Kent, Cyril Aubrey Smallhorn, M.A., M.B.Oxon., of Knutsford, only son of the late Dr. Thomas Smallhorn, of Eynsham, Oxford, to Isabella Maude, eldest daughter of the Rev. Bennet Forster, M.A., Rector of Sevington.

Deaths.

Maclean.—On June 12th at Charleville, Kew Gardens, Inspector-General Andrew Maclean, M.D., aged 96.

Rickards.—On June 11th, at Ellerslie, Augustus Road, Edgbaston Birmingham, Edwin Rickards, J.P., M.B.Oxon., F.R.C.P., consulting physician to the General Hospital, Birmingham, aged 66.

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Paris, 4th February, 1899.

Dr. E. Lancereaux,
Professeur à la Faculté de Médecine, Paris; Médecin honoraire des Hôpitaux;
President de l'Académie de Médecine.

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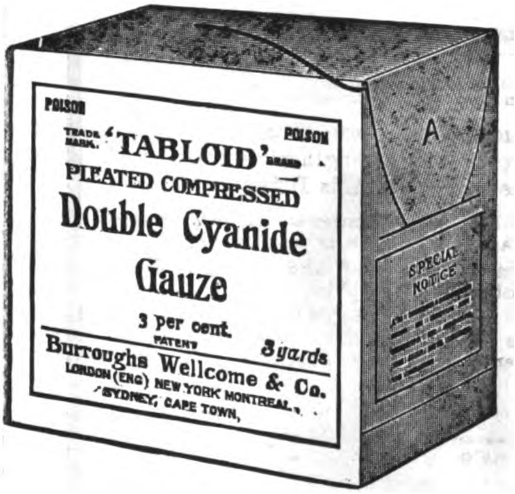
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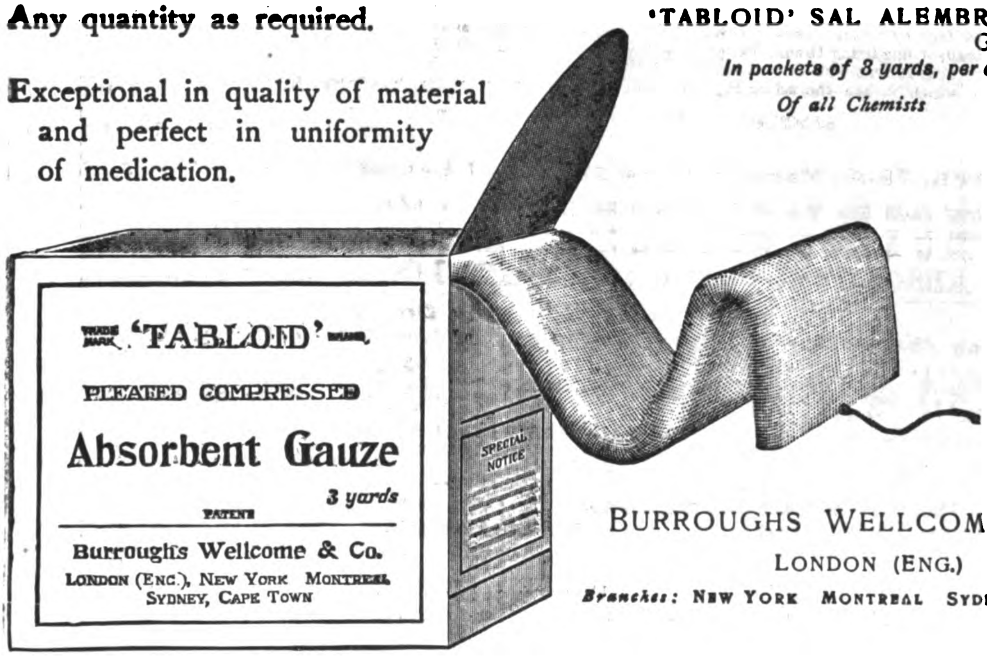
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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXVI. WEDNESDAY, JUNE 24, 1908. No. 26.

NOTES AND COMMENTS.

"Amazing Statues in the Strand."

THE bills of the evening papers last Friday in many cases contained as the *pièce de resistance* of their menu the words, "Amazing Statues in the Strand," and the eager public who crowded round the newsvendors were soon furnished with lurid tales of indecent statues erected outside—the *British Medical Association!* The sting of the tale lies in the element of truth it contains, and we confess we cannot conceive how the Council of the Association could have so lacked the element of humour as to have erected outside its new building statues which could only excite ribald remarks from the Strand urchins and pornographic references from Strand 'bus-drivers. We believe in art ourselves, and we are not totally averse from "the altogether"—in the proper time and season—but we cannot think that the buildings of the British Medical Association, facing into London's busiest street, constitute the most appropriate position for giving realistic demonstrations of the external genitalia of the human male figure. There are niches in the College of Surgeons' museum where such casts might be welcomed; there are art galleries (abroad) where similar exhibitions are not considered *outré*, but the Strand public is, perhaps, a little lacking in anatomical criticism and artistic perception, and the process of education might surely have been accomplished more gently. Moreover, if rumour speaks truly, what is now on view is nothing to what remains to be seen when the hoardings come down in Agar Street. To show that we are animated by no unfriendly feelings towards the Association, we are willing, on application by the secretary, to introduce him to an excellent stall in Covent Garden where fig-leaves are on sale at popular prices.

The Why and Wherefore of the Statuary.

FROM later information it appears that the designing of these figures was entrusted to a young and promising sculptor. The views of this artist with regard to the presentation of the anatomical facts commonly dealt with in the Temple of Æsculapius are not, to say the least of it, those that would secure the full approval of Mrs. Grundy. It is conceivable that nude figures of the kind might play a part in exterior mural decoration in all dignity and innocence, but, for all that, it is well to remember that even the ancient Greek sculptor found it desirable in many instances to cloak certain details with tracery. How he would have dealt with obstetrical complications we know not, but we fancy he would hardly have reproduced them in the way so boldly adopted by the Strand genius. The incident shows how necessary it is to keep unceasing vigil over those blameless gentlemen who sit on the Council, and to whose remissness in taste this extraordinary *gaucherie* is attributable.

Medical Longevity.

DR. T. L. HINTON, whose death at the age of a hundred took place last week, would be exceptional in any line of life, but he is almost phenomenal in a profession in which longevity is not a strong point. When the fact is recalled that Dr. Hinton not only passed a busy, active life, but that the best years of it were spent in India on active service or in camp, under hygienic conditions which would not be approved now, his constitution must be considered a marvellously good one. Sir Henry Pitman is, we believe, the only "centurion" left among us, and though he is a little senior to the late Dr. Hinton, his active life was passed in the more temperate climate and genial surroundings of the West End of London. It is encouraging to have these heroes of constitution to prove that there is some hope of the medical man outliving the meagre span apportioned to him by the Registrar-General, as the endless fumes and frets of practice often seem only worth enduring in view of a possible old age of retirement to contemplate the vista of a well-spent life. If the surly Atropos of Somerset House denies us even that solatium, many of the less successful members of the profession may feel inclined to have resort to the bare bodkin to end present discontents.

A New "Cure" for Consumption.

OUR enterprising contemporary *Tit-Bits* has presented to a startled world a new cure for consumption. The treatment recommended is lassoing. The intention is not, apparently, for the doctor to lasso the patient—that we could understand being an undeniable cure for the disease—but for the patient to lasso such objects of nature as fall within the range of his skill. The authority on whom our contemporary relies is Colonel W. F. Cody, better known to fame as "Buffalo Bill," who seems inclined to round off his adventurous career by imparting health to the ailing by this original plan. As mere medical men, we cannot conceive of any treatment less suited to the febrile stage of tuberculosis and more certain to excite hæmoptysis than riding bare-back on a horse and flinging the lasso far and wide, but we confess to never having tried the treatment ourselves, or having had the opportunity of watching its effects on others. "As at present advised," as the lawyers say, we can only express the opinion that nothing seems silly enough for people generally, and newspapers in particular, to say about consumption or cancer. It seems, indeed, that, having written all the rubbish they possibly can think of about these diseases, and written it over and over again, they are reduced to producing something palpably ridiculous, in the hope that no rival can say it is not their own original idea.

Wanted—an Entente Cordiale. In view of the Franco-British Exhibition and the new ties woven by the *entente cordiale,* we must accord a special welcome to a modest little announcement in *T.P.'s Weekly* which runs as follows:—

> To Doctors.—Parisian lady, middle aged, refined, intellectual, niece of well-known author, but with very small means, would give French conversation to doctor in exchange for medical attendance. (No. 1,083.)

As the great object of the practitioner's life is to avoid "conversation" on his rounds, the prospect of a daily discussion—carried on under the additional difficulty of an unwonted medium—does not strike us as very alluring, even when there is in prospect the sure reward which virtue holds out. The Parisian lady would, we fancy, need to be possessed of all the charm for which her race is famed to be able by this announcement to "draw" the most neglected of practitioners, and, at middle age, what can one expect? We are sorry for the lady, and we hope she may strike what she wants, but we cannot say we think the prospects are rosy. At any rate, there is a chance for any medical man who feels the obligations of international friendship to sit seriously on him. He has only to apply to No. 1,083.

Padgett, M.P. Dr. Pieron, of Paris, has lately been giving a dissertation on the psychology of lying, and, in accordance with the trend of modern criminology generally, his remarks go to prove that Padgett, M.P., is not a bad sort of fellow after all, and that his failing was not one of heart, but of failure of development of the ratiocinative faculty. This is a very cheerful and comforting doctrine, for there are few of us who have not at times been tempted to approach the border that demarcates fact from fiction, and now, on Dr. Pieron's authority, we may lay to our souls the flattering unction that it was not we, but an ontological perversion, that produced the shameful result. The old Adam appears to be a morbid embryological kink which our neurons assume independently of the will, and so we personally are blameless. The liar is born, not made. Let it not be thought, says the savant, that "lying is by any means the monopoly of women and children." The man may at any age up to fifty "kink"—through purely cerebral defect of course—into a "natural and spontaneous liar," a "brutal and malicious liar," a "psychopathic liar," or a mere "harmless liar." Images received on to the retina, in these morbid conditions, travel up the optic nerve to the brain, but at a certain junction, unconsciously, the image is switched off the original nerve line, and to the consciousness it presents a distorted idea. Thus, a camel may be duly focussed on to the retina in due proportion, but by the time that the brain has knowledge of it there may be three humps, a neck longer than a giraffe, a bright red hide, and pads three times their original size. No wonder the Pan-Anglicans are not all enthusiastic advocates of modern science.

LEADING ARTICLES.

THE KING EDWARD VII. HOSPITAL FUND, THE HOSPITALS, AND THE MEDICAL PROFESSION.

Like all other social institutions, the medical charities of the United Kingdom are being constantly subjected to the ordeals of an evolutionary discipline. In London the problems thrust in this way upon the attention of the public acquire a special importance from the magnitude of the philanthropic and charitable, as well as the economical and ethical, interests that are inseparably involved in the whole question of hospital administration. To some extent the existence of the great administrative funds affords a future promise of systematic organisation and co-ordination of the charities. That prospect, however, is at present somewhat deferred by the fact that the wealthiest and most powerful of those bodies, namely, the King Edward VII. Fund, is constituted on an absolutely autocratic and irresponsible basis. In other words, it is open to the Fund to make or mar the fortunes of medical charities by withholding grants, although it declines to state on what grounds such action is taken. The Council of the King Edward Fund, therefore, is in this sense a summary court wielding enormous power, but whose decisions are subject to no appeal, and whose constitution, being non-elective and non-representative of the interests concerned, is absolutely beyond popular control. We decline to believe that any such constitution, foreign as it is to the genius of the British nation, can be permanently maintained on these lines. As things stand, the fate of individual medical charities of the metropolis may be decided by the whims and the caprice of persons whose only claim to confidence may be that they happen to have been placed on the Council of the Fund. The policy of extermination of the smaller hospitals is tacitly adopted, for example, and from that moment is straightway put into force at all costs. By the power of the purse the Fund practically forces amalgamation upon groups of smaller institutions, regardless of the fact that in not a few cases members of the individual medical staff are deprived of their appointments in the newly-constituted collective bodies. Hampstead affords a peculiarly typical and instructive example of this high-handed procedure. The general practitioners of that district had organised and efficiently staffed a local hospital. The King Edward Fund insisted on amalgamation with a hospital in a neighbouring parish. The original staff lost their appointments, excepting two who were permitted to remain for a limited period, and a fresh staff was selected from consultants elsewhere. The Fund accepted the nomination in several instances of surgeons and physicians who were pluralists in various directions. Some of them, at least, hold so many other appointments that it is difficult to see how they could hope to do justice to their new duties at Hampstead. We wonder if the question of pluralism in hospital appointments has ever been considered carefully by the King Edward Fund. If not, can they defend any policy in which pluralism is concerned? If so, why should not the Fund openly declare its policy so that the lay and medical community may know on what lines the grants of the Fund and the interests of the sick public and of the medical profession are being dealt with? While the Fund declines to state the grounds of its action in this or that given direction, it will be impossible to maintain the confidence of the public indefinitely. If the policy of the Fund be sound, and its motives and impartiality above suspicion, why should it decline to make a public declaration of its principles, to explain and justify its decisions, and to permit an appeal where any complaint is made of individual injustice or unfairness? Above all, why should any great public body dread the wholesome discipline of public representative control? There is another pertinent point to which attention of the authorities of the Fund may be drawn. In one, at least, of the amalgamations that have taken place under their auspices the amalgamated hospital has been permitted to exclude holders of Scotch and Irish qualifications from appointments of the honorary medical staff. We allude to the Orthopædic Hospitals, in two out of three of which Scotch and Irish diplomates were admitted to the staff, but are excluded in the new or amalgamated institution. Can the King Edward Fund seriously defend this exclusion of legally qualified medical men from these posts? As the Fund enforces its will in so many directions, it could surely interfere to prevent the perpetration of an injustice of this kind. We beg further to draw the attention of the King Edward Fund to a recent meeting of the Irish Graduates' and Scotch Diplomates' Associations, whereat the action of the Miller Hospital at Greenwich in advertising for a surgeon with an English fellowship qualification was called in question. The advertisement was inserted in the *Times*, and the public thereby informed of the disabilities attached by the Miller Hospital to surgeons whose education, although carried out on lines administered by the State, was conducted in a Scotch or Irish school. Further, we invite the attention of the Fund to a statement, which may or may not be correct, that the Board of the Miller Hospital has the power to frame rules to fit particular cases without consulting governors. If the King Edward Fund assumes the post of *censor morum* of the London hospitals, the Miller Hospital appears to demand some share of its criticism. We believe that some years ago the Miller Hospital enjoyed the distinction of spending more money per patient than any other charitable institution in the metropolis. A wholly unnecessary advertisement in the *Times* certainly does not lend the impression of economical management. Why should the Board want to advertise outside the medical journals, unless, indeed, it be to emphasise the fact that no Scotch or Irish need apply. In the points thus raised, namely, the nature and cost of advertisements, the exclusion of legally-qualified British medical men from hospital appointments, medical pluralism, and the inherent rights of the small hospitals, we venture to think that the King Edward Fund will find a legitimate field of activity which will in the long run tend to place the sacred cause of medical charity on a sounder basis than is likely to be attained by the irresponsible administration of a well-meaning and honourable, but, at the same time, an autocratic and unrepresentative body. In making these criticisms it is hardly necessary to say that the motives of the King Edward Fund are transparently high and noble, but we feel it, nevertheless, our duty to review the situation, in the hope of consolidating this great body in the confidence of the community.

An epidemic of small-pox at Woolsthorpe-Belvoir, Lincs., originated with a soldier who had been discharged from a transport ship at Southampton. His removal into the district was not notified by the War Office, who have now expressed regret. The outbreak cost the district between £400 and £500.

CURRENT TOPICS.

An Army Nursing Organisation.

The attempt of the present Government to reorganise our Army system is, at any rate, comprehensive. Amongst various excellent non-combatant features connected with the Territorial force, one of the most important is the organisation of a Nursing Service in connection with its general hospitals. This step has been taken by the Army Council, which has decided to establish an Advisory Council in connection with this branch of administration. It is formally announced that this Advisory Council will frame rules for the admission of nurses into the Army Service, and make such recommendations as may seem necessary for the administration of the Service and for the appointment of matrons, sisters and nurses thereto. Her Majesty the Queen has graciously consented to become President of the Nursing Service, and has further approved the appointment of the Duchess of Montrose as Vice-President. The Advisory Council is under the chairmanship of Surgeon-General Sir Alfred Keogh, K.C.P., Director-General of the Army Medical Service. Its members include, amongst other, the Countess of Derby, the Countess of Jersey, Lady Grenfell, Miss Haldane, Miss Cox-Davies, matron of the Royal Free Hospital, and the matrons of four other hospitals and of a well-known institute for nurses. The secretary is Miss Sidney Browne, R.R.C. It may be noted that not a single one of the matrons is married, an observation that applies to most women who attain the prizes of the nursing profession in our great hospitals. Speaking generally, the institution of a proper nursing organisation for our new Territorial Army is a matter for congratulation. From the medical point of view, it is the duty of the State to tend the sick and wounded soldier with all the resources of modern medical science. It is only by preparation in time of peace that a proper equipment can be rendered available in time of war. The failure of the nursing service in the South African War was one of the most terrible features of the collapse of the Army medical organisation in that campaign. It is to be hoped and believed that the establishment of an efficient nursing service by the Army Council marks the passing of the old order of things with regard to the sick and wounded British soldier.

Mumps in the Navy.

The news of an unusual outbreak of epidemic disease has come from Portsmouth. The whole of the ship's company of H.M.S. *Nelson*, the training depôt for naval stokers, numbering 800, has been transferred by water to Haslar, where they are encamped outside the Naval Hospital. A careful daily inspection by the hospital medical staff last week resulted in the daily discovery of some ten to fifteen or twenty cases of mumps. There are about 2,000 sailors at the Royal Naval Barracks depôt, which has become involved in the outbreak by the appearance of several cases. The outbreak, it need hardly be remarked, is of an exceptional kind, as the disease is usually confined to children and young persons. Considering the marked characters of this common and obviously specific infection, it is not a little curious that its origin should be wrapped in complete mystery. No clue, for instance, has been obtained as to the reason why the brunt of the early inflammatory disturbances should fall upon the parotid and the sub-maxillary glands. Nor has the metastatic orchitis which so frequently follows the subsidence of the parotitis, been any more satisfactorily accounted for. On the whole, mumps may be said to offer a fine field for the collective medical investigation which is fast becoming a fixed feature in modern research. At the same time, it must be borne in mind that a similar obscurity of origin is shared by such familiar zymotic affections as whooping-cough, measles, and small-pox, the results of which are far more serious than that of the comparatively innocuous mumps. There is something almost ludicrous in the spectacle of the fighting-men of a great naval station being laid low by this schoolboy's malady. Some consolation is to be derived from the fact that one attack, as a rule, confers lasting immunity against the disease. At present there is a good opportunity for the study of this interesting complaint open to the scientific enthusiasts of the Navy Medical Department. Why should not Government make a special grant for such an investigation?

Infectious Disease and Examinations.

THE annals of modern high standard examinations, could they be even approximately written, would probably furnish an abundance of diverting reading. An incident in the recent Natural Science Tripos examination at Cambridge furnishes a case in point, although the University dons may take a different view of the matter. When Part II. of the famous examination became due, it was found that a certain famous Welsh scholar was suffering from an infectious disease, the precise nature of which has not been announced. As this brilliant undergraduate had already obtained the highest honours in Part I., it looked as if his chances of distinction had been suddenly extinguished by the hand of Providence. Obviously, it was out of the question that the sufferer should be permitted to take his place among his fellow students at the examination. We are glad to say that in this particular instance the somewhat conservative University authority rose to the occasion. A special room was provided and the patient conveyed thither in charge of a nurse, who remained with him all day, and administered stimulants to him at intervals, and at the end of the examination he was taken back to bed. As a result the invalid attained an honourable position in Class II. The precedent thus established may conceivably give rise to some amount of trouble in various quarters. The non-isolated and unstimulated examinees, for instance, may claim that they were placed at a disadvantage as compared with their sick rival. The principle is clearly capable of wide extension, and in some instances a good deal of individual disaster might be averted, for many a brilliant competitor has been thrown out of the struggle by the advent of sudden sickness.

A Schism among the Dentists.

THE penal clauses of the Dentists Act of 1878, like those of the Medical Acts, are almost complete failures. They were devised with the object of enabling the public to distinguish between the legally qualified practitioners and the uneducated pretenders, and they are, in fact, entirely ineffective in preventing ignorant and fraudulent impostors from palming themselves off as legitimate professional men. The British Dental Association, presumably with the best legal advice, has striven to establish the power of the law as suggested by the spirit of the Act, and has virtually failed. It is quite evident that prevention of grossly illegal dental practice will not be possible without amendment of the law. If this amendment is to be brought about, it will be first of all necessary to prove to the satisfaction of Parliament, or, at least, of the responsible statesmen, that reform is called for in the interests of the public as much as, or more than, for the advantage of the profession. The weakness of the law has been sufficiently demonstrated. The hope of reform lies in concentration of the whole forces of the profession to the task of establishing their case. If this cannot be done through the medium of the British Dental Association, which includes the great bulk of those having valid claim to authority and professional distinction, the case is hopeless. The proper course for those dissatisfied with the present state of things is to add their forces to the Association, and press forward the preliminary movements towards reform. Any attempt to establish a new society acting without the concert of the Association, in antagonism to it, will do nothing but injury to the cause, the promotion of which is so rightly desired

The Government and Tuberculosis.

LAST week the Chief Secretary for Ireland brought in his promised Bill dealing with the Prevention of Tuberculosis in Ireland. The provisions of the Bill are in the directions of reform which we have frequently suggested. They fall under three heads—Notification and Disinfection, Hospitals and Dispensaries, and Sanitary. In the first place tuberculosis is made, under conditions to be laid down by the Local Government Board, a compulsorily notifiable disease. For failure to notify a medical man will be liable to a fine not exceeding forty shillings, and for each certificate of notification he will receive a fee of one shilling if the patient be in a public institution, or of two shillings and sixpence, if anywhere else. As to the provision of hospitals and dispensaries, county councils are empowered now, for the first time, to erect and maintain such institutions. Several important clauses are classed as "Sanitary." Sanitary authorities are to have power to provide and pay for courses of lectures in their districts, and to appoint bacteriologists for the examination of meat, milk, sputum, or pathological specimens. Medical officers of health and other authorised officers are to have power to take samples of milk or milk products produced or offered for sale in their districts. The Bill seems to us a thoroughly useful one, and we hope it may find its way to the Statute Book.

Research Defence Society.

THE inaugural meeting of the Research Defence Society was held on the 19th instant at the rooms of the Royal Society of Medicine, London. There was a large and enthusiastic attendance of members, who followed with attention the temperate and closely reasoned speech of the President, Lord Cromer. He said they must agree to differ from those who held the extreme view that it was not under any circumstances justifiable to destroy animal life. The full application of that theory would, in his opinion, carry us to some very strange and practically impossible conclusions. It required no special knowledge to be convinced that well nigh every advance in medical science since Harvey discovered the circulation of the blood has been, directly or indirectly, the result of experiments on living animals. One modern example was the discovery of the transmission of malaria by mosquitos, whereby it was aptly said the Tropics were going to be made habitable. Malta fever was another case in point. Fever, again had been banished from Ismailia, on the Suez Canal, a place that was formerly nearly uninhabitable, by the use of knowledge gained from vivisection. If the cause of cancer were discovered, he ventured to say, it would be by way of experimental research. He denied the assertion of those who attributed a wanton infliction of pain by experimentalists. A resolution by Sir Thomas Barlow was then carried unanimously:—"That the Research Defence Society be, and is hereby constituted, to make generally known the facts about experiments on animals in this country, and the regulations under which they are conducted, the immense importance of such experiments to the welfare of mankind, and the great saving of human life and health which is already due to them."

St. Bartholomew's Hospital.

ANYTHING which transpires in connection with the internal affairs of an important charity like St. Bartholomew's Hospital cannot fail to attract universal attention. It is true that in view of its rich endowment this hospital does not require to appeal to the public for its maintenance. Despite this fact, as a charity it is still amenable to the laws of the realm, applicable to the administration and control of charitable funds. From this point of view, then, the announcement that the Treasurer and five Almoners of the Hospital, that is to say, the working committee of the Governors, who are responsible for the administration and management of the great charity, have tendered their resignations, in consequence of a failure of agreement with the general body of governors, calls for more than a passing notice. So far the governors have not taken the public into their confidence in respect to the grounds upon which this disagreement is based. It is stated that the Treasurer and Almoners unanimously recommended a certain policy, of which the governors have seen fit to disapprove. In other words, those who from their position must know what is best for the hospital have been over-ruled by those who have merely a voting interest in its concerns. We cannot believe that a *contretemps* of this kind can have any other than a harmful effect upon the charity, even although it happens to occupy the commanding independent position of that of St. Bartholomew's. The incident clearly shows that, unique as it is in the history of the Hospital, something must have occurred to disturb the harmony and orderly working among those who are responsible for its administration, which calls for public notice. The governors, no doubt, were fully aware, in casting their adverse vote, what the result would be, and yet, despite this, they apparently did not shrink from recording their verdict. That verdict, naturally, carried with it a moral vote of censure upon the managing committee, who immediately adopted the only course open to them of tendering their resignations—which have been accepted—and there the matter stands for the present.

PERSONAL.

H.M. THE KING has conferred the Honorary Commandership of the Royal Victorian Order on Dr. Eugène Botkine, Physician-in-Ordinary to the Czar.

HIS MAJESTY THE KING laid the foundation-stone of the new King Edward VII.'s Hospital at Windsor. The cost of the building will be about £20,000, of which £12,000 have been already subscribed, including the King's present and previous donations.

THE BISHOP OF LONDON will preside at the annual distribution of prizes at St. Mary's Hospital Medical School, Paddington, on Monday next, June 29th, at 3 p.m.

DR. KITAZATO, who has just been elected a Fellow of the Royal Society, is the first Japanese to gain that distinction.

THE third Norman Kerr Memorial Lecture will be delivered by Dr. Taav Laitinen, Professor of Hygiene in the University of Helsingfors, and Director of its Hygienic Institute. He has selected as his subject "The Influence of Alcohol on Immunity."

DR. RAYMOND, Physician to the Salpêtrière Hospital, Paris, delivered an address in the library of the Royal College of Physicians of London on Monday last, June 22nd.

SIR JAMES SAWYER will take the chair at the dinner of the provincial meeting of the Society for the Study of Disease in Children.

SURGEON-GENERAL G. J. H. EVATT, C.B., will take the chair at the annual meeting of the Poor-Law Officers' Association, to be held at Hull on July 15th.

SURGEON-GENERAL W. L. GUBBINS, C.B., M.V.O., Principal Medical Officer of the King's Forces in India, has been appointed Deputy-Director-General of the Army Medical Service at the War Office, in place of Surgeon-General Fawcett, C.B., who is retiring.

THE EARL OF CREWE will unveil the statue of Her Majesty Queen Alexandra at the London Hospital, on Friday, July 10th, at 4 p.m. The annual prize distribution to the students and probationers of the Medical College attached will take place at 3.30 on the same afternoon.

LORD ROTHSCHILD has consented to distribute the medals and prizes gained by students at Guy's Hospital during the past winter and summer sessions, on Wednesday, July 8th, at 3.15 p.m., when the Governors and medical staff will give a garden party in the grounds of the hospital.

A CONGRESS of French medical practitioners, the second of its kind, is to be held at Lille from the 25th to the 28th inst. The members intend to come to London on the 30th inst., and remain till July 2nd. On the afternoon of Wednesday, July 1st, they are to be received by the Lord Mayor and the Lady Mayoress at the Mansion House.

PROBABLY no ambulance competition in South Wales has evoked such widespread interest as that which took place at Mardy, in the Rhondda Fach, on June 13th, for General Sir Charles Warren's Rhondda Ambulance Challenge Shield, which, by the narrow margin of one point, the local team succeeded in retaining for the coming year—an achievement which reflects the greatest credit upon the instructor, Dr. Glanville Morris.

LORD RAYLEIGH, as Chancellor of the University of Cambridge, on June 16th, performed his first official act by opening the new wing of the Cavendish Laboratory, which Lord Rayleigh, as a Nobel prizeman, presented to the University. The ceremony was interesting because it occurred upon the anniversary of the opening of the original Cavendish Laboratory, which the University owed to the generosity of the seventh Duke of Devonshire, who was Chancellor in 1874.

ON June 13th, Surgeon-Colonel Edward Hopkins, of Llandilo, was presented by the inhabitants of the district with a life-size oil painting of himself and other gifts "in recognition of the valuable medical services which he has so readily and gratuitously rendered for a great number of years." The painting shows the surgeon wearing his old A.M.D. uniform and six campaign medals.

DR. G. JUBB and Dr. R. Lawrence, have been appointed assistants to the County Medical Officer of Health, Cheshire, to devote their whole time to the inspection of children in attendance at elementary schools in the county elementary education area, at a salary of £350 each per annum and travelling expenses.

A CLINICAL LECTURE

ON

SCIATICA.

By ROBERT A. FLEMING, M.A., M.D., F.R.C.P.Ed.,

Physician to the Edinburgh Royal Infirmary, Lecturer on the Principles and Practice of Medicine in the Edinburgh Medical School, Examiner in Medicine, Aberdeen University.

I HAVE selected as a subject for this clinical lecture a very common ailment, and yet one which presents many difficulties both as regards the diagnosis of the cause of the sciatic pain and also the treatment which should be adopted in different cases. We constantly meet with patients in hospital and private practice who are suffering from sciatica. The ailment in many of these cases yields readily to ordinary anti-rheumatic or anti-gouty remedies; and yet there remains a quite considerable proportion of patients whose sciatica is not relieved in the smallest degree by such treatment, and whose affection tests our skill and patience to the utmost. I do not imply that none of these intractable cases are rheumatic or gouty in causation, but merely that they prove intractable to the ordinary line of treatment.

I propose to divide sciatica into three groups, and to try to differentiate these three groups or types as sharply as possible when describing the etiology and the clinical features of each group. If you keep before your minds these three distinctive types, then the treatment suitable for each will become clear.

ETIOLOGY.

Type I.—In this type I include all cases of interstitial neuritis and perineuritis, the involvement of the actual nerve fibres being generally secondary where they are involved at all. There is a history of exposure to wet or cold, or both, and the subject is usually of rheumatic tendency. Both sexes suffer, but men, from the nature of their work, supply a larger number of cases than women. The age is generally from puberty to the end of middle life. Rheumatism is the commonest cause of this type of sciatica, and, in fact, it is the chief cause of sciatic pain taking all the varieties together. Another group of cases belonging to this type are due to gout, and occur in gouty individuals who have broken some of the canons laid down by their medical advisers, and have probably, in addition, exposed the region of the sciatic nerve to cold or wet. Syphilitic neuritis also occurs, but it is rare, and diphtheritic neuritis, which differs from syphilitic inasmuch as it is generally parenchymatous, while the latter is interstitial, is also of comparatively infrequent occurrence.

It should be added that if an individual of rheumatic tendency is exposed to wet and cold, any local injury or pressure exerted on the sciatic nerve may aid in the production of the sciatica, and may determine the side to be affected.

Type II.—There is sciatic neuralgia, which is not due to any of the causes referred to under the first type, and which may occur apart from any tumour or other cause of pressure on the nerve or nerve roots of the sacral plexus, referred to under the third type of sciatica. The causes of neuralgia elsewhere produce sciatic neuralgia, although it must be admitted that a pelvic tumour such as a carcinoma may both cause sciatic pain by pressing on or infiltrating the nerve or nerve roots, and may also be directly responsible for a truly reflex neuralgic pain.

Type III.—Pressure on the sciatic nerve or on the roots of the sacral plexus causes sciatic pain. A familiar instance of such pain is common in advanced stages of pregnancy, when the uterine tumour presses on the nerve or nerve roots and causes pain which radiates down the nerve. A loaded bowel is sometimes responsible for sciatic pain more commonly on the left side, and any pelvic tumour such as a large uterine fibroid, or mass of glands as in lymphadenoma, may give rise to severe pain in the line of the sciatic nerve.

Hip-joint disease and rheumatoid affections of the spinal column have been held responsible, not merely for pain which might be mistaken for sciatica, but for the secondary development of true sciatica either a true neuritis of interstitial nature (Type I.) or a sciatic neuralgia (Type II.).

PATHOLOGICAL ANATOMY.

The inflammation is usually *interstitial*. It may specially involve the outer sheath of the nerve—a *perineuritis*, or it may affect the sheaths of the individual funiculi, or even the interstitial tissue inside the funiculi. The nerve is believed to be reddened or congested in acute cases, and is certainly swollen. The important points to remember are that wherever the inflammation may be, there is effusion of inflammatory lymph, and that that lymph cannot readily find exit and is slowly absorbed if in large amount. Where a serious intra-funicular effusion has occurred, atrophy of nerve fibres may follow and the functions of the nerve fibres may be interfered with at least temporarily. In this way wasting of muscles, areas of anæsthesia, and even trophic changes in the skin result. It is not necessary here to enter into a full description of Wallerian degeneration, or the pathological changes which may ensue in muscles, skin, and in the cell centres of the affected neurones; but it is easy to understand that a large effusion, if not absorbed or got rid of in some way, must in time lead to formation of connective tissue, and this will press on nerve fibres in a way which cannot easily be removed. Herpes occasionally develops in the line of the affected sciatic, but is rare.

There is no known pathological change in pure cases of neuralgia (Type II.) or where pressure merely induces pain and does not abrogate the functions of the nerve fibres nothing may be noted (Type III.).

THE CLINICAL FEATURES.

Type I.—*Interstitial and Perineuritis.*—In the simplest case a patient, predisposed to rheumatism, sits on damp grass or gets wet and chilled and develops sciatica. The pain is dull and aching, gradually becoming more severe, and rarely is it sharp or lancinating. It is generally constant, but may become worse at night, or may be paroxysmal in its mode of harassing the patient. The patient cannot sit, especially on a hard seat, except in an attitude that enables him to avoid all pressure on the buttock of the affected side. The pain shoots down to the knee or to the heel, and is often worst at night when he gets warm in bed. He cannot stoop so as to touch his toes, and if the nerve is very susceptible to pressure he limps with the affected leg. In a severe case he can neither straighten his leg nor can he bend it fully, because the pressure of the muscles on the nerve and the slightest stretching of the nerve are exquisitely painful. He walks on tiptoe by preference, and if the neuritis progresses still further he may become completely bedridden. It is most important to remember that sciatica is almost always unilateral. Bilateral sciatic pain should suggest a lesion of the nerve roots, or a lesion of the cauda equina.

There are certain painful points, described originally by Valleix. Those are situated (1) above the hip-joint; (2) at the sciatic notch; (3) about the middle of the thigh; (4) behind the knee; (5) just below and behind the head of the fibula; (6) behind the external malleolus; and (7) over the dorsum of the foot. They are certainly more commonly present in cases of neuralgia (Type II.), but are by no means absent in severe cases of neuritis. Cramps in the calf and other muscles may occur in bad cases, and there is sometimes a degree of pyrexia, but it is exceptional and only probably appears as an early manifestation.

On physical examination the nerve may be demonstrated to be painful to pressure between the sciatic notch (situated midway between the ischial tuber and the great trochanter of the femur) and the popliteal space, while areas of anæsthesia (outer side of leg below the knee, etc.) are not infrequently present where the exudate has damaged the conductivity of the sensory neurones. The muscles may become flabby and very marked wasting with fibrillary contractions may develop where motor neurones are involved. In cases of such gravity, formication and numbness may eventually be found, and even the reaction of degeneration on testing the affected muscles, but the latter is rare.

In some patients the small sciatic is specially involved or some other branch of the lumbo-sacral plexus, and it is probable that where Type I. has developed, Type II. or in other words a secondary neuralgia may be superadded.

Even mild cases are apt to relapse, and a sudden strain, over-exertion, or chill may cause another attack, often more severe than the first. In any case the pain usually passes off gradually. Severe cases with anæsthesia and wasting of muscles will certainly cripple the patient for months, and may even result in permanent deformity such as spinal curvature.

Herpetic eruptions sometimes develop along the line of the sciatic nerve and its branches.

Type II.—*Neuralgia of the Sciatic Nerve.*—Where the neuralgia is not merely superadded to cases included under Types I. and III. the clinical picture is fairly sharp and distinctive. The patient has been subject to neuralgic pains elsewhere, and very probably at the same time as he complains of his sciatic pain the 5th cranial nerve or some other cranial or spinal nerve may also be affected. The painful points of Valleix, one or more, are often the chief sites of pain, and other parts of the nerve and its branches are not tender to the touch. There is no anæsthetic area and no evidence of any wasting of muscles. The pain of neuralgia is typically periodic, and it does not shoot down to the knee or to the heel as it so commonly does in Type I. Lastly, it is rare to find the patient limp when walking.

Before leaving the description of this type may I again remind you that a neuralgia may be secondary to a neuritis or to a pelvic neoplasm, etc., and so it is by no means always possible to differentiate our cases of sciatic pain as I am trying to do here.

Type III.—*Sciatic Pain due to Pressure.*—Here there is often no difficulty in recognising the tumour or whatever is causing pressure after a careful abdominal, rectal or vaginal examination. The pain may shoot down the nerve, but the nerve itself is not, as a rule, tender to the touch, and walking or anything which increases the pressure of the muscles on the nerve in the thigh rarely increases the discomfort. Unless a secondary neuralgia has been set up there is no evidence of the existence of the painful points of Valleix.

DIAGNOSIS.

In hip-joint disease, pressure on the head of the femur and forcing it against the acetabulum causes severe pain, and where the *sacro-iliac synchondrosis* is at fault, pressure exercised on the iliac crests so as to force them against the sacrum increases the pain. In affections of the *cauda equina* the sciatic pain is usually bilateral, and similarly, if there is an extensive bilateral lesion of the *lumbo-sacral plexus,* the pain is not so local and distinctive. Bilateral sciatica is rare, and should always suggest a cause which is situated higher up than the sciatic nerve.

PROGNOSIS.

Severe intractable cases are very difficult to speak of with enthusiasm, but I believe much can be done to prevent cases becoming chronic and intractable.

TREATMENT.

I do not purpose describing the treatment appropriate for neuralgic cases (Type II.) or pressure cases (Type III.), but wish to devote a few minutes to a *résumé* of treatment applicable for cases which belong to the first of our types.

Most ordinary cases of sciatica yield to large doses of *sodium salicylate* and *sodium bicarbonate,* but it is essential in every case which is not of the most trivial character to remember the inflammatory exudate and order *physical rest* for the limb, and even the use of a long splint, if the patient can tolerate it. Wrap the limb up in cotton wool and apply methyl salicylate or some more vigorous counter-irritant, such as the linimentum terebinthinæ aceticum, fly-blisters (along the line of the nerve), or the actual cautery. Rest is the main thing, the exact method of local counter-irritation being of less importance. Hot-air baths of the Greville type are also useful, the hot air being applied to the limb locally, and a temperature of 200° to 300° F. may be attained.

When there is a more severe case to be treated I believe in *acupuncture.* At least half-a-dozen sterilised needles should be inserted into the nerve, the highest close to the gluteal fold and the lowest well above the popliteal space. A double row of needles is better than a single, and, dexterously inserted, the patient should not be aware of more than the first three. The line of the nerve should be carefully marked with ink before beginning the operation. Leave the needles in position for half to one hour, keeping the patient lying flat on his face or on his unaffected side, with a cage over the legs and of course well covered with bedclothes. Relief is prompt, but several insertions may be necessary. Benefit depends almost certainly upon the escape of exudate from the swollen nerve sheath.

Injections into or near the nerve are sometimes used. 80 per cent. alcohol and 1 to 2 per cent. osmic acid injected into the nerve should never be used on any consideration. They may do much damage to the myelinated nerve fibres, and are dangerous remedies. Various strengths of eucain or cocaine in saline solution have been recommended, and are preferable. Schleich and Lange were among the first to advise large injections of saline solution into the nerve, and both used B. eucain (1 in 1,000 of 8 per cent. salt solution). Similar injections have been recommended, only of larger bulk, into the tissues round the nerve and specially into any painful area. It is thought that the solution by its bulk (100 or more c.c.'s) may tear away or separate nerve endings, and so arrest pain. Injections of sterilised air into the painful areas have also been much used. Half a litre of atmospheric air, sterilised by being passed through antiseptic wool, is injected under the skin and around the nerve: Cordier succeeded in 23 out of 25 cases, but others have not been so fortunate with this procedure.

Electrical treatment I have found disappointing. I think high frequency and galvanism have given me the best results, but there is no feeling of certainty as to the result being even temporary benefit, and I should never hesitate in choosing between acupuncture and electricity, to prefer the former. Of baths I might say much. All spas where rheumatism and gout are treated successfully are well worth a trial. Mud baths, the hot under-current douche, and a combination of hot baths with very carefully applied massage will be found most efficacious. Gouty patients, and, of course, the much less common cases of syphilitic origin, should be treated on constitutional lines.

Of *surgical treatment* for sciatica it is not possible in the time at my disposal to speak. If there are adhesions then separation of these adhesions does good, but are there often adhesions? Nerve-stretching and excision of a portion of the nerve are serious operations and may not lead to definite and certain recovery, therefore they should not be lightly undertaken. Where nerve-stretching is employed the limb may be lifted off the table by the sciatic nerve, and this is thought to cause the breaking down of adhesions, to which the pain is due. It certainly seems probable that in a very long-standing case of inflammation of the sheath of the nerve, adhesions might form, and if so nothing short of dissection or stretching can break such adhesions down Possibly fibrolysin, which is said to be so efficacious for the removal of pathological fibrous tissue, might be tried before resorting to operation, but I have no personal successes with this remedy to report. If care is taken, however, with the early treatment of sciaticas, such cases should be very much more uncommon than they are.

I have merely been able to summarise a few of the methods of treatment, and have not discussed the treatment of neuralgia or pressure siaticas, but if I have succeeded in giving you a better understanding of the causation and the clinical features of a somewhat difficult subject my labour will not be entirely in vain.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by T. Percy C. Kirkpatrick, M.D., F.R.C.P.I., Physician to Steevens' Hospital, Dublin. Subject: "On the Physical Examination of the Stomach."*

ORIGINAL PAPERS.

SOME CASES OF GALL-STONE SURGERY. (a)

By DENIS KENNEDY, F.R.C.S.I.,

Surgeon to Jervis Street Hospital, and to the Children's Hospital, Dublin.

In the present contribution I wish to bring under your notice some cases of gall-stone surgery. In no branch of our profession has more progress been made in the last decade than in the surgery of the gall-bladder and bile ducts. An important factor in this progress has been the recognition of the fact, by physicians as well as surgeons, that drugs have not the slightest influence in dissolving a biliary calculus before its exit from the body, or in dislodging it from the position it may occupy in any part of the biliary tract. And drugs have just as little influence over the many grave and pathological lesions that may ensue from gall-stones. Consequently, although the physician has his part to fulfil in the early recognition of the disease and in the general guidance of the patient, the treatment of the disease itself, as well as of the sequelæ that may ensue, belongs entirely to the surgeon. Of course, no one can deny that many patients carry their gall-stones with them to the grave, and that their life has not been materially shortened nor made too unpleasant by their presence. Others, again, get rid of a large number of gall-stones, when Nature is aided in her expulsive efforts by the improved vigour and tone which the system receives when a time is spent at some of the popular health resorts, such as Carlsbad. But these must be looked on as exceptions to the ordinary course of events which accompany the presence of gall-stones in the biliary tract.

A statement is frequently made that gall-stones may be present in the gall-bladder without giving rise to any symptoms. I think this is rarely true. There may be no symptoms which point directly to gall-stones, but stomach troubles are nearly invariably present, due to the pathological lesions that follow the presence of biliary calculi when they remain for any time in the gall-bladder or bile ducts.

These pathological changes consist essentially in the formation of adhesions between the viscera in the upper and right side of the abdomen. The pyloric end of the stomach, the colon, the gall-bladder, and liver are found matted together by dense adhesions. Consequently, when food is being passed through the pylorus, which is narrowed and inflamed on account of the adhesions, pain is experienced resembling that due to gastric ulcer. And I have met many cases that were treated for years for stomach trouble, especially for ulceration, when the primary and essential disease was the presence of calculi in the gall-bladder. A typical example is the following case:—

Mr. G., æt. about 45, I saw in February, 1906, in consultation with Dr. Cox. For 15 years he was dieted and doctored for stomach trouble, and labelled "chronic dyspepsia." He travelled twice round the world, and wintered abroad for years, in the endeavour to get health. In spite of this he was sometimes bad, sometimes better, but never well. Occasionally he got rather bad attacks of abdominal pain, which were always attributed to some indiscretion in diet. For a couple of years previous to my seeing him these attacks became more and more frequent, and rendered his life miserable. On examination, all I had to do was to confirm the diagnosis of gall-stones already made by Dr. Cox, and to agree to carry out operative treatment recommended by him. On operation, I found the viscera matted together in the upper abdomen, the gall-bladder full almost to bursting point with calculi. On opening the gall-bladder I removed hundreds of small black calculi resembling particles of coal in appearance. I provided for free drainage from the gall-bladder, and the patient made a rapid and complete recovery. He has since remained in perfect health, gained a few stone in weight, can eat what he likes, and never knows he has a stomach.

A much more serious condition of things that we have frequently to deal with is when the calculus or calculi become lodged in the common bile duct. The symptoms that such a condition give rise to are, as a rule, definite, and not very difficult to diagnose. Jaundice and its associated symptoms will be more or less pronounced according to the degree of obstruction produced in the duct. Pain is usually present, but not necessarily severe; wasting of the patient occurs, and most intense irritation of the skin and eyes are also usually present. But probably the most significant set of symptoms are attacks, ague-like in character, from which the patient is prone to suffer. These attacks are said to be due to either a catarrhal or suppurative inflammation, occurring in the gall-bladder and bile ducts above the obstruction. They may, however, be completely absent, especially when the common bile duct is completely occluded. It is then more difficult for the infection to travel upwards from the intestine. Such a case is the following:—

Mrs. S., æt. 52, consulted me in October, 1905. Her history was as follows:—Four years previous she got an attack of abdominal pain, lasting with remissions for three days. It then passed off. Six months subsequently she got a second attack; the pain lasted two days; she then became jaundiced, and continued so. On examination, the patient was deeply jaundiced, looked emaciated, and complained of feeling very languid and weak. She also suffered from considerable irritation of the skin and eyes. There seems to have been a complete absence of any febrile attacks, or of rigor. She suffered no pain. The liver was apparently enlarged, reaching down below the umbilicus; there had been no hæmorrhages, nor any vomiting. I diagnosed obstruction of the common bile duct by a calculus, and recommended operation, which I subsequently carried out. On opening the abdomen by an incision through the right rectus muscle, I found the liver very enlarged, but had the greatest difficulty in finding the gall-bladder, on account of the dense adhesions that were present. The viscera were matted together as if with malignant growth. The gall-bladder was atrophied and contained neither bile mucus nor calculus. With considerable difficulty I exposed the common bile duct and palpated a calculus just as duct passes behind the duodenum. I incised the duct and removed a stone, which measures 2 in. in circumference and weighs 55 gr. I stitched a drainage tube into the cut bile duct in order to afford free drainage. A couple of iodoform strips placed down to the incision in the duct and surrounding the drainage tube completed the operation, which lasted one hour and 50 minutes. The exposing of the gall-bladder and bile ducts through the dense adhesions was the sole cause of the prolonged time necessary. Convalescence was uninterrupted; the patient left hospital five weeks subsequently, completely well, and she has remained so since.

(a) Paper read at the Surgical Section of the Royal Academy of Medicine in Ireland, March 25th, 1908.

A most interesting case is one that came under my care last July. She then had perforation of the gall-bladder, and I subsequently had an operation for occlusion of the common bile duct by calculi. The history of the case is as follows:—

Mrs. O'F——, æt. 35, I saw in consultation with Dr. Savage and Dr. Gibson in July, 1907. In the previous April she had her first attack of gall-stones, during which she was jaundiced, and which lasted for about three weeks. Her present attack had lasted about a week. She was deeply jaundiced, was collapsed, had continuous pain, quick pulse, and a temperature ranging about 101°. Vomiting was present; she complained of great tenderness all over the right side of the abdomen; the abdominal muscles over the same region were quite rigid. We diagnosed perforation of the gall-bladder and had the patient removed to a nursing home, with a view to having operation immediately carried out. On opening the abdomen, bile and pus escaped freely from the peritoneal cavity. I found the viscera and the peritoneum covered with flakes of thick lymph. On further examination, I found a large opening towards the neck of the gall-bladder through which bile and calculi had freely escaped into the peritoneal cavity. Luckily, the whole area was isolated by adhesions, so that I had only localised instead of a general peritonitis to deal with. I removed 18 large calculi from this pouch of peritoneum and from the gall-bladder, and had to content myself with providing for free drainage from both. Being purely a life-saving operation, and being afraid of breaking down adhesions and thereby carrying infection to the general peritoneal cavity, I made no attempt to expose or palpate the bile ducts. The patient's recovery was slow and was not complete. After about two months she went for a trip to Portrush, and there the biliary fistula, which remained open since the operation, became closed. A few days subsequently she suffered from another attack of biliary colic. This lasted only a couple of days, and she again became comparatively well. However, she was never free from pain, she did not gain strength, she had attacks of vomiting, and a complete distaste for food. The attacks of colic recurred again and again, increasing in frequency and in intensity until they were practically continuous. She gradually also became deeply jaundiced. In January of this year I again saw her in consultation with Dr. Savage, and we were both agreed that the trouble was obstruction of the common bile duct by calculi, and that the remedy was operation. This I carried out a few days subsequently. Through the usual incision in the right rectus muscle I had considerable difficulty in getting into the abdominal cavity, as the stomach and colon were adhered to the anterior abdominal wall. The liver was well under the ribs and the gall-bladder buried in adhesions down towards the posterior abdominal wall. With great difficulty I exposed the gall-bladder and bile ducts and was enabled to palpate them. There were no calculi in the gall-bladder, but the cystic duct and common bile duct felt like a rosary of beads, from the number of calculi they contained. I incised both, removed two calculi from the cystic duct and six from the common bile duct. I stitched a drainage tube into each duct, surrounded them with strips of iodoform gauze, and suturing the abdominal wall completed the operation. The patient's recovery was rapid, complete, and I hope permanent.

It will be noticed that each of these two patients had only one attack of biliary colic previous to very grave troubles supervening. It should warn us that a patient is no more safe with a gall-stone in a gall-bladder than with a suppurating appendix in the abdomen.

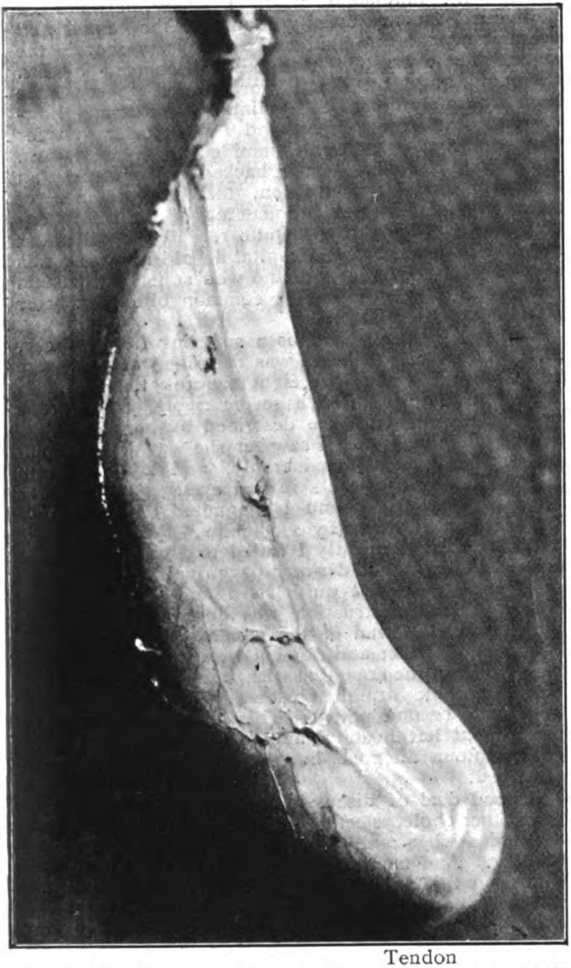
It is important for us to remember that obstruction of the common bile duct is sometimes brought about by inflammatory trouble in the head of the pancreas; and, still further, that this pancreatic inflammation may be the result of the presence of calculi in the gall-bladder or bile ducts. As one would expect, the symptoms of obstruction to the common bile duct, are pretty much the same in both conditions. But with a careful examination certain important points of difference can usually be discovered. In obstruction due to pancreatic inflammation, the gall-bladder is usually enlarged, sometimes even forming a tumour palpable through the abdominal wall. Besides, particles of undigested fat are usually found in the fæces, and peculiar crystals are said to be always present in the urine. These crystals have been discovered by Dr. Cammidge, and the details for their discovery have been accurately described by him. These details, however, are rather elaborate, and I must refer you for their description to Dr. Cammidge's original work. He claims, and his claim is backed up by no less an authority than Mayo Robson, that the presence of these crystals is pathognomonic of inflammatory changes in the pancreas. Quite recently I had under my care in Jervis Street Hospital an old lady who was sent to me by Dr. Savage, and who suffered from this pancreatic obstruction of the common bile duct. Her history was as follows:—

For two years she had been suffering from attacks, at long intervals, of what was described as gall-stone colic. But for the last eight months these attacks were associated with such severe rigors and nervous symptoms that they were described by her people as being epileptic. When I saw her she was deeply jaundiced, had wasted considerably, and suffered from intense irritation of the skin and eyes. The liver was apparently enlarged, and I diagnosed obstruction of the common bile duct by a calculus. When operating a few days subsequently I failed to find any calculus either in the gall-bladder or biliary ducts, but the head of the pancreas felt quite hard and indurated. I concluded the obstruction was due to inflammatory trouble in the head of the pancreas; I opened the common bile duct and fixed a drainage tube into it. This I did in the hope that with free drainage the pancreatic trouble would subside and the common bile duct again become patent. This hope was fulfilled, as the patient left hospital a couple of weeks ago with her symptoms all gone, but a small biliary fistula still remained.

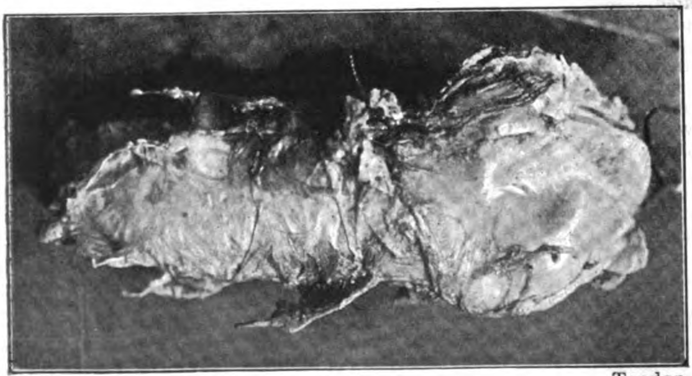
A good deal of discussion has been indulged in as to whether cholecystectomy should not be the operation of choice when gall-stones are present in the gall-bladder. And many supposed advantages are alleged to favour this procedure; but we must remember that the gall-bladder may be of great use surgically for purposes of draining the biliary ducts, or for carrying out an anastomosis with the intestine in case of permanent obstruction to the common bile duct. And in the absence of some definite condition, such as malignant disease or occlusion of the cystic duct, that calls for removal of the gall-bladder, cholecystotomy is the operation that should be done. On two occasions I have removed the gall-bladder. In both I considered that the conditions present warranted the operation. The cases are as follows:—

Mrs. O. K. was sent to me by Dr. Kelly, of Portumna. She had been ailing for about ten months, and during that time had a couple of severe attacks of abdominal pain, with vomiting. In the interval of these attacks she was comparatively well, but a tumour gradually formed in the right upper half of her abdomen. On examination, the symptoms were practically negative other than the presence of a well-marked tumour, and some wasting of the patient. She had neither a pain, jaundice nor vomiting. At first I was inclined to think the tumour was renal in origin, but an examination of the urine and of the bladder with the cystoscope gave negative results. Besides, the tumour was dull on percussion, and consequently I decided it was growing either from the liver or the gall-bladder. Through an incision through the right rectus muscle I opened the abdomen, and found the tumour to consist of a large gall-bladder extending from the costal margin down below the brim of the pelvis, and containing numerous calculi. This gall-bladder resembled in shape and size a small stomach. On examining it I found the cystic duct occluded with a calculus, and I at once determined to remove the whole thing. This I carried out without the slightest difficulty. The patient made a rapid and perfect recovery, and has remained well since.

The second case of cholecystectomy was done for a patient sent to me by Dr. Cusack, of Cashel. This was much more difficult, as the gall-bladder was adherent to the surrounding viscera. The breaking down of these taking a considerable time, and causing pretty free bleeding from the liver surface after their separation. As in the other case, the gall-bladder was filled with calculi, and one was firmly impacked in the cystic duct. She also made a rapid and complete recovery.



Gall-bladder removed from Mrs. ——. It reached below the brim of the pelvis and contained numerous calculi.



Gall-bladder with calculi removed from Mrs. K. The dense adhesions which had to be cut through before removal are well shown.

Apart from the details connected with any of the operations on the gall-bladder or biliary ducts, there are a few general principles that should always be borne in mind. A sandbag or cushion placed under the back of the patient brings the gall-bladder and biliary ducts quite near the anterior abdominal wall, and consequently renders the manipulation much more simple. The incision through the outer border of the right rectus, prolonged upwards and inwards, as described by Mayo Robson, gives the easiest access to the bile ducts. The bile ducts must be examined as a routine practice, if necessary any adhesions present being broken down for the purpose.

The area of operation must be well walled off by suitably placed pads, and the less changing there is of these pads during the operation the better.

No attempt should be made to crush a calculus *in situ*, but incisions may be freely made through any part of the bile ducts for the removal of a calculus or for drainage.

I frequently find the gloved or ungloved finger the best scoop for removing calculi from the gall-bladder.

We should remember that our operation fails to be a success unless we free the biliary ducts from calculi, and this procedure may tax to the utmost our skill, energy and perseverance to bring it to a successful conclusion.

THE DIAGNOSIS AND TREATMENT OF SYPHILITIC NEURASTHENIA.

By G. MILLAIN.

Physician to the Paris Hospitals.

The diagnosis of syphilitic neurasthenia is, as a rule, fairly easy; indeed, close scrutiny of any single symptom may enable us to come to a conclusion. The headache, for instance, is very characteristic, there is a sensation of emptiness, of weight, of compression, rather than of actual pain. Then, too, it comes on in the morning on awakening, clearing up towards evening, never interfering with sleep, and getting better as soon as the patient lies down, and it may persist for years.

The course and development of the symptoms, again, will greatly assist us in arriving at a positive diagnosis. Note, for example, the multiplicity of the painful sensations of which the patient complains during the day, or even during his quarter of an hour's conversation with his doctor. Then, too, their mobility, coming one day and disappearing the next, only to recur after longer or shorter intervals, their indefinite duration, spreading over several years, with intermissions, their presence in a subject who in other respects appears to enjoy the best of health and independently of any somatic sign, in spite of its old standing, all these are valuable elements in the diagnosis.

The characteristic features just enumerated enable us to distinguish between neurasthenic headache and that of cerebral syphilis, which is severe, nocturnal, interfering with sleep, and running its course in a few weeks or months, terminating either in recovery under mercury and iodides, or the supervention of obvious organic lesions.

There are, however, cases in which an exact diagnosis presents no little difficulty. We meet with subjects suffering from typical organic syphilitic headache, who get well in the course of a few weeks under appropriate treatment. Some time, soon after recovery, the headache returns, and once again subsides under a repetition of the treatment. This may take place several times over in the course of a year, but each succeeding attack proves less amenable to treatment, the character of the headache changes, and it is extremely difficult to make out whether we are dealing with syphilitic headache, a functional disturbance following cicatrised organic lesions, or a neurasthenic headache. Such patients must be kept under observation, and we may have to suspend our judgment for two or three months while we investigate the exact nature of the attacks, the times at which they supervene, the precipitating causes and the effects of treatment.

There are two principal forms of neurasthenia: the cerebral or cerebro-asthenic form, associated more particularly with headache, insomnia, depression of the intellectual faculties, aboulia, and various phobies; and the spinal or myelasthenic form, the principal symptoms of which are rachialgia, vertebral hyperæsthesia, thoracic or abdominal pain, weakness of the legs, and even lightning pains, impotence, etc. Both these forms of neurasthenia are met with in syphilitic subjects, and are with difficulty distinguishable, the former from general paralysis at its onset, the latter from the pre-ataxic period of locomotor ataxy.

It is almost impossible to discard the possibility of general paralysis from one's mind, in presence of these aboulic, phobic syphilitics suffering from headache and general depression, and we are often constrained to await further developments. The neurasthenia may last for years without any evidence of actual cerebral mischief, whereas general paralysis reveals its presence by mental disturbances, which assume the aspect of dementia or mania. Lumbar puncture is often of assistance in such cases, because general paralysis is accompanied by cerebro-spinal lymphocytosis.

It may happen, though rarely, that general paralysis, especially at the onset, is not associated with cerebro-spinal lymphocytosis, so that a positive conclusion can only be drawn when we find actual lymphocytosis, that is to say, the presence of lymphocytosis will lead us to decide in favour of general paralysis. Its absence only amounts to presumptive evidence in favour of a diagnosis of neurasthenia.

Tabes is also very difficult to differentiate from simple neurasthenia in its myelasthenic form. It would, however, be rather surprising if attentive clinical examination failed to reveal one or more of the pathognomonic symptoms of tabes—the abolition of one or both reflexes, Westphall, Romberg, or Argyll-Robertson's sign, ulnar anæsthesia, disturbances of micturition, etc.

Latent Graves' disease, again, is sometimes by no means easy to distinguish from neurasthenia, especially when the latter happens to be associated with disturbance of cardiac function. The headache and the mental condition may enable us to make up our minds, but there are cases in which we cannot but hesitate; in which, indeed, we may be led to infer the co-existence of the two morbid states.

Lastly, as Dutil points out, "apart from the well-defined neuroses, neurasthenia, hysteria, and the vesanic states, there is a whole series of neuropathic states, as yet unclassed, which we must be careful not to confound with neurasthenia. It is admittedly extremely difficult to establish the lines of demarcation, but it does not follow that all eccentric, debile, unbalanced subjects, neuro-arthritic and migrainous subjects who display a certain tendency to depression and complain of vague pains, ought to be classed as neurasthenics. We must, at any rate, discover in the patient, some of the fundamental symptoms which constitute the morbid type: headache, rachialgia, dyspepsia with gastro-intestinal atony, cerebral depression, a particular mental state, neuro-muscular asthenia and insomnia, all these being the symptoms described by Charcot as the true stigmata of neurasthenia.

Treatment.—The treatment of neurasthenia is a very delicate matter, and, more than any other, demands special tact and patience on the part of the practitioner. Syphilitic neurasthenia falls within the scope of this injunction. Every kind of neurasthenia entails two distinct treatments, ætiological and symptomatic, and this remark applies with equal force to syphilitic neurasthenia.

The ætiological treatment of syphilitic neurasthenia must be twofold—the treatment of the determining cause of the neurasthenic state, and the treatment of the syphilis proper. With respect to the former, we must ascertain to the best of our ability what is the most salient feature of the patient's preoccupations—is it his pathological future, the possibility of getting married, the risks of contagion, and so on, and we must reassure him on this point as far as is humanly possible. We must not be satisfied by replying to his various questions in the negative, for they are usually suggested by things that he has read; so we must try and convince him that what he reads in books can only apply to a very small proportion of such cases—in fact, only to persons who have not been properly treated, or who, during treatment, led an irregular life. He must be persuaded of the beneficent effects of treatment, and induced to base his hopes thereupon.

In short, he must be reassured by showing him the remedy side by side with the evil. Above all, we must not display inattention when he is telling us of his woes, we must not interrupt him abruptly under pretext that he is too diffuse; on the contrary, we must let him see that we are devoting our whole attention to his narrative, and must reply with patience and tact to his questions. Avoid, above all things, treating his complaints as imaginary, for in this case he would logically conclude that you cannot possibly cure him, since you do not believe in the reality of his ills. If the physician, by a sympathetic, tactful attitude, can only succeed in gaining the confidence of his patient, the battle will already be half won.

At the same time we must immediately commence the anti-syphilitic treatment. In this secondary neurasthenia the effect of the treatment will be immediate and striking. The asthenic symptoms will follow the same lines as the cutaneous eruptions. The intensive treatment is the more indicated seeing that at this stage such patients bear mercury remarkably well, for all the world as if there were some relationship between the quantity of mercury that can be injected and the outward and visible manifestations. Under the direct influence of the treatment the asthenia will disappear, and the mental state will improve *pari passu* in view of the obvious influence of the treatment on the visible manifestations.

The treatment is much easier at the tertiary period. We all know the depressing influence and the general fatigue produced by the iodides and mercury, especially when the latter is given hypodermically: fugitive it is true, but none the less real. The neurasthenic subject often feels much weaker under the influence of the mercurial treatment, and it is difficult to get him to understand how his recovery can be brought about by a method which begins by intensifying his previous symptoms. It is therefore necessary to warn him beforehand on this point, while, on the other hand, the practitioner does his best to devise a treatment that entails a minimum of discomfort, and can be continued for a sufficient length of time. If grey oil be used in view of a protracted treatment, only a small dose should be given—say 3 centigrammes at each injection, to be repeated twice a week instead of the usual plan of injecting 7 cg. once a week. If pills are prescribed, preference should be given to sublimate pills containing a sixth of a grain in each, one with meals twice a day. Benzoate of mercury is given in doses of 2 cg. every other day, never exceeding this quantity, which is in some instances too strong.

Lastly, it is undesirable to continue the same treatment indefinitely. As soon as any untoward symptom makes its appearance, we must change the drug. Instead of grey oil, we may employ the benzoate of mercury; instead of injections we may give pills; pills may give place to inunctions in order that the mercurial course may not be interrupted. Or, instead of the mercurial course, we may order arsenic, which has the double advantage of prolonging the antisyphilitic action of the treatment, and of acting as a general tonic. Arseniate of soda may be prescribed in doses of a sixth of a grain a day, either by the mouth, or, still better, by hypodermic injection. This is persevered with for a month, whereupon iodide may be given in whatever quantity the patient can tolerate—say, from 10 to 40 grains daily. After four months of this alternative antisyphilitic treatment, it may be suspended for a month, to be followed by two more months of mercurial treatment, one of arsenic and one of iodide.

Symptomatic Treatment.—The general health of the neurasthenic patient has everything to gain by a period of rest in the country or at an altitude. The seaside, being more stimulating, does not appear to suit them as well. Faradic electricity and massage are often valuable adjuvants.

Weir-Mitchell's plan of absolute isolation may be found useful in grave cases, and when the patient's surroundings are unfavourable, as, for instance, when his friends and relatives, under pretext of testifying to their interest, are everlastingly asking him about his health.

The headache, the pain, and the digestive disturbances, must be treated separately. It must be conceded that they often resist medicinal treatment, and disappear little by little, just as they came without any obvious explanation of their behaviour.

Pyramidon and injections of isotonic sea-water, however, often exert a favourable influence. In neurasthenic subjects generally it is important to keep the bowels empty, and we must see to this by ordering appropriate aperients, enemata, and abdominal massage. Many of these patients are only "themselves" just after going to stool.

THE TREATMENT BY DIET OF BRONCHIAL ASTHMA. (a)

By A. C. F. RABAGLIATI, M.D.Ed., F.R.C.S.,

Consulting Surgeon to the Bradford Children's Hospital; Hon. Gynæcologist to the Bradford Infirmary.

This case is that of a young gentleman, æt. 25, who came to me along with his mother on October 11th, 1907. They told me that from the age of two years he had suffered from recurring attacks of asthma, that is, that he would suffer, say, for ten days at a time or for fourteen days or so from severe cough, during which time, although confined to bed, he was unable to lie down, because of the distress of breathing, and that there were loud whistling sounds audible in the breathing, with feverishness, quick pulse, high temperature, loss of appetite, etc. After recovery he would be able to be about again for a week or two. Even when well, however, he never could lie down with fewer than four pillows to support his head, as lowering of the head brought on difficulty of breathing, and might wake him out of sleep and compel him to sit up. Further, in the morning, even when well, or apparently well, he always coughed to get rid of some phlegm. During the attacks the marked tendency to suffer from an exacerbation of cough and breathlessness, or a sudden onset of distress of breathing in the small hours of the morning—1, 3, or 5 a.m.—was so noticeable as to have forced itself on the attention of the patient and of all the members of his family. I suppose it is this feature which in popular language, as well as in medical terminology, determines the naming of the disease ἄσθμα. When symptoms of bronchial catarrh, without pneumonia, are present, *i.e.*, cough expectoration and feverishness, the affection is called bronchitis: when distress of breathing is super-added to these, and particularly when the distress prevents the patient from being able to lie down and compels him to adopt the sitting position, the affection is called asthma. Of course, there are numerous intermediate gradations and conditions of bronchial catarrh in various patients, the symptoms of bronchial catarrh prevailing in some and those of distress and orthopnœa in others. "Nervous asthma," I may remark, a condition which I used to see in my earlier days of practice, or which I used to think I saw, I never see now; and have not for many years. I believe that bronchial asthma is always catarrhal and inflammatory. And treatment suggested by this belief has resulted in this—that whereas I formerly believed asthma to be one of the least tractable of conditions, obscure in its nature, erratic in its manifestations, uncertain in its course, and little amenable to treatment, I now believe it to be one of the most tractable of diseases and one as to which it is most easy to promise cure of patients who will follow the advice given to them. The cases one sees have usually lasted for a long time, that is, the attacks have usually recurred from time to time, as in this case, over a long series of years; and treatment, to be effective, must be continued for a considerable length of time if relief is to be effected, because, of course, Nature cures each attack herself by compelling the patient to take his bed, stopping the appetite, furring the tongue, raising the temperature, and quickening the pulse, as she does in acute and in recurring diseases generally.

Probably the most fundamental law in medical practice is that illness is long-lasting or frequently recurring, in proportion to the length of time during which the inducing causes have been in operation. I may at once say—for it is the essence of this communication—that as it is the discovery that wrong feeding is far the most important factor in the causation of asthma, as it is this discovery which has given one confidence in promising cure in a large number of cases, it follows that after recovery a patient must on no account return to his old way of living—or he will be ill again. It must be so. If the action of certain causes makes a person ill, and if the removal from the sphere of those causes enables him to recover, obviously re-subjection to the action of those causes must make him ill again. And conversely, if he wishes to escape new attacks he must continue to live in a new way—and not to put too fine a point upon it—for it is just here that our difficulties with patients are greatest—he must in the future eat less and less often.

To proceed with the history of this case: the mother told me that they had suffered so much in having to attend to the child, boy and man during practically the whole of his life, and were so tired of the recurrence of the attacks, one being no sooner recovered from, as a rule, than he had entered on another—they were so sick of these experiences that they were prepared to do anything I advised. She incidentally coloured the narrative by suggesting that, as the boy had not been well since he had been vaccinated, vaccination was the cause of his illness. There was, however no proof whatever of this allegation; and, in fact, it was not quite compatible with the other statement that the child had suffered from asthma from the age of two years; as vaccination, performed under the age of three months, might have been expected to show its hurtful influences sooner than 21 months after the operation if it had any hurtful effect at all. Finding my patient in the thus hopeful mental state of being willing to do anything in order to get well, as he and his family were so thoroughly tired of the futility of all previous treatment, a fortnight's illness having been followed for many years by two or three weeks' recovery, or partial recovery, and the partial recovery by another attack, and so on indefinitely; I said that unless I found consumption or some other incurable condition present, I had no doubt about the curability of the asthma and the chances of preventing subsequent attacks. On examining the patient I found a markedly emphysematous chest, barrel-shaped, with prolonged expiration and whistling sibilus more or less all over it. He was not very ill at that time, being able to be about. In fact, the object of his visit was to get advice as to the preventibility of future attacks, which, from experience, he well knew he might expect. There was no attack on then. He incidentally mentioned that he had lost eight relations by death in 1907. But this unfortunate experience, while it no doubt rendered his family more anxious on his account, had no distinct bearing on his illness. I showed him that, besides the emphysema and the recurring colds of which he knew, as his attention had frequently been directed to them, he was suffering from periostitis of the sternum, which was very tender on pressure just above the xyphoid cartilage, that he had arthritis at each sterno-costal cartilage, especially the 4th, 5th, and 6th left, and that many of the muscle sheaths, as, for instance, the sterno-mastoids, trapezii, rhomboids, teretes majores, etc., as well as those of the lower limbs were tender on pressure, showing the general initis or rheumatic congestion from which he suffered, and which appeared to me to be at the bottom of his asthma. But mal-assimilation was at the bottom of the general initis; and it was necessary, therefore, to deal with the mal-assimilation if any influence was to be had on the illness. Meantime, in order to treat the catarrh of the mucous membrane of the lungs, I advised the use of a wet flannel compress for an hour morning and evening. This compress to be made of flannel about 18 in. wide and a yard and a quarter long, put wet round the chest and covered with two or three dry blankets; a cool application to be placed also on the forehead to prevent headache. He was to take a demulcent expectorant two or three times a day, and some sedative in a wineglass full of hot water at night, if required.

(a) Read before the Bradford Medico-Chirurgical Society, June 16th, 1908.

About food: he was to have a cup of hot tea, weak, in the morning at breakfast-time with nothing to eat; and to dine early for the present (by and bye I hoped to make some more satisfactory arrangement as to this). Dinner might be as early as 11.30 or 12, with a plain tea, without jam, at 7 p.m., and no other food. On this plan he improved from the first. He came to me on October 17th, 24th, and 31st. He did not lose weight to any appreciable extent under the treatment, remaining about 7 st. 7 lb. (height 5 ft. 3 in.). He had weighed 7 st. 13 lb. two months before I saw him. On the night of October 30-31st he had been awoke at 3 a.m. with dyspnœa. There were some sibilant *râles* in the chest. On November 7th he was much better. I had, however, warned him that the progress which I confidently expected, would be (like the onset of his illness) intermittent, and that he could not expect to recover straight away. On November 27th he was sleeping right through the night and was much improved. Still we were not greatly surprised that on December 18th he had "a cold" and lost 3 lb. in weight down to 7 st. 5 lb. After this I advised him to have a cup of tea for breakfast simply, dinner about 11 a.m., as under the new *régime* he still found it hard to wait longer (and also because I did not wish to put too much strain on him yet) a cup of tea at 5 p.m., and about 7 a glass of Allen and Hanbury's Food or Horlick's Malted Milk or Maltine with Milk. On this he did very well for some time.

After the beginning of the year I advised him to wait for his first meal till he could join the family dinner party at 1.30; to have a cup of tea alone in the morning; and about 7 to have Horlick's Malted Milk or Benger, or Allen and Hanbury without bread. On February 5th he had gained weight on this practically monositious *régime* to 7 st. 9 lb. I advised him to abstain from Yorkshire pudding and pastry, but otherwise to take at the family dinner whatever was set before him. On March 12th he had gained another pound in weight, eating once a day (this is, however, not an uncommon experience in practice, I have many observations of patients who gain body weight by eating less—the explanation, I suppose, being that if they eat less, they assimilate better what they take; on that day one could hear some fine dry sibilant *râles* over the back of both lungs. But he was sleeping right through the night with one pillow and a bolster, not the four pillows of former times, was going out in all weathers without any fear of catching cold, and was getting up early in the mornings to look after his fowls in the country place where he lived. He has continued this *régime* up to the present, and remains well. The emphysema is not gone; probably never will quite go; but it does not incommode him. Under the breathing exercises I recommended for him in the mornings (which, although I advised them I omitted to mention), as also under the general methodised exercises I advised him to have in the act of dressing, as well as the free expiration recommended, no doubt the emphysema will become less and less. Whether it will ever be quite got rid of is doubtful.

I do not know if my medical colleagues have noticed what I call the delusion of the asthmatic? He feels as if he could not get his breath; while, in point of fact, he can't get rid of it. The asthmatic, if you watch him in the paroxysm, takes a succession of forced inspirations at very short intervals between one another; and he hardly expires at all. You can frequently mitigate an asthmatic paroxysm by persuading the patient to expire freely and long. Often and often have I been able to shorten an attack by this means. "Breathe out, exhale, expire," you say to the patient; and in a little while he begins to obtain relief. And obviously the fact that emphysema follows asthma, or makes part and parcel of the asthmatic condition, is a fact corroborative of this view, for otherwise if the patient could not get air, atrophy of the lungs would be the dominant pathological condition instead of over-distension.

I have no doubt that this young man, who has suffered so much and for so long a time, and so recurrently, that his parents have taught him no trade and no profession, can remain well so long as he continues to follow his present mode of living. Equally little doubt have I that if he returns to the conventional 3, 4, or 5 daily meals, he will have a recurrence of his illnesses. He may make this differential experiment if he likes. I do not advise him to do so. What is the use, one is driven to ask—what is the use of advising a patient suffering in this way, to avoid cold, to avoid draughts, to avoid fatigue, etc., etc.? Is it not much better to advise him that if he is to live at all (and he cannot help himself as to this, for he is alive without his consent being asked) he had better adapt his way of living to the country and climate he is in than fly to other climes, where if he gets rid of one set of ailments he will almost certainly suffer from some others? In the matter of climate it seems to me it is far rather how we live than where. I might have paralleled this case by many others treated on similar lines, and treated equally successfully, but I leave the natural and logical inferences to your own minds. I am not by any means the first to have drawn attention to the influences of wrong dieting in causing dyspnœa, nor even, perhaps, to have shown the immensely beneficial effects to the sufferer from asthma, of advising him to eat nothing after about the middle of the day (12 to 2 p.m.). But I seem to have rediscovered the principle that the great majority of asthmatics will recover in a few weeks or months, and not fall ill again if they follow this simple rule. I think it is an excess of carbonaceous stuffs that are efficient in causing asthma, and therefore I am careful to advise an alteration of the diet in this direction. Still, an excess of *any* sort of food beyond the bodily requirements is hurtful in some direction—if not in causing asthma, then in some other way. So that very good advice is that the patient should not eat after mid-day, and then in moderation. I remember being told by a distinguished physician of the vagaries of asthma, and how you never could predict what plan would suit, and what other would not suit the asthmatic patient. I listened with open mouth as he told me of a mother and son, very much attached to one another, and both asthmatic; but the place which suited the mother did not suit the son, and so they could not live together—which was a great distress to them—but could meet only occasionally and at very long intervals, at some neutral place for some short time and then part again. I have often wondered since whether, by making simple changes in their dietary, these two unwillingly separated relatives might not possibly have been able to re-unite. It would be still more awkward if, instead of being mother and son, the two had been man and wife! ! ! I have thought your readers might feel interested in the details of this case. I have not dealt with the pathology, except incidentally, and I can well imagine that some here might be disposed to cavil at my definition of disease, viz., that it is generally the process by which Nature eliminates unnecessary material from the body, which unnecessary material mostly finds its way in through the digestion. But I do not enter on the discussion of this point. There are, however, as Professor Stewart says, few diseases which are not in some sense alimentary.

OUT-PATIENT'S ROOM.

METROPOLITAN HOSPITAL.

Gout.

By LEONARD WILLIAMS, M.D., M.R.C.P.

This man, æt. 44, and who is a "handy-man," comes to us with an interesting story, which, in the light of his symptoms and physical signs, becomes extremely instructive. He has been suffering from tenderness in his hands, feet, and knees for 23 weeks, of which 8 weeks have been spent in bed. The diagnosis at the institution where he has been treated was "rheumatic fever," and he tells us that he suffered a similar attack, also labelled rheumatic fever, three years ago. Fourteen years ago he had an illness of the same nature. He is quite certain of the fact that in none of these attacks did his joints swell. They were very painful and rather red, but there was no swelling. He further tells us that, in the last attack, at any rate, he never had a high temperature. This he knew, not only because he kept his eye upon the chart which was hanging above his bed, but also because he did not feel ill in himself. He had no sweats, and the pains did not fly from one joint to another. Now, in the light of this story (and I think you will admit that the patient is an exceptionally good witness), we need have no hesitation whatever in saying that, certainly so far as his last attack was concerned, and probably so far as the two previous attacks were concerned, this man has not had the disease which is known as acute rheumatism or rheumatic fever. He has had an arthritis—of that there can be no doubt. If there were any, it would at once be dispelled by an examination of his hands, which have the appearance so characteristic of a sub-acute or chronic arthritis from whatever cause arising. That is a point to which I would direct your very special attention. If the joints of the hands become sub-acutely or chronically inflamed, there is no means by which you can be sure of the cause of the inflammation if you confine your examination to the joints themselves. Arthritis is like pleuritis or conjunctivitis, or any other inflammation which may be produced by various causes. To discover the meaning of an arthritis, it is necessary to examine the patient rather than his joints; to restrict your view to the latter is to court misfortune. If we were asked to describe this man's general appearance, we should say that it was that of a person of robust physique; over-nourished rather than the reverse, but without evidences of any excess. He has been a teetotaller for thirty-five years, but remembers that both his parents, especially his mother, "were very fond of their glass of ale." He has always been a hearty eater. You notice that he is prematurely bald, and, if you examine his mouth, you will see that the gums have receded considerably, and that he has what dentists call erosion cavities between the gums and the dentine. When you look at his hands you will observe that his nails have that longitudinal striation which is described as "reedy," that he has the enlarged metacarpo phalangeal joint of the index on each side, the over-extension of the proximal and the flexion of the distal phalangeal joint in several of the fingers, which tells of a chronic or sub-acute arthritis. On these findings alone I have no hesitation in saying that this man is gouty, though I confess that if you press me for a definition of this term I should find it very difficult to supply you with one which could be considered as altogether satisfactory. The truth is we do not to-day know much more about gout than they did in Sydenham's time; certainly we know very little more about its pathology than was then known. Theories there have been, and still are, some of which are plausible, but none of which contribute anything to a real understanding of the disease. Of one of them, the uric acid theory, it is indeed possible to assert that it has done more to darken counsel, to obscure the real issue, and to retard progress than anything else. Gout is no more due to uric acid than consumption is due to "chill." And if we are not in a position to explain gout, we are still less equipped for dogmatising about goutiness. Nevertheless, goutiness is a condition which we must learn to recognise clinically, and the earlier we can recognise it the more likely are we to be able to guide the patient into those paths of physiological righteousness upon which his salvation depends; for the treatment of goutiness is far more a question of general hygiene than it is one of drugs. The stigmata of the gouty diathesis are many. Some of them we have already seen this man to possess; from others he is free. One of the latter, namely, cutaneous eruption, is a very common finding; it is, indeed, probably the manifestation which most often drives the patient to the doctor. Another common manifestation which is present in this case is varicose veins, which more often than not take the form of hæmorrhoids. In such cases gastro-intestinal troubles are almost invariably complained of, and they generally take the form of dyspepsia of the acid, sthenic type, which is relieved by bismuth and soda, and constipation, which requires the occasional administration of mercury for its complete relief. The state of the cardio-vascular system in the gouty is one of very considerable interest and no little complexity. The French say that gout is to the arteries what rheumatism is to the heart, meaning that gout is as liable to cause arterial degeneration as true rheumatism is prone to produce endocarditis. The method of production of this arterial degeneration is believed by many to consist in the production of hypertonus by the gouty toxins, giving rise to high blood pressure and consequent fibrosis. This may be the mechanism in some of the cases. I will even go so far as to say that I am convinced that it is the mechanism in many of them, but I am quite as certain that in a certain proportion the mechanism is entirely different. This man is a case in point. His blood pressure is not only not high; it is, for his age, distinctly on the low side. We have taken it twice, and on neither occasion did it rise above 120 mm. Hg., which, though normal for a man of 24 years of age, is certainly below the normal for a man of 44. When you examine this patient's heart you will find the apex-beat, as it is improperly called (the *élite* now call it the "impulse point") in the nipple line—that is, somewhat to the left of its proper place. There is no enlargement in any other direction. With the stethoscope you will hear a faint systolic murmur in the mitral area which is not conducted, and at the aortic base a loud systolic murmur which is conducted into the vessels of the neck. Now what is the significance of this basal murmur? If you believed the text-books you would have to conclude that it meant stenosis of the aortic orifice; they give you no alternative; they tell you that a systolic murmur at the aortic base means obstruction at the aortic valve, as inevitably as two and two make four. But text-books are devoid of imagination, and do not realise that the calcareous degeneration of the first part of the aortic arch which we so often see on the post-mortem table will produce a rough systolic murmur in the aortic area even more effectually than a narrowing of the aortic ring will produce it. The point of interest here is to discover what has caused this calcareous degeneration. We know that syphilis is a very potent cause, but, without going into details, I may say that such a cause has been almost certainly absent in this case. High blood pressure is, as I have already said, another very common cause, but the manometer tells us that this patient's blood pressure is low. One may of course reasonably ask if the pressure has always been low, or whether it is not possible that it has been high, that it remained high for a sufficiently long time to bring about the chronic aortitis of which we now find the evidence, and has since fallen to the point which the instrument now registers. That, no doubt, is a possibility, and it is a possibility which would seem to be supported by the slight outward displacement of the impulse point, but I can hardly bring myself to regard it as a probability. A fair proportion of people who are definitely gouty have low blood pressures all along, in the same way as many of them have a subnormal temperature all along, and I believe that persistently low blood pressure may bring about an aortitis almost as effectually as a persistently high blood pressure. This is, however, a question which is rather too intricate for present discussion, so I pass to the more congenial atmosphere of treatment. I have already said that the treatment of these cases is largely one of general hygiene; but it is one of general hygiene as applied to the individual. There is no use telling a man who works hard with his muscles in the ordinary way that he must take exercise. It is quite evident that such a man has become gouty, as this man has, in spite of the exercise. We must therefore look to some other factor. In all probability that factor will be found somewhere in connection with his diet. There are people who "throw back," so to speak, to their Simian ancestors, and are consequently unable adequately to metabolise meat foods, in the same way that there are pepole who "throw back" to their carnivorous ancestors, and are unable adequately to metabolise carbo-hydrate foods. In either case if the patient adopts the ordinary plan of eating a mixed diet, some form of goutiness will result. So far as drugs are concerned, guaiacum and iodide of potassium are the most generally useful, but there can be no doubt that salicylate of soda, especially in the form of aspirin, will occasionally succeed when these others fail. Where the goutiness takes the form of arthritis nothing, in my experience, does so much good as radiant heat baths. Where the blood pressure is high, as in some of these cases it is, I find that ipecacuanha in small doses, not sufficient to nauseate, does a great deal of good; but where the blood pressure is low, as it is in this man's case, even if I am moved to give ipecacuanha for the purpose of stimulating the liver, I always protect its action by the addition of a certain proportion of nux vomica. Were this patient a rich man instead of a poor one, I should have no doubt whatever as to how to treat him. I should send him to Vichy, where he would be subjected not only to the sodium bicarbonate waters, but also to electricity, massage, and a scheme of diet, based upon a careful investigation of his digestive capabilities.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Cases of Appendicitis.

(*Concluded from p. 645.*)

Acute Appendicitis Simulating Acute Cholecystitis.—Mr. Edred Corner operated on a married woman, æt. 45, who had been ill a week with pain below her right hypochondrium, accompanied by pyrexia, sickness, inactivity of the bowels, and some jaundice. On examination, the skin of the abdomen was tinged yellow, and by the right costal margin was a tender mass, dull on percussion. Thus it may be said shortly, Mr. Corner pointed out, that the case presented all the signs and symptoms of acute cholecystitis. The mass was too far out, and there were not the concomitant signs or symptoms for it to be connected with the stomach, pylorus, or duodenum. But there was the appendix to take into account; it was a clinical factor which must always be reckoned with when the disease was on the right side of the abdomen or in the pelvis. Not infrequently it entered also into the diagnosis of troubles on the left side of the abdomen. In children the appendix was often up under the liver, which was its natural and normal situation in the fœtus. On occasions it remained in this subhepatic position throughout adult life. But the usual condition was that the free end remained more or less in the subhepatic region, the appendix being pulled out longer and longer as the cæcum descends to the right iliac fossa. As suppuration generally affects the distal end of the appendix, the abscess in these cases forms in the subhepatic region, and presents below the costal margin of the right ribs. The abscess was opened from the front, the fibres of the rectus muscle behind being separated and held apart by retractors. Yellow offensive pus alone was evacuated as from an appendix abscess. There was no bile present, but a fæcal concretion was found which proved that the appendix had been perforated. Mr. Corner pointed out that these cases in which the appendix abscess was situated high are very liable to be followed or accompanied by a subphrenic abscess, the pus being between the diaphragm and the liver. It would be therefore necessary for a very careful outlook to be kept on the lower part of the right lung behind, because it is in this situation where the physical signs are to be found. These are those of fluid; dulness, loss of breath sounds, loss of vocal fremitus and vocal resonance, etc. These signs must be particularly looked for if the temperature remained up or becomes irregular.

In the case of this patient the convalescence was slow, but interrupted by no spread of the infection.

Acute Appendicitis.—The same surgeon operated on a girl, æt. 25, who had been in a doctor's household. Recently she had come from the country to stay in London, the change in her life producing great difficulty with her bowels, a trouble she had never experienced before. There was, Mr. Corner remarked, a very great connection between inflammation of the appendix and constipation. In consequence, after being in town for some time, she woke up one night with acute abdominal pain and vomiting. Her temperature was 101°, and the pulse 110 in the morning. As a clinical feature of great importance he thought it should be noted that the attack of pain commenced in the night, waking her up. She had another bad night, and when Mr. Corner saw her the temperature was 102.4°, and the pulse 120. On examination, the abdomen was soft in the upper part; tender and not moving well in the lower. A most important point in the examination of acute abdominal cases, he considered, was a rectal examination which should *never* be omitted. It was of special importance when the signs found on abdominal examination were not decisive, such as in this case. When the abdominal examination reveals the disease and decided the treatment, a rectal examination was not nearly so helpful. In the case of this girl a hard mass was felt behind the uterus. It was tender, and its examination was painful, but it was capable of being moved which peritonitic tumours in their acute inflammatory stage are not generally. Operation was undertaken at once, the abdomen being opened by an incision through the right rectus. The uterus, Fallopian tubes, and ovaries were normal. The tender swelling felt in Douglas' pouch turned out to be a large fæcal mass in the sigmoid colon prolapsed there. There was no sign of pus, and the intestines were only slightly ingested. The appendix was slightly swollen, but its external appearance showed little. It was removed. An incision was made through the upper part of the left rectus in order to exclude the possibility of any perforation of the stomach or duodenum. Nothing was found on the anterior surface of the stomach or duodenum. The omentum was then brought out of the abdomen with the transverse colon, until it was possible to incise the transverse mesocolon and examine the posterior surface of the stomach, no perforation was found. The gall-bladder and pancreas were healthy. It was important, Mr. Corner pointed out, to examine the upper part of the abdomen for two reasons. First, perforations of hollow viscera in the *upper* part of the abdomen are often followed by clinical signs found only in the *lower* part of the abdomen. Secondly, no *certain* cause of the patient's trouble had as yet been found. Moreover, she had suffered from indigestion since being in London. Both abdominal wounds were closed in the usual manner. The appendix, which had been removed, was then slit up and examined, the cause of the illness being then found. The mucous membrane was swollen, thick, and infected. The lumen was filled with fæcal matter and blood. There was acute inflammation which had hardly extended from inside the appendix before that organ had been removed. The case might be called acute endo-appendicitis. A final clinical lesson, Mr. Corner considered, must be pointed from this case. Whenever operating on a case, which has presented signs and symptoms of acute abdominal disease, always remove the appendix, even if it is not obviously diseased, if no clear cause of the illness has been found, such as the perforation of a gastric ulcer. It is a good rule to remove the appendix whenever the abdomen is opened, provided that it can be done without prejudicing the patient's recovery.

The after history of this case is of interest or, as Mr. Corner said, "the proof of the pudding was found in the eating." Immediately after the operation the temperature rose to 103°, after which it fell to normal, and remained so. The wounds healed by first intention, and the patient left the hospital on the sixteenth day.

TRANSACTIONS OF SOCIETIES.

THE RESEARCH DEFENCE SOCIETY.

The inaugural meeting, which was a large and influential gathering, of the Research Defence Society, was held in London on Friday last, in the rooms of the Royal Society of Medicine, Lord Cromer, President of the Society, in the chair. After the committee's report had been read, announcing that the membership of the Society amounted to 1,290, including 123 ladies, and that the Society had received £474 7s. 10d., and now had a balance of £317 0s. 2d., while £100 had also been promised by the Physiological Society, Lord Cromer delivered an address, in which he remarked that in asking him to accept the honourable position of President, and in inviting so many laymen to become members, the founders of the Society had, he said, wished to show that men of science had the support of those who could lay no claim to special scientific knowledge, and that they had the support of those who had taken an active part in preventing cruelty to animals. In this respect he could claim some qualification as having for years been President of the Society for the Prevention of Cruelty to Animals, which conducted a long and fairly successful campaign in Egypt. Lord Cromer further explained that there is nothing inconsistent between an absolute detestation of wanton cruelty to animals and approval of experiments on living creatures, having for their object the relief of suffering to both human beings and dumb animals. He would go further by saying that the one attitude is the necessary consequence and corollary of the other, and that if the necessity of the experiments may, as he held, be justified by any good and sufficient reasons, their execution should be, so far as possible, watched and controlled by a body of men who would shrink with horror from anything indicating indifference or callousness to the wanton infliction of pain. If he thought that the charge of indifference or callousness could be justified, the case would be very different, and the Research Defence Society would then have to look out for another President. He then asked: What are the main grounds on which vivisection can be defended? They are twofold. In the first place, it can be shown that experiments on living animals have already produced invaluable results, and may produce results still more invaluable. In the second place, it has been shown that the experiments are conducted in such a manner as to minimise, if not altogether to obviate, the infliction of pain, both of which propositions can be proved up to the hilt. Speaking of the methods of experiment, he contended that cases of harrowing and revolting details brought forward by anti-vivisectionists very frequently turned out to be either greatly exaggerated or, he might say, almost wholly imaginary. Many of the cases constantly presented to the public had occurred in a somewhat remote past, but they had not to deal with the history of vivisection, but with the operation of the system since the Act of 1876 was passed, and he ventured to consider that the working of this Act was satisfactory. After referring to the figures for vivisections in 1907, and paying a high tribute to Professor Starling's humanity in the conduct of experiments, Lord Cromer concluded by saying that, broadly speaking, the small amount of pain and suffering caused by experiments on living animals was a price which might justifiably be paid, in view of the enormous amount of pain and suffering prevented or relieved. . . . He therefore esteemed it a privilege to be the President of this Society, and to be thus associated with a number of very distinguished and humane men, who, in the interests of science, and in their persistent endeavours to relieve the sufferings of humanity, had exposed themselves to a great deal of very unjust obloquy.

Sir **Thomas Barlow**, in proposing the first resolution, which stated that the object of the Society was to publish the facts relating to experimental research and the benefits that had been derived from it, expressed his pleasure, as a member of the "rank and file of the practising medical profession," in being able to show their absolute sympathy with those who devoted their lives to research, and their appreciation for the invaluable help which they derived from their expert brethren. The Society did not exist for the encouragement of vivisection, but for the purpose of stating the facts to the public. The history of medicine as a healing art contained much that was humbling. Advance had in many cases been due to "happy flukes," and medicine till recently had been largely empirical, and was even now overladen with useless and even dangerous empiricisms, it was only by the scientific study of the natural history of man and of the natural history of disease that those encumbrances could be removed. One of the greatest achievements of the Right Hon. Joseph Chamberlain at the Colonial Office had been the very successful efforts he made to cope with tropical diseases, and not the least of the benefits which would follow from the work of the Society was the encouragement which it would give to workers in tropical disease through the realisation that their services were being appreciated.

Lord **Robert Cecil**, in support, said that if the infliction of pain was unjustifiable, nearly all forms of sport, the riding and driving of horses, the beating of disobedient dogs, and the imprisonment of animals at the "Zoo" were condemnable, whereas the infliction of pain on the lower animals could have no higher justification than experimental research. Animals were not on the same plane, and if the treating of animals with kindness involved the treating of our fellows with unkindness, those who did so would be guilty of a grave dereliction from morality.

Mr. **Walter Long**, in moving that it should be among the objects of the Society to establish branch societies, and to take such steps as the committee should from time to time think desirable, said that he had worked in two Government departments which had dealt with similar work to that which this Society proposed to undertake, and that he regretted nothing that he had been able to do in furthering their work which resulted in the avoidance of pain, the prolongation of life, and the prevention of disease.

Dr. **Martin**, the Director of the Lister Institute, said that the public did not realise the progress that was being made in the study of cancer, nor did they know that one of every 11 men or 8 women who reached the age of 35 was destined to die of cancer.

In proposing a vote of thanks to Lord Cromer, Mr. **Butlin** gave a number of illustrations to show that it was untrue that the men who were engaged in experimental research grew callous as a result of the experiments they performed.

Mr. **Sydney Holland** said that though they were not all researchers, they were all searchers after truth. He characterised Lord Cromer as a man who was typical of everything upright, truthful, and honourable.

In a brief reply, Lord **Cromer** paid a high tribute to the ability with which Mr. Stephen Paget, Honorary Secretary, had organised the Society.

CENTRAL MIDWIVES BOARD.

Meeting held Thursday, June 16th, 1908.

The President, Dr. **Champneys**, in the Chair.

There were also present Mr. Ward Cousins, F.R.C.S., Dr. Stanley Atkinson, Mrs. Latter, Miss Paget, Miss Wilson, and Mr. Parker Young.

PENAL CASES.

The proceedings were short. In the report of the Penal Cases Committee the only item which called for comment was the case of Sarah Ann Lambert, who had been convicted under the Notification of Births Act. It was agreed that inquiries be made:—(1) As to who were present at the birth on February 15th in respect of which S. A. Lambert was convicted of failing to notify, as it was desirable to find out why the midwife was responsible. (2) As to whether the L.S.A. find a *primâ facie* case within the meaning of Section 8 (2) of the Midwives Act, 1902.

PROBATIONERS.

The Standing Committee reported on a letter from Dr. Gibson, Master of the Coombe Hospital, Dublin, inquiring whether two probationers working together, and helping each other to conduct the delivery, can each obtain credit for a conduction. The Board passed a resolution that Dr. Gibson be informed that it would not tolerate the slightest relaxation of its rules relating to attendance on cases. The **Chairman** remarked on the shortness of training and small number of deliveries necessary for entering as a candidate for examination, and declared that it would be a most dangerous thing to lessen these qualifications in any way. Another letter bearing on the same subject was read from a midwife, training pupils, who inquired if, in the case of a pupil arriving at the patient's house too late to make examinations previous to delivery, but delivering the patient, it might count as a conduction. The **Chairman** called attention to Rule C. 1 (1), and it was agreed that the same answer be given to the midwife as to the Coombe Hospital. In reply to a letter from the Secretary of the Q.V.I.I.N. as to providing facilities for the written examination in Ireland of candidates for the C.M.B. certificate, it was decided that the Board could not accede to the request.

H. W. Husbands, M.R.C.S., L.R.C.P., was approved as a teacher, subject to the furnishing of a syllabus of lectures.

MEDICAL FEES.

The statement to be submitted to the Privy Council as to the payment of fees of medical practitioners summoned to assist midwives in emergencies was laid on the table, and, after some amendment, was approved, a resolution being passed that the deputation to the Privy Council, to be arranged for an early date in July, shall consist of *all* the members of the Board.

CANCER OF THE WOMB.

At the conclusion of the meeting the leaflet on the subject of cancer of the womb drawn up by the Chairman at the request of the Board was produced. It will be sent to all local supervising and sanitary authorities, and to all training schools for midwives throughout the country, and a copy can be obtained on application at the office of the C.M.B., Caxton House, Westminster. The leaflet calls attention to the absolute importance of *early* medical treatment of uterine cancer, and the mistake of attributing irregular hæmorrhage to the menopause, and it strongly advises midwives who are consulted by patients suffering from such irregularities to avoid expressing any opinion of their own, but to send the inquirer to a properly qualified medical practitioner for examination.

The next meeting will be held on July 23rd. The penal cases will be heard on July 9th and 10th, at 2 p.m.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held Friday, June 5th, 1908.

The President, **Richard Lake**, F.R.C.S., in the Chair.

Dr. Andrew Elliott opened a discussion on

THE CAUSES OF UNCONSCIOUSNESS

by a paper dealing with the causes of insensibility and, secondarily, with the general methods of investigation which would be found of use. He emphasised the necessity of a clear idea of the various possible causes of unconsciousness in order that none might be overlooked, and suggested a tabulation of the possibilities based on a *memoria technica.*

Referring to the examination of an individual case, he urged a systematic method of procedure, by a scrutiny of the following points in succession:—(1) The history, if obtainable, of the case. (2) The general condition of the patient and the depth of the coma present. (3) Signs of injury, especially cranial fracture. (4) Any peculiarity in the breath. (5) The condition of the tongue and mouth. (6) The pulse, temperature and respiration. (7) Local paralyses or rigidities. (8) The general sensation. (9) The reflexes. (10) The eyes—(muscles, pupils, cornea, fundus). (11) The urine. (12) The stomach contents. And lastly, if necessary, an examination of the cerebro-spinal fluid, withdrawn by lumbar puncture.

Dr. A. E. Russell continued the discussion and commented on the unconsciousness of epilepsy, and pointed out that in some cases convulsions might be so slight as to escape notice, or even be absent. In some cases of hysterical attacks the diagnosis from epilepsy was not easy, especially in view of the frequent complete absence of knowledge by the patient of what had occurred during the attack; the possibility of some of these attacks being really the sequel of unrecognised *petit-mal* had also to be borne in mind.

As regards apoplexy—in children embolism, and in young adults syphilitic endarteritis had to be considered, whilst in older adults thrombosis from cerebral arterio-sclerosis and cerebral hæmorrhage were the chief factors. Thrombosis was more common than was usually suspected. The chief points in coming to a diagnosis were, the presence of premonitory slight and transient attacks, the frequent mildness of onset, and the presence of a low pressure pulse and dilated heart in cerebral thrombosis, as compared with the more violent onset, the deeper and more prolonged unconsciousness and the high blood pressure and hypertrophied heart, so commonly found in cases of cerebral hæmorrhage. The importance of accuracy of diagnosis was obvious in view of the different methods of treatment required in the two classes. The condition of uræmia was also considered. Catalepsy was a rare phenomenon, but did occasionally occur. The unconsciousness met with in men working in deep wells and the holds of ships was also referred to. Professor Haldane had shown that this was due to absorption of oxygen from the air, leaving an atmosphere composed in the main of nitrogen. The danger of this was that the patient did not, as a rule, recognise his danger, owing to the absence of marked dyspnœa or discomfort, and unconsciousness occurred very suddenly.

THE ASSOCIATION OF SCOTTISH MEDICAL DIPLOMATES.

Annual Meeting of the Association at 11, Chandos Street, London, W., on June 22nd.

The President, Dr. **David Walsh**, in the Chair.

The President, in presenting the 5th annual report of the Council for the past year, remarked that their attention had been again directed to matters of much importance to all who held a Scottish medical diploma. The Royal Colleges of Edinburgh and Glasgow had been once more approached with the suggestion that a membership qualification should be substituted for the present licentiateship conferred under the conjoint examination. There could be no doubt whatever that in many instances a Scotch licentiate was placed at a disadvantage in practice by comparison with the English diplomate who had obtained a membership qualification. The public naturally regarded a licentiate as something inferior to a member. Seeing that the Scotch diplomates were scattered throughout the United Kingdom the Scotch Colleges might naturally be expected to take an active interest in the matter. The Colleges might at a stroke of the pen either convert the existing license into a membership diploma, or add the desired membership qualification. From the circular sent out to Scottish diplomates some years ago by the Association it was evident that many licentiates felt keenly the disadvantage which they were placed by not having a membership qualification. The Association asked for the support of every Scotch diplomate in the United Kingdom in their renewed attempt to secure a Scotch membership equivalent to that granted in England. Another point in which the Association had moved was an attempt to remove the disability attached to Scotch qualifications in many provincial and most London hospitals. The Council had taken the important step of uniting with the Irish Graduates' Association in a strenuous attempt to remedy that injustice. Representations had been made to the boards and the governors of hospitals concerned, to the English, Scotch, and Irish Colleges, and to the Hospital Funds. This matter it was proposed to follow up vigorously through the forthcoming year.

As regards the finances of the Society, the Hon. Treasurer, Mr. Sydney Stephenson, was able to report at the end of the financial year a balance of £44. This satisfactory state of the resources of the Association was eminently encouraging. As time went by they hoped year by year to increase their roll of membership. The value of a Society of that kind lay to a great extent in the moral support afforded by the mere fact of co-operation in the defence of common interests. In the course of time there was every reason to hope that a large number of them would join the Association, especially if it could be shown that unceasing efforts were being made to establish the claims of Scottish diplomates to the equality of social and of professional opportunity, to which, as legally qualified members of distinguished schools, they were entitled.

The report was then adopted, and the following officers elected for the ensuing year:—President, Dr. Walsh (re-elected); Treasurer, Mr. Skene Keith; Secretary, Dr. I. Parsons.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 21st, 1908.

Chronic Appendicitis.

Paroxysmal vomiting deserves more than a passing notice. For a long time periodic vomiting was attributed either to uræmia, migraine, hysteria, or hepatic disease, but those surgeons who operate on many cases of appendicitis—Jalagnier, Broca, Rontier, Ricard, etc.—noticed the frequency of cyclic vomiting in the antecedents of their patients, and this in the majority of cases disappeared after removal of the appendix.

Consequently, this kind of vomiting in children should be regarded with suspicion, as generally it is a symptom of chronic appendicitis.

The intestine acts as badly as the stomach. Constipation is the rule, and its persistence should draw attention to the appendix. Sometimes, on the other hand, enteric diarrhœa is observed or entero-colitis. Frequently the children complain of colic after meals, and its repetition should awake suspicion. These pains are exaggerated under the influence of purgatives and enemas, but are attenuated by rest and diet.

In many cases the patient localises the pain, not on the right side of the abdomen, but around the umbilicus and in the epigastrium. In any case, too much importance should not be attributed to the exact seat of the pain, but every child complaining of suffering in the abdomen should be examined for chronic appendicitis.

Such are the principal symptoms presented by the digestive organs. The general aspect of these patients would lead to suppose the existence of heart disease or consumption; pallor, palpitations, oppression, wasting, but auscultation of the respective organs reveals nothing abnormal. Some children present a notable arrest in development. They do not grow nor gain strength, and seem to be under their age.

Local examination clears up any doubt as to the nature of the affection. The abdomen will be found supple and almost insensitive to the touch But if the fingers are pressed down in the MacBurney region a pain is felt which is not found to exist elsewhere. Sometimes a hard cord is felt rolling under the fingers which is probably the painful and inflamed appendix. At other times the mass is difficult to define, but would seem to be formed by the glands of the region.

The prognosis of chronic appendicitis in children is variable. No immediate danger exists, but an acute attack accompanied by peritonitis or perforation is always to be feared. Spontaneous cure is possible, but cannot be counted on. Frequently the chronic inflammation persists indefinitely even to adult age.

The treatment is both medical and surgical. A good diet should be prescribed, the patient should masticate well, eat little and slowly, prefer the vegetarian *régime* to any other, avoid all excesses, violent exercises, and constipation, etc. Such a *régime* has its value, and may for a time produce, more or less, prolonged relief, but in general the removal of the appendix is necessary.

While on the subject of appendicitis it may be interesting to state that in acute appendicitis, the temperature taken in the axilla is higher on the right side than on the left. In no other febrile affection has any such difference been remarked.

Thiosinamin and Fibrolysin.

Injections of either of these agents have been freely used in certain pathological conditions, and with, frequently, much benefit.

The affections amenable to the treatment are: Cicatricial retractions following burns; retraction of the palmar aponeurosis; chronic articular affections (in arthritis deformans prompt absorption of the articular tumefactions results; cessation of pain, improved function of the joints are satisfactory results in ankylosis); stricture of the œsophagus; stricture of the pylorus; stricture of the rectum and the urethra; chronic prostatitis; plastic induration of the penis; adherences of the pleura; aortic disease (improves the dyspnœa and lowers the tension); chronic catarrh of the middle ear, with ankylosis of the bones; diseases of the eye (leucoma following keratitis, adherences, cicatrix consecutive to syphilitic iritis); gynæcological affections (parametritis, adherences between the bladder and the intestine following the ablation of myoma, causing, for years, great pain in evacuation—radical cure by injections of fibrolysin).

Such are, up to the present, the results of injections of thiosinamin and fibrolysin. It is possible that these facts will be confirmed by other authors in the near future, when the treatment will be more generally applied.

AUSTRIA.

Vienna, June 21st, 1908.

Hydronephrosis.

Moszkowicz presented a female, æt. 20, from whom he had removed a large tumour from the region of the kidney. The patient came to hospital with all the symptoms of hydronephrosis, and for which she was operated on. When the region was opened two large swellings presented themselves with an enormously dilated pelvis, and the kidney itself atrophied. Two centimetres below the pelvis the ureter seemed to be tightly tied as if by a ligature. When carefully examined the artery and veins of the organ had formed a loop on the ureter and strangulated it. After these vessels were relieved the contents of the nephritic pelvis passed along the ureter into the bladder, and the tumour thereafter disappeared without any further operation.

Ekehorn said that in the whole literature on the subject only twenty-five cases could be discovered that had any similarity to the present case in tying up the ureter and producing hydronephrosis. From this example we may learn something by asking ourselves if hydronephrosis does not always depend upon some anomaly in the vascular supply. The presumption is in favour of separating the abnormal vessels, and relieving the nephropexia that is assumed to be present.

Latzko thought these small vessels could hardly be congenital, but probably rose from some inflammatory basis which he had often seen to be present in that region.

Albrecht could not accept these hypotheses as an explanation of the complications as he had met with a large number of cases of hydronephrosis in the post-mortem room where no abnormal vessels were present, and where no inflammation could have existed.

Taudler remarked that the upper part of the ureters in the fœtus and infants lay in folds, and it was a long time in after life before they were stretched. Again, when the relationship of the adventitia ureteris which runs along the inner sheath of the ureter is considered, it is not improbable that the folds at the upper end might form a loop that would involve the ureter, thus producing hydronephrosis.

Blum showed three preparations of sacs formed in the pelvis of kidneys with abnormal arteries entering. All the three cases had the same clinical phenomena during life of intermittent hydronephrosis, viz., painful attacks in the loins, polyuria intermitting with oliguria, pyuria, and a palpable painful swelling over the nephritic region. In all the three the abnormal vessels crossed the ureters, and formed loops that interfered with the free circulation in the ureter. Latzko remarked that the higher position of the kidneys and ureters in the fœtus favoured this folding at a later period, which would probably produce a temporary congestion of the organ followed by compression and subsequent hydronephrosis.

EUNUCHS.

Prigl presented two cases where castration had been performed at 25 and 27 years of age respectively. In both the real typical eunuch could be observed notwithstanding the lateness in life of castrating.

SOLITARY TUBERCLE.

Tertsch exhibited two cases of tubercle in the eye. The first was a tumour about the size of a nut in the upper part of the right eye apparently rising from the sclera as a light reddish swelling. Though the diagnosis of tubercle could be made it was not so easy to determine its origin, whether from conjunctiva, sclera or choroid. His own diagnosis was the sclera.

The other case was a fold of the conjunctiva, half-moon shaped under the lid at the inner angle of the eye about the size of a bean. The conjunctiva could be easily moved over the swelling which fluctuated on percussion, and looked like a dermoid.

Although both of the patients were perfectly healthy the destruction of the eyes was inevitable.

NEPHRECTOMY AND TUBERCLE.

Kapsammer brought forward a healthy looking patient from whom he had removed a tuberculous kidney which was shown under the microscope. He spoke in rapturous praise of phloridzin in the diagnosis of any functional lesion in the kidneys.

The operation was performed under local anæsthesia; tropa-cocain 0.10 of a grain injected into the lumbar region. In tuberculosis of the kidney chloroform is contra-indicated as it produces a toxic condition in the other; if tubercle be present in the lung we cannot use ether, therefore we are reduced to a local agent as in the present case.

Blum agreed with phloridzin in the diagnosis, but as to the local anæsthesia he differed. It is well-known that albuminuria lingers long in the healthy after lumbar injections, therefore a constitutional narcotic is safer than this local one.

Kapsammer thought that Blum was prejudiced against local anæsthesia. It was the stovain-adrenalin that produced the albuminuria and not tropa-cocain.

HUNGARY.

Budapest, June 21st, 1908.

At the last meeting of the Budapest Royal Society of Medicine Dr. Benedict read a paper on

HYPERÆSTHESIA FOLLOWING HEART DISEASE.

The author mentioned two kinds of pain which occur in association with diseases of the viscera, one of these arises locally, the other by way of irradiation. The irradiation of the pains takes place by the painful stimulus entering the grey substance of the cord through the sympathetic centre, where it comes into connection with the spinal nerves entering the cord at the same level, and so the pain is reflected to these nerves also; and as the insensibility and pain localisation of the skin and subcutaneous tissue are considerably greater than that of the viscera, we are prone, therefore, to consider first the pains felt in the area of irradiation, *i.e.*, in the spinal nerves. The criteria of irradiated pains are of three kinds: First, the patient feels them, not only over the diseased viscus, in the thorax or abdomen, but he also feels them in his back. Secondly, the most painful spots are also very sensitive to pressure. Among these the easiest noted are those described by Boas, which occur in connection with stomach diseases. Thirdly, the skin over the painful viscus is hyperæsthetic even to a superficial touch. The hyperæsthesia runs round the body in a semi-circular form, has more or less horizontal borders, and disappears in the same order. These hyperæsthetic areas were first studied by Head. Every area has its anterior and posterior maximal spot, which corresponds to the point where the patient feels the most severe, spontaneous pain. Head differentiated twelve dorsal, five lumbar, and five sacral sections.

A much more general irradiating symptom is hemialgia. Dr. Benedict had found in patients complaining of painful sensations, having either functional or organic heart disease, that the sensitive nerves of the left side from the supra-orbital region to the peritoneal region were very sensible to pressure. If the disease is situated to the right side, as, for instance, in aortic aneurysm, or in congested liver, the hemialgia affects the right side.

The author then analysed 180 cases in which he investigated the symptoms just described more accurately. These observations showed that in aortic diseases the pains in the shoulder and in the occipital region, and along the outer side of the arm are most characteristic, chiefly on the left side. The most affected section is here the cervical segment. The painful areas, corresponding to the root of the aorta and left ventricle, are found in the regions supplied from the first, second and third vertebræ, and on the inner side of the upper third of the left arm. In sixty cases he found pains —corresponding to bicuspid affections—in the dorsal segments (fifth to eighth vertebræ). The very characteristic head and thorax hyperalgesias are due rather to the stenosis than to insufficiency. In insufficiency of the right ventricle the congestion of the liver, and the pains caused thereby, predominate. According to Benedict, the results attained by this method of observation help us greatly in the diagnosis of heart disease.

Dr. Alexander Korányi mentions a case in which he was able to distinguish between aortic aneurysm and thoracic tumour merely by the aid of this method.

Dr. Lukàcs showed a case of

ENCEPHALOPATHIA INFANTILIS.

The patient suffered during dentition from a febrile disease, after which paralysis developed on the left side. This typical paralysis exists to-day. The patient became subject to a mild form of epilepsy and was imbecile. This disease has no characteristic name, but is described from its most prominent symptoms. The reason of this we must seek in the fact that the three symptoms mentioned participate in the disease in a very variable degree. Dr. Lukàcs recommends the term—largely used by the French physicians—"encephalopathia infantilis."

A CASE OF TRAUMATIC MUSCULAR PARALYSIS OF THE EYE.

Dr. Por showed a patient who sustained a blow on the left eyebrow from the shaft of a carriage. He could not open his eye, on account of the great swelling, for a week. When he was able to do so he complained of double vision in every direction. The restriction of the eye movements and the diplopia supported the assumption that the inferior rectus and external rectus muscles were paralysed. How this condition was caused he cannot for certain decide. He related this case only for the reason that traumatic muscle-paralyses are very rare.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

New Medical Officer of Health for Edinburgh.—The Town Council have appointed Dr. Maxwell Williamson, Chief Sanitary Inspector for the City, to this important office. Dr. Williamson has already served the city efficiently for 17 years, and his promotion is welcomed by a large circle of friends. He assisted the medical officer of health for six years from 1891, and acted as his substitute during his absence on leave. He has also temporarily occupied the position of medical superintendent of the fever hospital, and was appointed chief sanitary inspector in 1898. In this capacity he created a new department, and has acquired an intimate knowledge of the sanitary requirements of the city, as well as of the conditions of housing, food supply, overcrowding, etc., which will stand him in good stead in the performance of his new duties.

Association of Physicians of Great Britain and Ireland.—The second meeting of the association took place in Edinburgh on June 12th and 13th, and was attended by about 140 members. The scientific proceedings occupied two forenoon and two afternoon sittings, and among the numerous communications made were several of more than ordinary interest. The dinner, held in the Hall of the Royal College of Physicians on the evening of the 12th, was well attended. Sir Thomas Fraser, the President of the Association, occupied the chair, and Drs. G. A. Gibson and Herringham acted as croupiers. In connection with the meeting demonstrations of interesting cases were given in the Infirmary, Longmore, and Sick Children's Hospitals, and a pathological museum was got together for the occasion. The meeting was voted a great success by the members and guests who took part in it.

Edinburgh School for the Medical Education of Women.—The difficulties in which this school finds itself have not yet been resolved. At a recent conference between the University Court and the Association, the latter were unable to put forward any feasible scheme by which the expense which the introduction of mixed classes would bring upon the University could be met, nor were they in a position to show where they could obtain new premises. The situation has arisen through the sale of Minto House to a commercial body, having deprived the women's school of a home. There does not appear to be the slightest likelihood of the University admitting women to its class-rooms, and as the women cannot, apparently, get accommodation elsewhere, matters are more or less at a deadlock. On the question of the desirability of mixed classes two diametrically opposed opinions may be held, and it is not, perhaps, unnatural that those who favour the system of men and women being taught together should be inclined to use the situation which now exists as a lever to attain their desires. On the other hand, the majority of those who are sincerely interested in the future and efficiency of the Edinburgh Women's Medical School see in a scheme of mixed classes nothing but imperilment of its hitherto successful career. Unquestionably, if the Association sets about it energetically, new premises could be obtained, though doubtless at some temporary inconvenience, and it is to be hoped that steps in this direction will now be taken, seeing that the University is obdurate on the question of mixed classes, even when met with the "non-possumus" argument which has been to some extent adopted. It has been said that the refusal of the University to admit women will mean that students in the future will be driven to Glasgow instead of Edinburgh. Be this as it may, a large body of the Edinburgh teachers, though they would regret such a step, would rather have it take place than see women and men sitting side by side in the University. It is not uninteresting, also, to note that some of the women who actually went from Edinburgh to Glasgow have already returned to their old school—even, as we are informed to one of the classes about which more than any other complaints have been made.

Leith Hospital.—The directors of Leith Hospital have appointed Dr. Lindsay Milne to be Pathologist to the institution, vice Dr. Comrie, resigned.

BELFAST.

Annual Meeting of the Ulster Medical Society.—On Thursday last, June 18th, the annual meeting was held, the President, Dr. John McCaw, in the chair. The report and statement of accounts showed that the society continues in a flourishing state. The treasurer has a substantial balance in hand, but he pointed out that much of this would be required for painting the interior of the institute, in view of the expected visit of the British Medical Association to Belfast next year. The following officers were elected for the Session 1908-9:—President, Mr. T. S. Kirk, F.R.C.S.; vice-presidents, Dr. R. Reid (Whiteabbey) and Mr. R. J. Johnstone, F.R.C.S.; honorary secretary, Mr. Howard Stevenson, F.R.C.S.I.; literary secretary, Dr. Rankin; treasurer, Dr. Victor Fielden; librarian, Dr. Storey; council, Drs. Robert Allen, A. Fullerton, T. A. Davidson, Robert Hall, W. J. Maguire, and Gardner Robb, with the seven trustees, Dr. John Campbell, A. Dempsey, J. A. Lindsay, John McCaw, A. B. Mitchell, Joseph Nelson, and Cecil Shaw. At the close of the meeting the President provided tea, coffee, and cigars, and then presented the handsome silver cup which he had offered for competition among medical golfers during his term of office, and which was won by Dr. McLorinan.

Medical Golfing.—The golfing members of the profession have had a busy time of late, for besides playing for the McCaw Cup, referred to in the report of the Ulster Medical Society, and which is a special competition for this year only, there has been the play for the Lindsay Challenge Cup, played for annually. On Wednesday, 17th, thirty-two competitors turned up on the Newcastle (Co. Down) links and played in nine hole heats. The result was a draw between Captain Archer, R.A.M.C., and Dr. Bailey, who will play off the draw at an early date. The competitors were entertained to luncheon in the Club House by Mr. T. S. Kirk, the President-elect of the Ulster Medical Society.

LETTERS TO THE EDITOR.

CHRISTIAN SCIENCE AT THE PAN-ANGLICAN CONGRESS.

To the Editor of The Medical Press and Circular.

Sir,—A good deal of sense and a good deal more nonsense was talked on the subject of Christian Science at the Pan-Anglican Congress on Wednesday last. The sense came from those whose speeches implied that the first and essential step in dealing with disease is the making of an accurate diagnosis, discovering the true cause; distinguishing between morbid states due entirely to mental conditions, merely functional disorders capable of being influenced by mental states, distinct concrete pathological changes in organic structures, and effects brought about by reception into the system of definite *materies morbi*. The nonsense was talked by those who seemed to have vague ideas as to what is implied by pathology, who made no attempt at discrimination, scorned medical science, and looked upon diseases as distinct entities to be exorcised and driven out of the body by methods of mediæval thaumaturgy. This latter is the view of the Christian scientist pure and simple. He undertakes not only by religious influence to give peace of mind to the hysterical or hypochondriacal sufferer, which sometimes is quite possible, he also undertakes to "destroy and cast out" every disease, whatever its causation, whatever phase of morbid process it may have arrived at—a feat quite impossible. Every medical man is aware of the influence of the mind upon the body, and is constantly taking this factor into consideration in determining the nature of his cases, and in advising measures of treatment. The influence of religion may be as much called for as a change of climate, may constitute as legitimate a therapeutical instrument, but we cannot put an end to the action of natural forces by prayer or ritual; we cannot control morbid processes by supernatural means; we cannot, in short, cure disease by miracle. To profess to do this in the names of Christianity and science is both blasphemous and truly murderous, albeit, unfortunately, it is not recognised as criminal in the present state of our code, in which laws regulating the practice of medicine are, as we know, unfortunately, almost entirely lacking.

I am, Sir, yours truly,

ALIENIST.

THE DANGERS OF SPIRITISM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—Whilst desiring in no wise to depreciate the laudable efforts of that most eloquent pulpit orator, Father Vaughan, to whom you refer in your annotation, nevertheless his counsel is more or less invalidated owing to his belief or acquiescence in *séances*. At any rate, he is reported as saying:—"No doubt many *séances* were frivolous enough; *others were very real indeed*." (The italics are my own.) and where did they come, were they the spirits and where did they come, were they the spirits of friends who once dwelt in the flesh? Were they the angels of God, or were they evil spirits from a land which none of us wished to know?" Now, Sir, it is obvious that so long as human nature is what it is, and until the human mind evolves to a higher degree of sanity, which, in spite of many drawbacks, we may hope at some distant date it will attain, I say it is obvious that teaching of this kind is certain to allure and fascinate many minds of a type who might be described as residing in the clouds, never happy unless on the look-out for something that never has existed nor can ever exist. We cannot be surprised if such as these, in spite of Father Vaughan's warning, and his own dire experience, should be attracted and led to pry into the research and literature of the subject, nor can we be further surprised that many, with the idea of having, say, a chat with their ancestors, would readily risk the chances of embracing or invoking the "unclean spirits," which to Father Vaughan appears problematic. Whilst so much is going on to eliminate physical disease, there is, unfortunately, no remedy to prevent the spread of pernicious and corrupting literature, which is as certain poison to the mind as contaminated milk is to the body. Nor is it easy to conceive (without interference in the freedom of public opinion), how any practical and legal method could be devised. But a short time ago an Anglican clergyman lent me for perusal a magazine of the occult science group, which might operate in different ways according to the jocularity or gravity of the individual concerned. However, with every semblance of solemnity, one of the articles opened with the following extraordinary serio-comic statement, which should be enough to initiate insane delusions in an illogical mind:—

"A certain amount of correspondence appeared in this magazine some months ago relative to the experiences that individuals had of the sensation of appearing to be outside their own bodies, and it would be interesting to know how far this experience is a common one."

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, June 19th, 1908.

MR. TROUTBECK AND THE PROFESSION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some admirable remarks upon the above-named question leave no room for criticism by your ordinary readers. They can only express their approval of the able and forcible manner in which you have discused the main issues. I would, however, like to call attention to one aspect of the matter which is brought into view to-day (June 19th) by the letter in the *Times* from the President of the British Medical Association, Mr. Henry Davy. He points out that as far back as May, 1903, the Association, with other medical societies, brought to the notice of the Lord Chancellor, by memorandum and by deputation, the procedure of Mr. Troutbeck in conducting inquests. From that day to this nothing has been done; the abuses have been allowed to continue and to increase, in spite of renewed protest; and even now it is doubtful whether adequate attention will be given to the representations of individual practitioners or to those of organised bodies having the right to speak in the name of the profession. Let it be noted that the evils complained of are of more importance to the public than to the profession; the reason for the neglect seems really due to the fact that the evils have been exposed by medical men; such treatment is, at any rate, never meted out to other professions. With similar grievances how long would solicitors or barristers have to wait for redress? There exists hardly another recognised profession so powerless as the medical to concentrate its influence and make it felt. This is the aspect of the present question which I feel needs regarding as much as any. What are the reasons for the political impotence of our profession; what can be done to cure it?

I am, Sir, yours truly,

AN OBSCURE PRACTITIONER.

June 19th, 1908.

THE DEPOPULATION OF FRANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A Parliamentary Commission on depopulation is now at work in Paris. The birth-rate statistics, from the patriotic point of view, are becoming more and more alarming. Numerous schemes are being proposed to encourage families by remission of taxation, or by taxation of bachelors and childless married couples. Last year's figures show that the deaths exceeded the births by no less than 19,929, a phenomenon that has occurred only ten times during the nineteenth century, and then was due to epidemics or war, not as now to the deliberate practices of virtually the whole people in restricting the number of offspring by artificial means. Whatever the effects of this custom upon the evolution of the race, its effects in improving or deteriorating the physical and moral qualities of the individual citizen, a question into which we cannot enter now, the fact remains that the population of France stands fixed at about 39,000,000, whilst that of her hereditary enemy, Germany, amounts to nearly 64,000,000, and is increasing at the rate of nearly a million a year. Unless we are to suppose that the French Army is so superior in physique and morale to the German that the odds would make no difference, it is evident that in "a fight to a finish" the victory would rest with the the big battalions, with the Power whose numbers are the greater. The plain fact is that France without allies would be at the mercy of Germany. True patriotism in the French citizens would seem to consist in the rearing of a numerous progeny, but whatever the excuse, this service to the State is evidently looked upon as a sacrifice too great to be borne by a people who are yet never tired of proclaiming their devotion to their beloved fatherland.

I am, Sir, yours truly,

A STUDENT OF SOCIOLOGY.

OBITUARY.

BERTRAM ABRAHAMS, B.Sc., M.B.LOND., F.R.C.P.

WE regret to announce the death of Dr. Bertram Abrahams, on the 21st instant, at his residence in Welbeck Street, London, after a few days' illness. Deceased was educated medically at University College, where he distinguished himself in various departments, and where he held a scholarship. He obtained first-class honours at the intermediate Science and the final M.D. examinations of the University of London. At Westminster Hospital he held the important position of Assistant Physician and of Lecturer on Physiology. He also acted as examiner for Physiology in the Conjoint Board of the English Colleges. Dr. Abrahams has been cut off at an early period of a distinguished career. His death will be a loss to the profession generally, and will be keenly felt in the hospital to whose service the best part of his brief professional life has been devoted. Amongst other accomplishments may be mentioned his attainments as a linguist, and his brilliancy as a public speaker. For a long time it has been known by his friends that he has been in indifferent health, and the immediate cause of death was anuria from exposure. Deceased has left a widow and one child.

GARRETT HORDER, M.R.C.S.ENG., L.R.C.P.ED.

WE regret to announce the death of Dr. T. Garrett Horder, of Cardiff, on the 15th instant. He had been in ill-health for the past two years, and had been confined to his room for about five weeks. Dr. Horder was the son of the late Mr. William Horder, of Salisbury, and was born in July, 1843. He was educated at a private school at Tisbury and at the City of London School. Afterwards he took up medical study at Edinburgh. He took his diploma of M.R.C.S.Eng. in 1886, and L.R.C.P.Edin. in 1873. For several years he was medical officer to the National Sanatorium, Bournemouth, a hospital for consumptive patients, and when he left that institution he practised for some time in Lancashire. He came to Cardiff 32 years ago, and will be remembered in the city as a valuable public servant. Politically he was a Conservative, and, a staunch supporter of his party, was always ready to offer his services. Dr. Horder had been president of the Cardiff Medical Association, a member of the council of the Medical Defence Union, hon. secretary of the Hospital Reform Association, and joint hon. secretary of the ethical section of the British Medical Association, and his name was closely identified with the subject of hospital reform.

DR. WILLIAM McHARRY, OF BELFAST.

WIDESPREAD regret is felt in Belfast at the early death of Dr. William McHarry, of Grosvenor Lodge, Belfast, last week, the result of a sudden serious development in a hitherto unsuspected chronic Bright's disease. Dr. McHarry qualified in the Royal Colleges of Physicians and Surgeons, Edinburgh, in 1897, and on starting practice in Belfast soon attained a wide measure of popularity and success. In football and Masonic circles, as well as in medical, his company was always welcome, for not only was he remarkably genial and kind-hearted, but he had a great share of native wit. He was unmarried. His funeral, which took place on Monday, June 15th, was largely attended.

REVIEWS OF BOOKS.

MODERN OTOLOGY. (a)

WHILE according every praise to the authors for the success of their undertaking, we find fault with the dedication. The otologist will feel slighted that he has not been coupled with the "students and general practitioners of medicine," for the book, in its completeness, is as worthy of the attention of the former as of the latter. Drs. Barnhill and Wales aim at producing a book for students and general practitioners in which the following objects are kept in view:—(1) To modernise the subject of otology; (2) to correct certain traditional beliefs; (3) to advocate the earliest possible prophylaxis or treatment; (4) to emphasise the importance of thorough examination and definite diagnosis; and (5) to thoroughly illustrate the text; and they have succeeded, in our opinion, in producing a volume which is warranted to succeed on all these points.

The first three chapters are allotted to anatomy, physiology and bacteriology of the ear. The anatomical illustrations are admirable and selected with evident care, the text accompanying them being very clear. The physiology is brief, but ample. All that is known about the bacteriology of ear disease is contained in ten pages, all of which are scientifically interesting, but they do not help us along very much on practical lines. We are then taken through diseases of the auricle, external meatus, general examination, the influence of nasal and naso-pharyngeal diseases; then, by easy stages, on to acute middle-ear catarrh, acute mastoiditis, chronic suppurative otitis, chronic mastoiditis, its complications (intra and extra-cranial), chronic non-suppurative otitis media, diseases of the perceptive portions of the ear, concluding with a short chapter on deaf mutism. We like the sequence of disease adopted, which strikes us as most rational, and adds much to the facility with which we can follow the various stages of the diseases. This is most felt when we are reading about the suppurative otitis, which develops into acute mastoiditis, or, later on, into the chronic mastoiditis, there being no digressions made to deal with "dry catarrh," for example. We congratulate the authors on the success of their labours, for they have given to the medical profession a work admirably suited to the general practitioner. We can confidently recommend the book to specialists, as they will find the book of much interest, for the operations are most carefully and clearly described, down to the finer details, by an otologist of extensive practical experience. The illustrations, mostly photographic, and the general production are very excellent and deserving of high praise.

RETINOSCOPY. (a)

THIS little book of 63 pages, with 54 illustrations, has reached the present edition through the appreciation accorded the earlier ones by those who desired instruction on the subject of retinoscopy. It is to be concluded that this popularity has been won by the concise and clear manner in which the practical details of retinoscopy, as practised with a plane mirror at a metre distance, have been described and illustrated in the former editions. The present edition maintains this position in the fullest degree. One feels, however, in reading it that there is too much of the scientific side of this interesting subject omitted, and that the practical knowledge to be acquired is thereby robbed of much of its interest and thoroughness. It seems to us a pity that Dr. Thorington does not render this practical little book more complete by devoting some space to the theory of retinoscopy, for we feel that he is the man to make it clear to his readers, and that the practical knowledge acquired without a backing of theory is unsound and "cheap." Opinions are very divided on the subject of cycloplegics in retinoscopy. The author has no doubt, for he advises that the "patient *must* have his accommodation thoroughly relaxed with a reliable cycloplegic."

We noted an error on page 40, where it is represented that —1 added to +0.5 equals —1.5 instead of —0.5.

To the increasing number of general practitioners who are going in for refraction work we can recommend this book as one to be relied upon for the practical teaching afforded in its pages.

ROYAL LONDON OPHTHALMIC REPORTS. (b)

THIS number contains the following articles:—E. Nettleship on "Retinitis Pigmentosa and Allied Diseases" (continued); W. T. Hancock, "Hereditary Optic Atrophy"; George Coates, "Pathology of Coloboma of the Optic Nerve"; G. Coates, "Congenital Pigmentation of the Papilla"; M. L. Hepburn, "Visual Fields in Retinitis Pigmentosa"; M. S. Mayou, "Lachrymal Abscess in the New-Born"; J. H. McIlroy, "Sympathetic Ophthalmia: Some Anatomical Considerations, with Special Reference to the Occurrance of Plasma Cells"; Charles Goulden, "The Fate of Eyes that have been Submitted to the Operation of Extraction of a Foreign Body by the Electro-Magnet."

(a) "Principles and Practice of Modern Otology." By J. F. Barnhill, M.D., Professor of Otology, Indiana University, U.S.A., and E. de W. Wales, B.S., M.D., Associate Professor of Otology, Indiana University. Five hundred and sixty pages with 305 original illustrations. Philadelphia: W. B. Saunders Company. 1907.

(a) "Retinoscopy (or Shadow Test)." By James Thorington, A.M., M.D. Fifth Edition, revised and enlarged. London: Rebman.

(b) "Royal London Ophthalmic Hospital Reports." Edited by Wm. Lang, F.R.C.S. Vol. XVII., Part II., January, 1908. London: J. and A. Churchill. Price 5s.

Weekly Summary of Medical Literature, English and Foreign.

Specially compiled for The Medical Press and Circular.

RECENT SURGICAL LITERATURE.

Ophthalmo-Tuberculin Reaction.—R. Mills (*Queen's Medical Quarterly*, April) gives his experience of 128 cases in which the ophthalmo-tuberculin reaction had been tried, and discusses fully its diagnostic value. He believes that, taken alone, it is a symptom upon which a definite diagnosis should not be based, notwithstanding the fact that several cases have been reported in which patients showing none of the usual signs of tuberculosis have reacted to this test, and have at a subsequent period developed tuberculous disease. With our present knowledge a reaction cannot be regarded as an absolute diagnostic symptom, but rather as confirmatory evidence of great value. Observations of the patient's pulse, temperature, weight, and other clinical symptoms may still leave the physician or surgeon in doubt. It is then that the ophthalmo-tuberculin reaction becomes a valuable factor in diagnosis. G.

The Treatment of Large Herniæ.—J. Hahn (*La Semaine Médicale*, March, 1908) says when herniæ become very large, they may lose their right of domicile in the abdomen. Their reduction, if they can be reduced at all, can only be accomplished at the price of a dangerous increase of the intra-abdominal pressure, as the abdominal cavity has become unable to accommodate the herniæ. In such cases an operation for the radical cure of such herniæ has a special gravity, not only from the mechanical difficulty of reducing the hernia, but also from the tendency for the over-distended abdomen to impede respiration, and produce a state of slow asphyxia, ending in cardiac failure. The patient is apt to exhibit increasing dyspnœa, cyanosis, with progressive feebleness of pulse, and often dies within two or three days after the operation. When the patient happens to be both elderly and fat, this risk is greatly increased. The author prepares such patients for operation in the following way:—The patient is allowed to eat and drink as much as he likes of a diet containing no fat, and very little meat. An hour after the two principal meals of the day, a sufficient quantity of a purgative mineral water is given to produce a liquid stool which removes most of the intestinal contents. This treatment is continued for eight days; it is then stopped for a few days, and resumed and continued until a sufficient reduction of the patient's abdominal fat has been accomplished to allow a partial reduction of the hernial contents. The patient is kept in bed with the feet raised rather higher than his head; taxis is tried two or three times a day for some fifteen to twenty minutes. The rupture may be gradually reduced in this way, and prevented from bursting out again by plaster strapping. In this way, by gradual stages, the whole hernial contents may be accommodated inside the abdomen without producing any signs of dyspnœa. A sufficient period must be allowed to elapse for the abdomen to get accustomed to its contents before a radical cure is performed. Where this plan has been followed, the results in the author's hands have been uniformly satisfactory. G.

Early Sitting Up after Laparotomy.—Chandler (*Albany Med. Annals*, February, 1908) treats all his laparotomies in the following way:—No matter how weak they are, they recover from the ether in the sitting posture, in which they are supported by a bed-rest. As a result, the nausea is usually slight. They are kept in this position for twelve hours, and then allowed to assume any position that is comfortable, but are encouraged to use the bed-rest as much as possible. On the third day, if they are strong, and in any case on the fourth day, the patient is allowed out of bed and put sitting in a chair. All patients are allowed to walk on the fifth day, and from that time on are up and walking about until they leave hospital, which they usually do from the tenth to the fourteenth day. The author, after the abdominal wound has been dressed, covers the dressing with a broad strip of zinc oxide plaster, except in cases where drainage is required. His experience of this method extends over 1,000 laparotomies, and the results have been most gratifying. It prevents phlebitis. The patient is not weakened by enforced rest, recoveries are better, hernia is less frequent, vomiting is prevented, and convalescence is shortened. G.

Pneumothorax and Posture: the Importance of the Abdominal Posture in Operations on the Pleura and Lungs.—Elsberg (*Med. Record,* May 23rd, 1908) forms his conclusions on this subject by experimental work on dogs. A dog on its back under deep anæsthesia will stand a small opening into his pleura well, but sudden heart failure or dyspnœa and death sometimes follow. With large openings typical expiratory dyspnœa results, the heart becomes irregular and weak, the anterior mediastinal septum bulges into the opening, and often ruptures, double pneumothorax or stoppage of the heart occurring. With the animal lying flat on its belly very different results were obtained, the dog surviving with even one half of the chest wall removed. Furthermore, if a dog on its back has violent dyspnœa, the breathing will often become quiet and regular again when turned on its belly, and get worse when turned on its back again. The author made some further experiments to elucidate the explanation of these phenomena. He observed that the anterior mediastinal septum is lax, flaps to and fro, bulges, and is apt to rupture when the pleura has been opened. The posterior mediastinal septum is much tougher, more fixed and tense. When the dog is on its back, the heart falls backwards, and bulging of the anterior septum is made more easy, interfering with the respiration of the sound lung. The author found that if before the pleura is opened with the dog on his back, the pericardium be stitched to the anterior chest wall, marked dyspnœa does not follow opening the pleura. If the stitch is cut and the heart falls backwards typical pneumothorax symptoms appear. Also with the dog on its belly and the pericardium stitched back pneumothorax symptoms occurred, which were relieved by cutting the stitch, and letting the heart fall forward. The author employs the prone position in all patients requiring operations necessitating opening of the pleural cavity. In this position operations on the lateral and posterior aspects of the thorax can be done with ease. The anæsthetic was not interfered with. In patients in whom the operation for empyema was done, it was noted that with only one exception the coughing and interference with breathing, regularly observed when the opening in the pleura is made for this effection, was entirely absent. S.

Thirty-One Cases of Congenital Dislocation of the Hip Reduced by Manipulation.—Abbott (*Med. Record*, May 23rd, 1908) records thirty-one cases treated by him. The ages of the patients varied from two to thirteen years, the greater number were females. Twenty-nine were unilateral, two bilateral. The operation performed was the same as that described by Lorenzo, with the exception that, in some cases, the plaster-of-Paris spica was extended below the knee, in order better to control the after position of the limb. In three cases weight traction was used preliminary to the reduction. The author advises early operation, stating that the development in a dislocated joint is much retarded, and that after reduction is made the whole limb grows in a normal manner. Preliminary traction lessens the amount of force necessary at the time of reduction, and should be employed in all older patients. If the two bilateral dislocations be considered as four unilateral, the author's results may be summed up as follows:—Total number of hips operated on 33; 22 or 66 per cent. normal; 9 or 27 per cent. anterior position; 2 or 6 per cent. complete failures. S.

Nine Cases of Fracture of the Carpal Scaphoid.—Ely (*Med. Record,* May 9th, 1908) reports nine cases, the diagnosis of which were confirmed by X-ray photographs. From these cases he draws the following conclusions: Fracture of the scaphoid is comparatively frequent, and is often mistaken for sprain of the wrist. It often escapes detection, and recovers without any treatment. It is usually caused by a fall on the extended hand. It may be caused by punching with the closed fist, or rarely by superflexion of the hand. The one important symptom is tenderness over the scaphoid on the dorsum of the wrist. All other classical symptoms of fracture may be absent, except pain on motion. If fracture be accompanied by dislocation of the semilunar, extension of the fingers, especially the middle, will be limited and painful. The prognosis of simple uncomplicated fracture is good, that of fracture with dislocation less favourable. A good treatment of simple fracture is immediate immobilisation. If the semilunar is dislocated a piece of the scaphoid often goes with it. The dislocated bone must be replaced, or if that is not possible, removed. S.

The Surgical Treatment of Alveolar Pulmonary Emphysema.—Goodman and Wachsmann (*Med. Record,* May 16th, 1908) report nine cases of resection of costal cartilages for the treatment of alveolar pulmonary emphysema. Four of these cases were their own, and five were collected from medical literature. The treatment depends on Freund's teaching that emphysema is the result, not the cause of barrel-shaped chest. Pathologically the costal cartilages are in a state of fibrillation with calcareous deposits, and are devoid of their normal elasticity. This prevents the proper excursions of the corresponding ribs. By removing or resecting the offending cartilages the proper functioning power of the chest may be restored. The cartilages of the second and third ribs of the right side are most frequently involved, but all may be involved, the first usually being last affected if involved at all. The authors have performed the operation even under local anæsthesia with good results. The following is a fairly typical history. Patient, æt. 50, had frequent asthmatic attacks. He had great dyspnœa, and the finger tips and mucous membranes were cyanotic. Respirations shallow, and chest rigid. The third, fourth, and fifth ribs on the right side was resected for about 2 cm. together with the anterior perichondrium. To prevent reformation of the cartilage the posterior layer of the perichondrium was dissected from its attachments, and reflected over and stitched to the stump of the corresponding rib. The third night following operation the patient was able to sleep quite comfortably, and cyanosis had disappeared. Chest expansion was increased from less than 2 cm. to 5 cm. Four weeks later the right second and left second and third cartilages were resected. Following this the chest expansion increased to 6 cm., and the vital capacity, before the second operation 1,800 c.c. increased to 2,700 c.c. The authors from their own experiences form the following conclusions: 1. Freund's operation is of great benefit in emphysema with a rigid dilated condition of the thorax. 2. When the costal cartilage is resected, the rib recedes immediately. 3. The ribs move so freely that the finger tip is distinctly squeezed when inserted between the sternum and the rib. 4. The lung visibly contracts. 5. Relief may be afforded by operating on one side. 6. The operation is not dangerous, and is not followed by shock. 7. Cardiac insufficiency, asthma, chronic bronchitis, and albuminaria, are not necessarily contraindications of the operation. 8. Patients are very gratified with the results. S.

MEDICAL NEWS IN BRIEF

Royal College of Surgeons of England.—Election of Examiners.

A MEETING of the Council of the Royal College of Surgeons was held last Thursday, Mr. H. Morris, President, being in the chair, when the following examiners were elected for the ensuing Collegiate year:—Board of Examiners in Anatomy and Physiology for the Fellowship:—Anatomy: W. McAdam Eccles, M.S.Lond., F.R.C.S.; F. G. Parsons, F.R.C.S.; Arthur Thomson, F.R.C.S.; A. H. Young, M.B., LL.D., F.R.C.S. Physiology: T. G. Brodie, M.D.Lond., F.R.S.; G. A. Buckmaster, M.D.Oxon.; C. F. Myers-Ward; W. H. Thompson, M.D., F.R.C.S. Elementary Biology: James P. Hill; T. W. Shore, M.D.Lond. Anatomy: W. H. Clayton Greene, M.B.Cantab., F.R.C.S.; Arthur Robinson, M.D.; William Wright, M.B., F.R.C.S. Physiology: Bertram L. Abrahams, M.B.Lond., F.R.C.P.; J. B. Leathes, M.B.Oxon., F.R.C.S. Midwifery: Hugh J. M. Playfair, M.D.Lond., M.R.C.P.; W. R. Pollock, M.D.Cantab., F.R.C.P.; J. H. Targett, M.B.Lond.; Walter W. H. Tate, M.D.Lond., F.R.C.P. Public Health (Part I.): Harold R. D. Spitta, M.D.; (Part II.), H. Timbrell Bulstrode, M.D.Cantab.

It was decided to send some suggestions to the Committee of the General Medical Council engaged in revising the British Pharmacopœia of 1898, the college having been invited to express their views to the committee. A letter was received from the President reporting the proceedings of the General Medical Council at their recent session, and the best thanks of the Council were given to him for his services as the representative of the college on that Council.

A small committee was appointed to report on the answers received from the Fellows and Members regarding the admission of women to examination for the diploma of the college. The President reported that he had undertaken to place a room in the college at the disposal of the authorities of the Imperial Cancer Research Fund for their annual meeting which would take place on July 14th, with the Duke of Bedford in the chair.

It was decided to recognise the Dreadnought Hospital, Greenwich, for the purposes of study required for the Diploma of Fellow. Laval University, Quebec, McGill University, Montreal, and the Italian Royal Universities were added to the list of Universities whose degrees are accepted, under certain conditions as qualifying for admission to the final examination for the Fellowship.

The list of candidates who were awarded the Fellowship Diploma at this meeting will be found under the heading of "Pass Lists."

The President reported that he had received a letter from the Director-General of the Survey Department of the Egyptian Government asking that facilities may be given to Dr. Elliot Smith and Dr. Wood Jones, of the Cairo Medical School, to carry out in the museum of the college an examination of a collection of material found in the course of excavations made in the Nile Valley, and representing the varied races of people who inhabited Nubia in ancient times. The Egyptian Government has offered to the museum of the college the collection of material which is sent over for the purpose of this comparative study. The President stated that he had informed the Director-General of the Egyptian Survey Department that facilities would be given Dr. Elliot Smith and Dr. Wood Jones to carry out their investigations in the manner suggested. The Council thereupon resolved that the Egyptian Government be informed that the Council would regard the collection of specimens as a most valuable addition to the museum, and would accept the collection with grateful thanks.

A letter was read from Mr. J. W. Batterham, F.R.C.S., reporting that Mr. Thomas Lambert Hinton, who became a member of the college in the year 1833, died at St. Leonards-on-Sea, on the 14th instant, at the advanced age of 100 years 45 days.

The Position of the Royal College of Surgeons and the Irish Universities Bill.

During the past week the Prime Minister received privately at the House of Commons a deputation from the Royal College of Surgeons in Ireland to ask him to consider in a sympathetic spirit the injurious effect likely to be produced on the College and its School by the Universities Bill as it stands. It was pointed out to Mr. Asquith that the medical school of the Royal College of Surgeons in Ireland enjoyed no State endowment, that such an endowment was to be given to the Cecilia Street Medical School, Dublin, and that the advantage thus given to the latter institution would prove ruinous to the former. The deputation also emphasised the popularity of the diploma of the Royal College of Surgeons in Ireland conjoined with that of the Royal College of Physicians. The injury to the medical school of the Royal College of Surgeons must react unfavourably on the College itself. Sir Edward Carson introduced the deputation, and supported its prayer. Mr. Lentaigne, President of the College, and Sir Henry Swanzy, ex-President, put the case on behalf of the College, and Sir William Collins, Sir John Batty Tuke, and Mr. Butcher, all, like Sir E. Carson, University representatives, asked the Prime Minister to meet them as favourably as possible. Mr. Asquith promised that the arguments laid before him should receive careful consideration.

In committee on the Bill on Friday last Mr. Butcher proposed an amendment giving the Commissioners under the Bill power to affiliate the School of the College to the new University. Mr. Birrell said that the College had not as yet asked to be affiliated, and that he did not know that they wished to be. The amendment was lost. Later Mr. Birrell indicated that his sympathies were in favour of the affiliation of the College.

Irish Graduates and the Scottish Medical Diplomates' Associations.

At a recent conjoint meeting of members of the Councils of the Irish Graduates and the Scottish Medical Diplomates' Associations, it was proposed by Sir Charles Cuffe, seconded by Mr. Sydney Stephenson, and carried unanimously:—"That this meeting of representatives of the Councils of the Scottish Medical Diplomates and Irish Medical Schools' and Graduates' Associations protest against the advertisement in the medical and lay press for the appointment of a surgeon to the Miller Hospital, Greenwich, whereby an unmerited slur is cast upon the Fellows of the Royal College of Surgeons of Edinburgh, the Faculty of Physicians and Surgeons of Glasgow, and the Royal College of Surgeons of Ireland in excluding such Fellows from candidature for the appointment, although members and Fellows of the Colleges of Physicians of both countries are not so disqualified for appointments as physicians to this hospital."

A Tuberculosis Prevention Bill for Ireland.

The text has been issued of a Bill, which was introduced by Mr. Birrell a few days ago, to prevent the spread and provide for the treatment of tuberculosis in Ireland. The Bill is divided into four parts. Part I. deals with notification and disinfection and contains *inter alia* the following provisions:—

If any medical practitioner attending on any person becomes aware that that person is suffering from tuberculosis of any form, or at any stage, and in any circumstances prescribed by an Order of the Local Government Board under this section, the medical practitioner shall forthwith send to the medical officer of health of the district in which the patient is a certificate in the prescribed form and containing the prescribed particulars.

The Local Government Board may from time to time by Order prescribe the forms and stages of tuberculosis to which, and the circumstances in which, this section shall apply.

If any medical practitioner required by this section to send a certificate fails to send the certificate forthwith, he shall be liable on summary conviction to a penalty not exceeding forty shillings.

The sanitary authority shall pay to every medical practitioner for each certificate duly sent by him in relation to a patient in their district a fee of one shilling if the case occurs in an infirmary, public hospital, or workhouse, and a fee of two shillings and sixpence if the case occurs elsewhere.

Where the medical practitioner required by this section to send a certificate is himself the medical officer of health of the district, he shall be entitled to the fee to which he would be entitled if he were not such officer.

The Local Government Board may make regulations for carrying into effect the provisions of this section, and such regulations shall, among other matters, prescribe the form of certificate to be sent under this section and the particulars to be inserted therein, and shall provide for the proper custody of all certificates, and for securing that, so far as is, in the opinion of the Board, consistent with the public advantage, no publicity shall be given to any of the particulars contained in any such certificate.

Part II. deals with the establishment of hospitals and dispensaries for the treatment of tuberculosis, and provides that a County Council may, if they think fit, provide hospitals and dispensaries for the treatment of inhabitants of their county suffering from tuberculosis, and for that purpose may—(*a*) themselves establish and maintain such hospitals and dispensaries; or (*b*) enter into an agreement with any person having the management of any hospital or dispensary for the reception, maintenance, and treatment therein of any such inhabitants of their county as aforesaid.

Part III. contains sanitary provisions and provisions relating to lectures and to the distribution of information relating to tuberculosis. It contains the following provision amongst others:—

A sanitary authority may, with the approval of and subject to such conditions as may be prescribed by the Local Government Board, provide and pay for the delivery of public lectures within their district, and for the distribution of pamphlets, notices, and leaflets on subjects relating to tuberculosis, and may, with the like approval and subject to the like conditions, provide any drugs or appliances which would tend to prevent or check the spread of the disease.

A County Council may appoint for their county a bacteriologist, with such qualifications and at such remuneration as may be approved by the Local Government Board, for the examination of meat or milk or milk products, and of sputum or pathological specimens, and may, at their discretion, dismiss such bacteriologists.

Part IV. contains various "general" provisions, definitions, etc.

PASS LISTS.

Royal College of Surgeons of England—Fellowship Examination.

The following candidates having passed the Final Examinations for the Fellowship (all of whom were qualified in Medicine and Midwifery), received the Diploma of Fellow on Thursday last, June 18th:—

John J. Urwin, Capt. I.M.S., M.B.Glasg.; Archibald M. H. Gray, M.D.Lond.; Geoffrey S. Hett, M.B.Lond.; Clifford A. Moore, M.B.Lond.; Harold Rischbieth, L.R.C.P.; Hamilton Irving, M.B.Lond.; James G. Gibb, M.B.Durh.; Montague L. Hine, M.D.Lond.; Charles M. Page, M.B.Lond.; Robert Davies-Colley, L.R.C.P.; Donald W. Roy, M.B.Camb.; Samuel W. Daw, M.B.Lond.; Alexander Kinder, M.B.New Zeal.; Harold A. R. E. Unwin, M.B.Camb.; Claud H. S. Frankau, L.R.C.P.; George C. E. Simpson, M.B.Camb.; Wilfred W. Holtzmann, M.B.Camb.; Arthur R. Short, M.D.Lond. F. J. F. Barrington, George P. Mills, and Chas. H. Smith also passed, but have not attained the legal age of 25 years.

Trinity College, Dublin.

At Trinity Term, the following candidates passed the Examination for the Diploma in Public Health:—Part I.—George E. Nesbitt, Thomas O. Graham, Richard G. S. Gregg, William R. Galwey.

Part II.—George E. Nesbitt, John A. Pringle, William R. Galwey, Thomas O. Graham.

NOTICES TO CORRESPONDENTS, &c.

☞ Correspondents requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," etc. Much confusion will be spared by attention to this rule.

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THE AUSTRIAN TYROL AS A HEALTH RESORT.

The value of the mountainous province known as the Austrian Tyrol can hardly be over-estimated as a health resort. The air, even in mid-winter, is pure, mild and bracing. The valleys are sheltered in spite of their high altitude, and offer climatic conditions suitable to many maladies, such as anæmia, neurasthenia, heart disease and many early pulmonary conditions. The magnificent scenery should alone suffice to render this country one of the most popular of touring grounds. Special hotel advantages may be obtained for medical men and their families. Particulars may be obtained by application to the Editor of the Medical Press and Circular.

Fibroid.—We know of no such person. Of course, he is not on the Medical Register. Our judgment is that the less you have to do with him the better. "Systems" of that kind are generally synonymous for something much less desirable.

K., D., S. & Co., Ltd.—We are sorry we can say nothing in favour of the pamphlet, and fear it will do little to promote the cause of public morality. We do not see that it will tell any parent or schoomaster anything he does not know well already. The writing is clumsy; the ideas confused; and the "humour" in bad taste.

CHINA TEA.

To the Editor of The Medical Press and Circular.

Sir,—There seems to be a concerted action on the part of the chairmen of the numerous companies who deal in Indian and Ceylon teas to deplore that medical men "in their ignorance" recommend the use of China tea to their patients. It is quite clear that they (medical men) are disinterested in doing so, as many of their patients from dyspepsia owe their troubles to the modern fashion of drinking strong astringent teas at all hours of the day.

It is an interesting sidelight on the subject that a majority of the persons engaged in exploiting the produce of our dependencies *drink China tea themselves*, notwithstanding that it is prepared by hand labour, the highly-coloured details of which are revived from time to time when it is found that people of light and leading are not to be deterred from its use, to the great benefit of their digestions.

Yours truly,
The Secretary of the China Tea Association.
Chesterfield House, London, E.C.,

L.R.C.P.Lond.—The Institution about which you inquire is a quack concern, started some years ago by an individual who was struck off *The Register* for "infamous conduct." We are not surprised to hear that a patient of yours was "had," to use your expression; he is not the first by a long way. He would however, find the money would be disgorged if it were found to be his determination to bring the case into Court.

Meetings of the Societies, Lectures, &c.

Wednesday, June 24th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. M. White: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. W. Carr: The Treatment of Acute Pneumonia.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Cliniques: Medical Out-patient (Dr. Whipham); Skin (Dr. Meachen); Eye (Mr. Brooks).

Thursday, June 25th.

Royal College of Physicians of London (Pall Mall East).—5 p.m.: Croonian Lecture:—Dr. A. E. Garrod; Inborn Errors of Metabolism.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. W. D'E. Emery: Lumbar Puncture.

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—2.30 p.m.: Gynæcological Operations (Dr. Giles). Cliniques: Medical Out-patient (Dr. Whiting); Surgical (Mr. Carson); X-Rays. 3 p.m.: Medical In-patient (Dr. Chappel). 4.30 p.m.: Demonstration of Selected Medical Cases (Dr. Auld).

Friday, June 26th.

Medical Graduates' College and Polyclinic (22, Chenies Street, W.C.).—4 p.m.: Dr. D. Grant: Clinique. (Ear.)

North-East London Post-Graduate College (Prince of Wales's General Hospital, Tottenham, N.).—10 a.m.: Clinique: Surgical Out-patient (Mr. J. H. Evans). 2.30 p.m.: Surgical Operations (Mr. Edmunds). Cliniques:—Medical Out-patient (Dr. Auld); Eye (Mr. Brooks). 3 p.m.: Medical In-patient (Dr. R. M. Leslie).

Saturday, June 27th.

Royal Society of Medicine (Otological Section) (at the Ear and Throat Department, Royal Infirmary, Edinburgh).—10 a.m.: Demonstration: Professor Cunningham. Cases and Specimens: Drs. McBride, A. Logan Turner, Henry Wade, J. S. Fraser, W. G. Porter, J. M. Darling, A. Bronner, Dundas Grant, W. Permewan, C. A. Ballance, MacLeod Yearsley, Richard Lake, Gibbon, Urban Pritchard, Sydney Scott, Albert Gray, W. Milligan, and T. Barr.

Vacancies.

County Borough of Derby.—Medical Officer of Health. Salary, £600 per annum, office assistants, clerks, etc., being provided. Applications to G. Trevelyan Lee, Town Clerk, Town Clerk's Office, 15, Tenant Street, Derby.

London County Asylum, Bexley, Kent.—Junior Assistant Medical Officer. Salary, £100 a year, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, London, S.W.

Portsmouth Borough Asylum.—Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Hamlet of Mile End Old Town.—Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to Benjamin Catmur, Acting Clerk to the Guardians, Guardians' Office, Bancroft Road, Mile End, London, E.

Leicestershire and Rutland Lunatic Asylum.—Junior Assistant Medical Officer. Salary, £150 per annum, with board, lodging, and washing. Applications to W. J. Freer, Esq., 10, New Street, Leicester.

Fermanagh County Hospital.—House Surgeon. Salary at the rate of £72 per annum, with Board, &c. Applications to C. Wilson, Secretary. (See Advt.)

Manchester Royal Infirmary.—Honorary Assistant Surgeon. Applications to W. G. Carnt, General Superintendent and Secretary. (See Advt.)

Appointments.

Clowes, Edward Francis, L.R.C.P.Lond., M.R.C.S., Medical Officer for the Charfield District by the Thornbury (Gloucestershire) Board of Guardians.

Davidson, J. A., M.B., Ch.B.Aberd., Clinical Assistant to the Chelsea Hospital for Women.

Eakin, David, M.B., Ch.B.Edin., Medical Officer and Public Vaccinator to the Driffield Board of Guardians.

Glasier, H., M.B., B.S.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Mildenhall District of the county of Suffolk.

Hill, Francis R., M.B., C.M.Glasg., Surgeon in Charge of the new Eye Department of the Cumberland Infirmary, Carlisle.

Locke, W. Lindsay, M.B., Ch.B.Edin., House Surgeon to the Carnarvonshire and Anglesey Infirmary, Bangor.

Milward, F. Victor, M.B., B.C.Cantab., F.R.C.S.Eng., Honorary Surgeon to the Royal Orthopædic and Spinal Hospital, Birmingham.

Pritchard, Eric, M.D.Lond., M.R.C.P.Lond., Physician to Outpatients at the City of London Hospital for Diseases of the Chest.

Scott, G. Waugh, M.B., Ch.B.Glasg., Medical Officer to Bundi Tin Mines, Malay Peninsula.

Sinclair, Alexander, M.D.Toronto, Clinical Assistant to the Chelsea Hospital for Women.

Stewart, George Irvine Thompson, M.B., C.M.Aberd., F.R.C.S. Eng., Medical Inspector of School Children to the East Suffolk County Education Committee.

Marriages.

Armitage—Major.—On June 20th, at All Saints', Margaret Street, London. Charles Ernest Augustus Armitage, M.A., M.B., elder son of Charles Armitage, C.E., of Scaleford, Lancaster, to Gladys Emily, youngest daughter of the late John Clarkson Major, of The Bhylls, Wolverhampton.

Hallam—Edge.—On June 17th, at the Parish Church, Shifnal, Salop, Arthur Rupert Hallam, M.D.Edin., eldest son of Mr. and Mrs. Arthur Hallam, of Sheffield, to Kathleen Marian, second daughter of Mr. and Mrs. Joseph Edge, of Shifnal.

Deaths.

Abrahams.—On June 21st., at 14, Welbeck Street, Cavendish Square, Bertram Abrahams, M.B., B.Sc. (Lond.), F.R.C.P., aged 38, only son of Louis B. Abrahams, of The Cabin, Seaforth Road, Westcliff-on-Sea.

Ellerton.—On June 17th, at Leamington, Frederic Charles Grant Ellerton, M.R.C.S., L.R.C.P.Edin., second son of the late J. F. Ellerton, H.E.I.C.S., in his 89th year.

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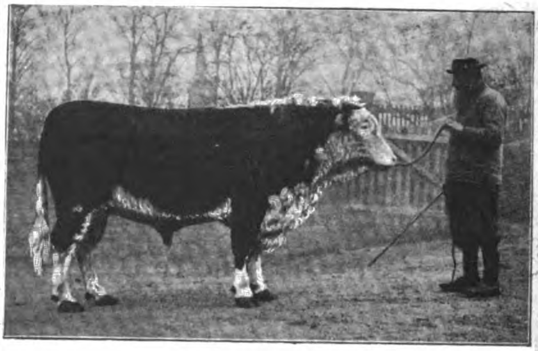

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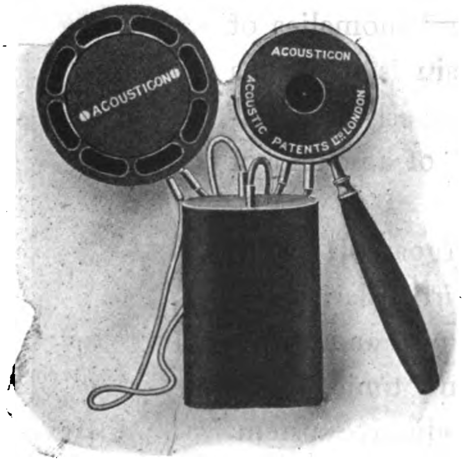

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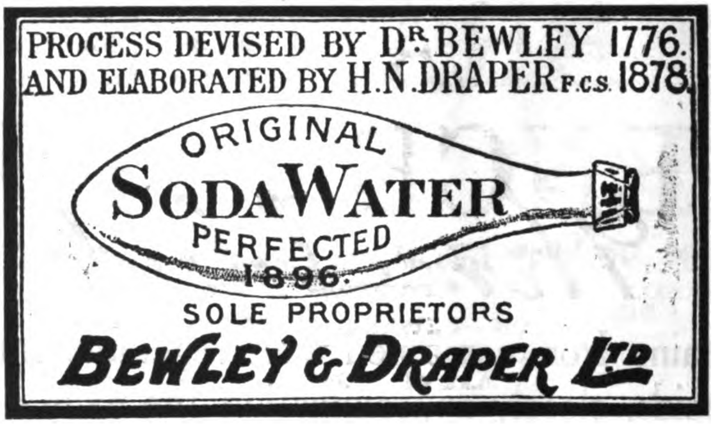
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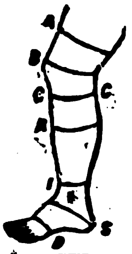

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